When care is needed: the role of whistleblowing in promoting best standards from an individual and organizational perspective

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Abstract

Purpose – *The aim of this paper is to scan the evidence and to make sense of the processes underpinning the maintenance of care standards and the meaning and significance of whistleblowing in the available literature. It formed part of a project examining attitudes to whistleblowing in the care of older people in Wales. The paper focusses on the actions of employees within organizations (such as hospitals or domiciliary care organizations) or professional groups (such as nurses and doctors) but does not include reference to whistleblowing or the raising of concerns by members of the public (such as relatives or patients).*

Design/methodology/approach – *Published literature concerning whistleblowing in the UK and internationally was considered. Health and social care databases were searched (including PubMed, MEDLINE, CINAHL, BNI, PsychLit, ERIC) and a wide variety of opinion pieces, research and theoretical explorations were accessed. Additionally, because whistleblowing occurs in workplaces other than health and social care, databases in the humanities, law and business were also searched. Other useful documents included public inquiry reports on matters both of public concern occurring in health and social care (e.g. The Shipman Inquiry, The Bristol Inquiry) as well as inquiries into events outside of this sector where whistleblowing was significant.*

Findings – *There is no widely accepted theoretical framework or universally accepted conceptual underpinning for whistleblowing in the literature. This paper reveals various associated meanings, but all sources agree that whistleblowing is an imposed, rather than a chosen, situation and that whistleblowers are usually ordinary people who become aware of negative situations forcing them into a decision to remain silent, or to speak out. Another area of agreement within the literature is that the term whistleblowing has attracted overwhelmingly negative connotations. The simple choice between taking action or remaining silent belies the complexity of workplace cultures; including the care of older people.*

Originality/value – *The paper explores a range of published sources from health care as well as other sectors. Although whistleblowing has been recognized as making an important contribution to patient safety, and the saving of lives, it has also had a somewhat tortured history in the health and social care sector, as well as in other industries. This paper explores whistleblowing in the context of recent UK policy developments and suggests the need for workplace cultures to be better understood; as well as promotion of open communication regarding concerns or unsafe practices.*

Keywords *Safety, Whistleblowing, Workplace culture*

Paper type *General review*

Introduction

The authors wish to acknowledge the Older People's Commissioner for Wales for funding this project.

Although whistleblowing has been recognized by authoritative reviewers as making an important contribution to patient safety (Bolsin *et al.*, 2011) and saving lives (Public Concern at

Work, 2008), it has also had a somewhat tortured history in the health and social care sector, as well as in other industries. A highly critical House of Commons Health Select Committee report (2009) stated: "The NHS remains largely unsupportive of whistleblowing, with many staff fearful about the consequences of going outside official channels to bring unsafe care to light."

The fate of whistleblowers is characteristically bleak in that if they have not already decided to resign they can often be dismissed (Gallagher, 2010). There is also the prospect of those remaining being blacklisted or ostracized by colleagues leading to personal suffering with marital breakdown, long-lasting health, financial and personal problems being documented (Perry, 1998; Jackson *et al.*, 2010). Those who choose to remain silent in the face of apparent wrongdoing are similarly negative as they too may experience significant physical and emotional sequelae (McDonald and Ahern, 1999) and moral distress (Corley *et al.*, 2001).

Whistleblowers have been described in the literature as courageous employees who act to maintain standards against the might of an organization (Jackson and Raftos, 1997), and who do so sometimes at great personal cost (Iliffe, 2002). An alternative view, and one that is sometimes promulgated by targeted organizations (Firtko and Jackson, 2005), is that whistleblowers are malcontents, who will stop at nothing to pursue their own agenda, regardless of the destructive and negative outcomes of their actions – either for colleagues or for organizations. Whether the whistleblower is viewed as a "tragic hero" or "trouble-maker" it is precisely because of the concept's anomalous character that whistleblowing remains of special interest:

> In my view individuals must be encouraged to raise their honest concerns; they need to know how to do it and they need to have the confidence that, if they do, those concerns will be taken seriously and that they will not be victimized in any way (The Shipman Inquiry, Final Report, 2004, p. 319).
>
> You have a duty to raise concerns, but you don't […] you don't kick up a fuss, a great kerfuffle, get it plastered all over, and get a rapping […] and then nothing happening (Registered Nurse working in the NHS; Attree 2007, p. 395).

Purpose

As systems of health and social care governance in the UK and beyond become increasingly complex, whistleblowing has evolved into an important consideration in public policy circles in terms of how institutions are viewed as trustworthy and accountable. Limitations to the current system of reactive justice have resulted in Governments, public bodies and organizations reacting to episodes of mistreatment by implementing a system of proactive protection of public interest via "identifiable integrity systems" (Brown, 2007) such as whistleblowing and complaint procedures. Such systems testify to the fact that few individuals are better placed to observe or suspect wrongdoing within an organization than its own employees. In the UK this has been brought into sharp relief recently by the Mid Staffordshire Inquiry into the avoidable deaths of several hundred patients, which established that nurses had reported concerns internally about the quality of patient care on over 500 occasions.

Whistleblowing by employees has been explored extensively in the business, law and healthcare literature over the last 20-30 years, and is a phenomenon which continues to attract attention worldwide. Since the 1990s empirical evidence appears to suggest that the number of whistleblowing cases, and the public support for whistleblowing, have risen; although the interest of the media in whistleblowing is far outpacing the growth of academic research on the issue (Near and Miceli, 2005; Liyanarachchi and Newdick, 2009; Bjørkelo *et al.*, 2011).

The aim of this paper is to scan the evidence and to make sense of the processes underpinning the maintenance of care standards and the meaning and significance of whistleblowing in the available literature. It formed part of a project examining attitudes to whistleblowing in the care of older people in Wales (Older Persons' Commissioner for Wales, 2012). Following the rationale of Greenhalgh *et al.* (2009) we undertook the review in this way for the following reasons: first, comprehensive reviews and a meta-analysis of the literature have already been produced in several papers; second, a more exhaustive search of all relevant fields was not feasible; and third, we considered that making sense of the literature was a worthy goal in its own right.

This research scan addresses the following questions:

1. What bodies of knowledge and specific research traditions are relevant to the understanding of employee whistleblowing?
2. What are the key concepts, theories, and methodological approaches to be considered?
3. What are seen as the seminal theoretical works and high quality empirical studies?
4. What are the main empirical findings, and what may be concluded from them?

The paper focusses on the actions of employees within organizations (such as hospitals or domiciliary care organizations) or professional groups (such as nurses and doctors) but does not include reference to whistleblowing or the raising of concerns by members of the public (such as relatives or patients).

Methods

Published literature concerning whistleblowing in the UK and internationally was considered. Health and social care databases were searched (including PubMed, MEDLINE, CINAHL, BNI, PsychLit, ERIC) and a wide variety of opinion pieces, research and theoretical explorations were accessed. Additionally, because whistleblowing occurs in workplaces other than health and social care, databases in the humanities, law and business were also searched. Other useful documents included public inquiry reports with a focus on matters both of public concern occurring in health and social care (e.g. The Shipman Inquiry, The Bristol Inquiry) as well as inquiries into events outside of this sector where whistleblowing played a significant role (e.g. The Space Shuttle Challenger Congressional Inquiry, Vaughan, 1996).

What's in a name? Defining whistleblowing and/or raising concerns?

> Whistleblowers cannot be stereotyped […] Motivation can range from the most altruistic to the most self-serving. Some whistleblowers are conservative, others are liberal, some are braggarts, others self-effacing; some are gregarious, others are painfully shy. Their jobs range from maintenance positions to seats in high management. What they have in common is that they have learned something that they are unwilling to keep to themselves, and the have chosen to act on that knowledge. (Tom Devine, Legal Director of the United States Government Accountability Project).

There is no widely accepted theoretical framework or universally accepted conceptual underpinning for whistleblowing in the literature (Lewis, 2006; Jackson *et al.*, 2010). A search of published definitions reveals various associated meanings, but all agree that whistleblowing is an imposed, rather than a chosen, situation and that whistleblowers are usually ordinary people who become aware of a negative situation forcing them into a decision to remain silent, or to speak out (Iliffe, 2002).

Another area of agreement within the literature is that the term whistleblowing has attracted overwhelmingly negative connotations; often being associated with individuals "snitching" (Welsh Institute for Health and Social Care, 2010) or "grassing" (Attree, 2007) on colleagues. Some commentators have suggested that the emotionally laden undertone related with the word "whistleblowing" (and its derivatives) has actually resulted in the term becoming a powerful deterrent to employees speaking out (Peternelj-Taylor, 2003). However, the perceived negativity of the term has not prevented health and social care organizations from producing "Whistleblowing policies" to guide staff to deal with the concerns they wish to raise.

Somewhat befitting of a word that is often related to dispute, the etymology of the terms "whistleblowing" and "whistleblower" are contested, with Bolsin *et al.* (2011) describing the whistleblower as:

> A person who raises concern about wrongdoing. The term is quintessentially English derived from the practice of police officers blowing their whistles to alert colleagues and the public when they saw a crime committed and needed assistance (p. 278).

Elsewhere, the word is reported by Eby (1994) as originating from:

> The world of sport and refers to the referee blowing the whistle to stop play when a foul is suspected or observed (p. 60).

According to Vandekerckhove (2006), a large majority of the literature on whistleblowing in an organizational context can be traced to a conference held in 1972 and a resulting publication by Nader *et al.* (1972). Since then the term whistleblowing has been firmly embedded into the public consciousness through such popular films as *The Whistleblower* (2010), *Time* magazine declaring 2002 "Year of the Whistleblower" and public inquiries revealing the extent which organizations and agencies refused to heed the concerns of employees with disastrous consequences ("9/11", The Bristol Royal Infirmary Inquiry, etc.).

Whistleblowing's entry into public consciousness has been accompanied by an assortment of academic studies. Quantitative and qualitative research methods have been employed in a variety of studies and settings to ascertain, for example, the antecedents of whistleblowing; to describe the effects of choosing to blow the whistle; to compare different institutional approaches to whistleblowing and to debate the conceptual definition of whistleblowing itself (Teo and Caspersz, 2011). However, the predominant method applied in empirical studies of whistleblowing in healthcare and other organizations has been survey methods (Jackson *et al.*, 2010; Teo and Caspersz, 2011) to gauge perceptions and attitudes.

The most widely used definition sees whistleblowing described as a:

> Disclosure by organization members (former or current) of illegal, immoral or illegitimate practices under the control of their employers, to persons or organisations that may be able to effect action (Miceli and Near, 2002, p. 689).

The definition is popular within academia as it is broad, allowing for a wide initial conception of whistleblowing and for the many variations it can take. A similarly broad definition from the work of McDonald and Ahern (2000) is often quoted within healthcare literature, where a whistleblower is defined as one:

> Who identifies an incompetent, unethical, or illegal situation in the workplace and reports it to someone who may have the power to stop the wrong (p. 314).

The term "raising concerns," or the "raising of concerns," has been suggested as a more positive, less stigmatized phrase to whistleblowing. Dame Janet Smith, who chaired the Shipman Inquiry, reported her wish to avoid using the expression "whistleblowing," but found that avoiding the term was difficult due its ubiquity, particularly within policy documents. She also found that many witnesses to the Inquiry used the term whistleblowing synonymously with the phrase "the raising of concerns" (The Shipman Inquiry, 2004, p. 319). Bolsin *et al.* (2011, p. 278) similarly use these terms interchangeably when they write, "a whistle-blower is defined as a person who raises concern about a wrongdoing."

While whistleblowers in health and social care have both internal (within the organization) and external (bodies outside of the organization, e.g. police, professional bodies) reporting channels available to them for raising concerns, research suggests that nearly all whistleblowers will attempt, initially, to report wrongdoing via internal channels before utilizing (or in lieu of) external channels (Miceli and Near, 2002; Attree, 2007).

There are four common situations (Bolsin *et al.*, 2011) in which an employee may consider raising concerns, although there is overlap in each situation:

1. reporting on the systemic failure of an organization (e.g. a doctor raises concerns about staff shortages leading to poor standards of care for older people at Tameside General Hospital);
2. requesting a review of the clinical outcomes of a whole department (e.g. Bristol Paediatric Heart Surgery);
3. reviewing poor clinical outcomes involving a single individual (e.g. Harold Shipman, Beverly Alllitt events); and
4. anticipating and reporting a single catastrophic event (Baby Peter affair).

The process of whistleblowing is described by Bjørkelo *et al.* (2011) as an activity consisting of five stages. These are discussed below with the addition of other sources that expand on certain stages of the process:

- *Discovery* – the wrongdoing observed.
- *Evaluation* – the wrongdoing is evaluated as wrong or illegal. The perceived cost and effect of the effort of whistleblowing is also evaluated.
- *Decision* – to report the wrongdoing, or not. If the cost is too high and perceived effect is too low then whistleblowing tends to be suppressed. It has been argued that whistleblowers' loyalty to principles, commitment to preventing harm and concern with moral practice, so outweigh all other factors that there is no "deciding" when they are faced with the possibility of blowing the whistle – they have a "choice less choice" (Alford 2001, p. 40).
- *Reaction to the whistleblowing* – varies from whistleblowers being victimized/persecuted for their actions to, more rarely, being lauded for their actions. According to McDonald and Ahern (2000) no matter how legitimate the concern, or how serious the offence, whistleblowers will almost certainly be victimized to some degree for reporting an incident.
- *Evaluation of the reaction* – often determines whether the whistleblower and/or others decide to whistleblow in the future.

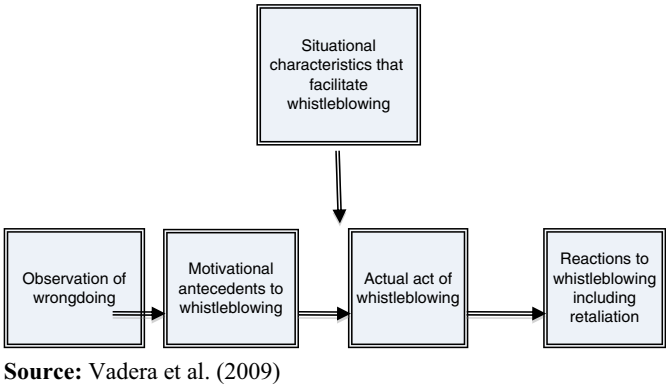
The recent review of whistleblowing in business by Vadera *et al.* (2009) provides an useful schematic of the extant literature (see Figure 1). This links with the stages described by Bjørkelo *et al.* (2011).

Several studies have variously explored the evaluation/decision stage (Bjorkelo *et al.*, 2011), or the motivational antecedents/situational characteristics of whistleblowing. However, those seeking clear answers to questions about the characteristics of individual whistleblowers may be disappointed. For example, no studies appear to examine age of whistleblowers, although Mesmer-Magnus and Viswesvaran (2005) state that "we would expect that older employees are also more likely to follow through and blow the whistle" (p. 289).

Studies are also split on the issue of gender. For example, females were more likely than males to "blow the whistle" according to Mesmer-Magnus and Viswesvaran (2005, p. 285), in contrast Keenan's (1995) study found that males were more likely to do so.

The meta-analysis of 193 whistleblowing correlations obtained from 26 samples ($n = 18{,}781$) undertaken in the field of business studies by Mesmer-Magnus and Viswesvaran (2005) consisted, unsurprisingly, of the largest mass of data reported in one study. While they report that results differed slightly across studies, whistleblowers (compared to inactive observers)

Figure 1 Schematic representation of the extant literature on whistleblowing in business studies



Source: Vadera et al. (2009)

tended to have good job performance, were more highly educated, held higher level or supervisory positions, scored higher on tests of moral reasoning and valued whistleblowing when confronted with unethical behavior.

This meta-analysis provides a useful insight into the complexity inherent within the topic of whistleblowing. However, the authors caution readers as only two studies examined whistleblowing from the perspective of both intended and actual whistleblowing. This warning is particularly relevant when we consider that stronger relationships were found between personal, contextual and wrongdoing characteristics and whistleblowing intent than with actual whistleblowing.

In comparison to business studies and law the antecedents and consequences of whistleblowing, as well as the beliefs and values of whistleblowers, have not been well described well in the nursing or health and social care literature (Black, 2011). Most research in health and social care has been undertaken in relation to nursing; however, many studies have tended to focus on hypothetical scenarios or intentions. For example, King (2001) asked nurses what they would do if confronted with an unethical situation, or if they had concerns about practice standards (Burrows, 2001; Beckstead, 2005; Attree, 2007). However, in light of the earlier quoted "psychological distance" between intention and overt action seen in the business and law research these studies are obviously limited.

Factors that mitigated against nurses raising concerns include the possibility of retribution, repercussion, labeling and prediction of inaction to address the situation (Kingston *et al.*, 2004; Attree, 2007). However, nurses were found to be much more likely to report wrongdoing compared to doctors (Firth-Cozens *et al.*, 2003; Kingston *et al.*, 2004).This raises the question about socialization practices, as well as the benefit of education and training to overcome them.

As Jackson *et al.* (2010) state the impact of being a whistleblower can be divided into professional effects (McDonald and Ahern, 2000; Kingston *et al.*, 2004; Attree, 2007; Ohnishi *et al.*, 2008); physical and emotional effects, and effects on the whistleblower's personal life (McDonald and Ahern, 2000; Firth-Cozens *et al.*, 2003; Kingston *et al.*, 2004; Calcraft, 2005). The extent of these effects is also described as having a negative correlation with the likelihood of whistleblowing occurring.

Interestingly McDonald and Aherne (1999) report that nurse whistleblowers reported effective coping behaviors compared to non-whistleblowers. The authors proceed to explain that the whistleblowers in their study were more experienced, and a higher percentage reported advanced levels of education. Literature from psychology (Lazarus and Folkman, 1984) indicates that experience and education are moderating variables when individuals determine how they respond to a stressful event, whilst research in nursing also suggests that experience and higher education increase the nurse's ability to cope with ethical dilemmas (e.g. Chafey *et al.*, 1998; McAlpine, 1996; Soderburg and Norberg, 1993).

A large whistleblowing survey of nurses ($n = 752$) in the UK found that 68 percent of respondents said they had a concern about a serious risk to patient safety in the three years preceding the survey, with 87 percent of respondents actually raising their concerns (Public Concern at Work, 2008). The majority of the nurses who responded (58 percent) worked in a hospital and nearly two-thirds (64 percent) had worked in nursing for more than six years. Nurses with six years or more experience were more likely to blow the whistle (90 percent) than nurses with less than six years experience (80 percent). This suggests the need to pay attention to junior nurses' needs.

Although 17 percent of nurses said their organizations had used their whistleblowing arrangements to discourage staff from raising concerns, the main reason cited by respondents for not doing so was that they felt their actions would make little difference, followed by loyalty to colleagues and a fear of disapproval by colleagues. Fewer nurses working outside the NHS (30 percent) reported that serious concerns were handled fairly or well, compared to those within the NHS (51 percent) and twice as many (65 percent) non-NHS nurses reported suffering reprisals for speaking up (34 percent in the NHS). Although nurses, both in and out of the NHS, suggest that inaction is the strongest deterrent, nurses outside the NHS identified the fear of dismissal or discipline as having a stronger deterrent effect than a worry about the reaction

of other colleagues. However, within the NHS more nurses in primary care (45 percent) reported suffering reprisals for raising their concerns compared to those working in the hospital sector (29 percent). Once again this suggests the need for more research and innovations in training across different sectors where older people actually receive care.

Problems with narrow definitions of whistleblowing

As already pointed out, some definitions suggest that all occasions of staff raising concerns, either internally or externally, can be considered as whistleblowing. The problem with such a blanket definition is that some events, such as completion of an incident report or verbal reporting to line managers is routine and desirable professional behavior which might be undermined by calling it whistleblowing (Firtko and Jackson, 2005).

Another tendency sees the research literature, and the media, presenting employees, when confronted with wrongdoing, as having a straight choice between either speaking out or remaining silent. This inclination to divide the issue of staff reporting their concerns into two sharply contrasting behaviors is illustrated in one of the earliest research papers examining whistleblowing in nursing. McDonald and Ahern (1999, p. 5) outlined that "when misconduct or incompetence is identified in the patient care setting […] the nurse must decide whether to report the incident ('blow the whistle') or remain silent ('non-whistleblow')."

Positioning whistleblowing as an "all or nothing" event can also be seen in the comments made in 2009 by the then health secretary, Alan Johnson. Commenting on failings estimated to have resulted in between 400 and 1,200 deaths at Mid Staffordshire Foundation Trust, Mr Johnson said he was "amazed" that nurses and doctors "failed to blow the whistle on poor practice" (Moore and Smith, 2009). However, the subsequent Mid Staffordshire pubic inquiry found that nurses had raised concerns internally on 515 occasions between 2005 and 2008, strongly suggesting that an outward impression of silent inaction may not always be an accurate representation of true events. Inquiry counsel Tom Baker described the repeated raising of concerns in Mid Staffordshire as "a cry from staff who appear to be being ignored":

> Extract from Staffordshire hospital incident report: "This staffing level at night shift particularly in ward 2 [is] seriously dangerous and this incident form I have done many times. No action no feedback. I am very unhappy about patient care."

Organizational silence

As discussed earlier the complex decision to whistleblow, or not, is always subject to myriad organizational, personal, social and ethical factors. Much effort has been invested by academics interested in reasons why individuals choose not to raise their concerns. For example, the literature on "organizational silence," is defined as:

> The collective-level phenomenon of doing or saying very little in response to significant problems or issues facing an organization or industry (Henriksen and Dayton, 2006, p. 1540).

Researchers have explored forces within organizations that cause "widespread withholding of information" (Morrison and Milliken, 2000, p. 706). Factors favorable to creating an organizational climate conducive to widespread silence include, amongst other things; "tall" organizational structures which see managers less likely to interact with lower-level staff; the belief amongst managers that negative feedback from employees is a threat to the organization's health which, in turn, engenders a belief in subordinates that voicing one's opinions and concerns is dangerous (Morrison and Milliken, 2000; Henriksen and Dayton, 2006).

We agree that organizational silence is a potentially dangerous feature of some workplace cultures which can lead to harm occurring to patients and staff, and as such is a topic area worthy of further consideration. However, we are unsure, in light of the evidence heard at Public Inquiries and empirical literature which suggest that staff frequently raise concerns within organizations, of the value of describing organizational silence as "the *dominant* response within many organisations" (Morrison and Milliken, 2000, p. 707, our emphasis). Instead, where whistleblowing is concerned we would prefer to see health and social care organizations and

cultures being viewed as "patchwork quilts" of events rather than uniform, "smooth fabrics." Silence is likely to flourish in local units where the managers are prone to blame seeking, whereas under conditions which value open discussions and a just culture it is reasonable to expect an increase in the raising of concerns (Henriksen and Dayton, 2006).

The notion that remaining silent is somehow the "easy option" also needs to be challenged. For example, although those who remain silent in the face of misconduct do not experience professional problems, like whistleblowers, they experience many physical and emotional problems (McDonald and Ahern, 1999) as well as moral distress (Corley *et al.*, 2001) because of failure to follow through on their ethical decisions, i.e. nurses knew what they should do, but did not, or could not, do it.

Summary

Health and social care is delivered within a system which is extremely complex, continually changing and subject to high levels of external regulation. Yet despite the existence of an extensive regulatory framework stories of neglect and abuse within health and social care surface with seemingly increasing regularity, with a number of high profile reports over the last few years citing shocking cases resulting in criminal prosecutions.

However, complaints about poor standards of care are not new. As long ago as 1967 serious allegations of abuse and mistreatment of vulnerable, long-stay patients at Ely Hospital in Cardiff led to the Howe Inquiry, which is regarded as the first modern inquiry into the NHS. The Howe report described problems of poor clinical leadership, an isolative and inward-looking culture, inadequate management structures in terms which seem to parallel the findings of later public inquiries such as the Bristol Royal Infirmary (Department of Health, 2001; Walshe, 2003).

Another fact which directly ties the tragedies of Ely Hospital, Bristol Royal Infirmary and more recently Mid Staffordshire is the extent to which staff attempted to raise concerns to more senior decision makers about mistreatment of patients, only to be ignored in one way or another. The Howe Report (Department of Health and Social Security, 1969, p. 2) describe the "indifference on the part of the Chief Male Nurse to complaints that were made to him," leading eventually to a whistleblower (only identified as XY) contacting the News of the World who duly published details of ill-treatment being meted out to patients by a small number of staff[1]. Moreover, those staff members who did raise concerns suffered retribution from colleagues for their actions. In the 45 years since the publication of the Ely report the nature of health and social care has developed beyond all imagination, we now have stem cell technology, key-hole surgery and assistive living technologies, however, in other ways it seems that little has changed in terms of the promotion of dignity and humane interactions in clinical settings:

> I reported the incident to the Chief Male Nurse. He told me that if I made an official complaint I would not be popular with the staff and things could be made unpleasant for me. Things have been unpleasant for me. I have to perform the lowliest tasks which should be done by the cleaners (Testimony of whistleblower XY, Ely Hospital, Cardiff, 1967).
>
> I supported and helped 2 colleagues and the police when they blew the whistle on our manager who had been stealing thousands of pounds from vulnerable elderly residents. We were all hounded out of our jobs and had our lives ruined. This woman was charged and went to prison but our senior managers still did not thank any of us. I would do the same again and will never ignore bad practice, but attitudes and managers actions HAVE to change. We all experienced victimisation, bullying, intimidation, and labelled trouble makers (Reader's comments on Nursing Times discussion thread – 10th August 2010, www.nursingtimes.net/specialist-news/management-news/fear-of-victimisation-stops-nurses-whistleblowing-says-nmc-research/5018050.article).

However, some progress has been made in understanding the nature of whistleblowers and whistleblowing. A body of research has developed that explores employee whistleblowing both from the perspective of the organization and the individual within workplace cultures. At the same time many questions remain unanswered, which, in part, may be due to a tendency by policy makers and researchers to over-simplify the reasons why concerns are raised (or not).

For example, previous research has mainly focussed mainly on actions rather than interactions, focussing on the person blowing the whistle (e.g. the type of person who blows the whistle and what would make them do so), rather than exploring the inherently more complex interactions between those who raise a concern and those (often very vulnerable people) about whom a concern is being raised (Lewis and Vandekerckhove, 2012).

Moreover, we have shown that the silence vs whistleblowing dichotomy overly simplifies an inherently complex set actions and interactions at the personal and organizational level. One effect of this over-simplification is a failure to see, or hear, that raising concerns can (and often does) happen in a multitude of different ways. Therefore as well as questioning why professionals remain silent when confronted with wrongdoing, we suggest questions should also be raised about organizational "unresponsiveness" that occurs when staff do attempt to do so. The refusal to act on the concerns of staff during what has been called the "incubation" period frequently results in the loss of valuable time to rectify a rapidly deteriorating care situation. Thus it is important that both the mechanisms that cause organizational unresponsiveness are identified – as well as the conditions that may predispose individual workers to stay silent – in order that action can be taken and those that concerns which are raised are attended to effectively and fairly.

Conclusion

The ethical and moral issues relating to employees who raise concerns about ill-treatment of patients are complex, but not impossibly so. Coherent arguments can be identified within the literature that will assist the health and social care practitioner, manager and policy maker in making an informed, rational and ethical decision about a course of action in situations where the raising of concerns may be indicated. Some of these actions have been explored in this paper, although we are eager to acknowledge that, inevitably, there is much more that could, and should, be said. When care is needed more attention needs to be paid to how the culture of organizations can best be understood in order to promote a sense of fairness and openness, rather than their opposite.

Note

1. A minister in the then Labour Government, Richard Crossman (1977) reveals in his diaries that senior civil servants at the Department of Health and Social Security were aware of conditions at Ely Hospital. Crossman also gives a fascinating account of attempts by government to keep the Howe Report out of the public domain.

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