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Perceived barriers to whistle blowing in healthcare amongst healthcare professionals

An integrative review

Mandu Stephene Ekpenyong, Mathew Nyashanu, Amina Ibrahim and Laura Serrant

Abstract

Purpose – Whistleblowing is a procedure where an existing or past participant of an establishment reveals actions and practices believed to be illegal, immoral or corrupt, by individuals who can influence change. Whistleblowing is an important means of recognising quality and safety matters in the health-care system. The aim of this study is to undergo a literature review exploring perceived barriers of whistleblowing in health care among health-care professionals of all grades and the possible influences on the whistleblower.

Design/methodology/approach – An integrative review of both quantitative and qualitative studies published between 2000 and 2020 was undertaken using the following databases: CINAHL Plus, Embase, Google Scholar, Medline and Scopus. The primary search terms were “whistleblowing” and “barriers to whistleblowing”. The quality of the included studies was appraised using the Critical Appraisal Skills Programme criteria. The authors followed preferred reporting items for systematic review and meta-analysis (Prisma) in designing the research and also reporting.

Findings – A total of 11 peer-reviewed articles were included. Included papers were analysed using constant comparative analysis. The review identified three broad themes (cultural, organisational and individual) factors as having a significant influence on whistleblowing reporting among health-care professionals.

Originality/value – This study points out that fear is predominantly an existing barrier causing individuals to hesitate to report wrongdoing in care and further highlights the significance of increasing an ethos of trust and honesty within health care.

Keywords Health care, Health-care professionals, Perceived barriers, Whistleblowing

Paper type Literature review

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What is already known about this topic:

- Evidence emerging from published research are necessary and valid sources of knowledge for nursing practice.
- Whistleblowing is a subject that remains to increase concerns in nursing and in the broader health-care setting.
- Whistleblowers are viewed for some as tragic heroes and with others as troublemakers.

What this paper adds:

- This review considers the potential barriers to whistleblowing in health care among nurses and further highlights the significance of rising ethos of trust and honesty within health care.

- It identifies the methodologies used by published studies, the types of evidence produced and the issues in the study.
- It also provides suggestion for further exploration of whether factors such as the level of success of the hierarchy health-care profession or organisation influence the success of the whistle-blowing report, determining how far or how much influential change occurs.

Introduction

The issue related to health-care quality is a worldwide concern. There is a clear understanding of barriers within the literature highlighting concerns among health-care professionals not raising concerns or whistleblowing when required to do so. However, whistleblowers are viewed for some as tragic heroes and with others as troublemakers, with the inconsistent nature of whistleblowing; it makes it a special topic to researchers working in the care of vulnerable individuals (Jones and Kelly, 2014). Whistleblowing is a subject that remains to increase concerns in nursing and in the broader health-care setting (Firtko and Jackson, 2005; Jackson, 2008). Despite nurses existing in the centre of health-care delivery and well positioned to raise apprehensions around care excellence and patient protection issues, substantial evidence shows that endorsing the reports of ongoing wrongdoings have substantial adverse and harmful penalties (Jackson *et al.*, 2010a, 2010b, 2011).

Nevertheless, because of two main reports issued in 2015: The Freedom to Speak Up review, by Robert Francis Report (2015) and Anthony Hooper's (2015) review on cases involving whistleblowers and how they are treated by the General Medical Council (2015), whistleblowing within the National Health Service has become a mainstream topic. The freedom to speak up review was developed following Robert Francis's (2013) inquiry concerning the ideals of care at the Mid Staffordshire National Health Service foundation trust, including the failures to follow up raised concerns by managements and regulators (Francis Report, 2013). The Francis Report (2015) Freedom to Speak Up review supports an open and true reporting ethos in the National Health Service. The purpose of this review was to deliver guidance and recommendations to ensure that National Health Service staff in the UK feels safe to raise concerns and is self-assured that their concerns will be listened to and taken seriously.

The main principles that were highlighted in the review in relation to culture change included normalising raising concerns within the National Health Service to improve how raised concerns are handled; the need for measures to be put in place to support good practice; measures for vulnerable groups and the extension of legal protection. The review also focused on showing that raising concerns is a positive activity that will lead to a learning opportunity rather than a basis of condemnation (Francis Report, 2015). Following the Francis Report, the UK Government supported the recommendations to device a duty of candour on both providers and individuals (General Medical Council, 2015; Nursing and Midwifery Council, 2015). The duty of candour involves the disclosure of information when something goes incorrect with patients' handling of their well-being, which will possibly cause damage. Raising concerns without a fear of being stigmatised is vital to patient health and safety (Holt, 2015). Health-care professionals must be educated on whistleblowing as well as reassured that this will not affect their working circumstance.

Aim

This review aimed at exploring the barriers of whistleblowing within health sectors in Europe, America and Australia, analysing the results obtained.

Method

An integrative review was undertaken using guidelines for identification of both qualitative and quantitative data. We set clear objectives, formulated selection criteria and defined a search strategy for identifying papers. We then analysed the selected articles and synthesised the results using published guides for assessing qualitative ([Critical Appraisal Skills Programme, 2017](#)) and quantitative studies ([Coughlan *et al.*, 2007](#)).

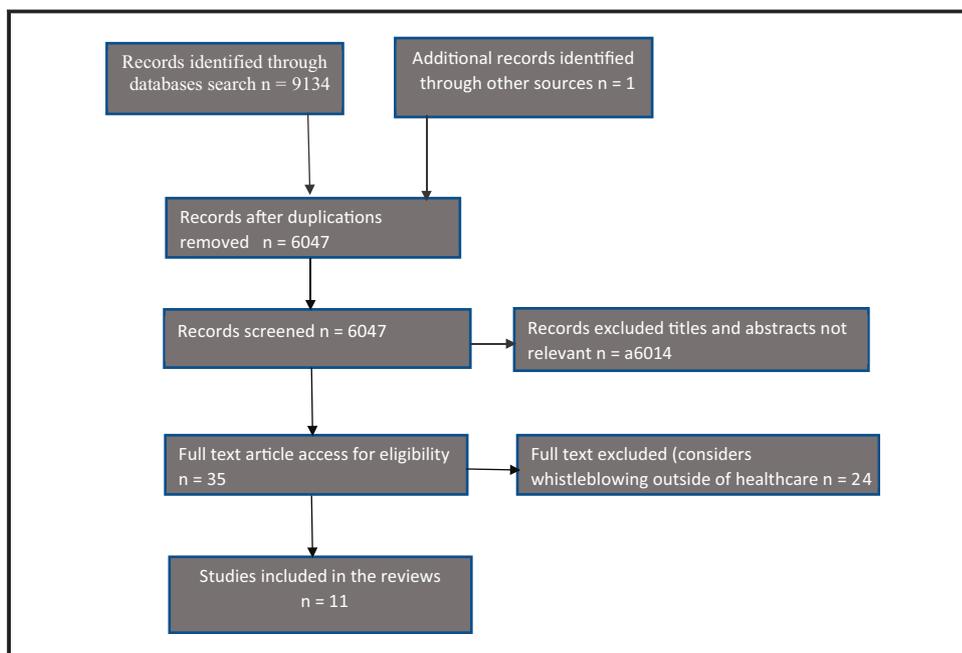
Search methods

A systematic search was conducted for qualitative and quantitative studies on whistleblowing. The five databases used were CINAHL Plus, Embase, Google Scholar, Medline and Scopus. Reference lists from relevant studies and websites of relevant nursing organisations were also searched. Subject limiters were then applied to remove any papers that were not directly relevant to the topic, and abstracts of this articles were then read and those not meeting the study inclusion criteria were further eliminated from the review ([Figure 1](#)). The primary search terms were “whistleblowing” combined with “barriers” or with “nursing”, “wrongdoing” and “whistleblowing”, or “barriers” of “wrongdoing” in nursing, “Whistleblowing and health care”, “telling the truth and nurs*”, using the Boolean search operators to define the relationship between the keywords.

Inclusion criteria and studies selection

Only studies which were peer reviewed, written in English language and published between 2000 and 2020 that examine barriers to whistleblowing among health-care professionals in America, Australia, Europe and in the UK were included in this review. All primary studies were included as they could offer insight into the phenomena under study: quantitative, qualitative, theoretical and mixed methods studies. The included studies were selected based on the relevance of their titles, contents of the articles and abstract as summarised in the flow diagram in [Figure 1](#).

Figure 1 Prisma flow chart illustrating articles screening process



Quality assessment

The literature obtained was appraised using critical appraisal tools. The quality of the research/evidence was evaluated using a quality appraisal tool. The tool used for the qualitative studies was the [Critical Appraisal Skills Programme \(2017\)](#) checklist ([Table 1](#)). The [Critical Appraisal Skills Programme \(2017\)](#) checklist was used to reveal the validity by removing bias and evaluating the quality of the studies to ensure reliability ([Singh, 2013](#)). A critical appraisal skill program provides a background within which to consider issues in a clear way ([Singh, 2013](#)).

For the quantitative literature, a critical tool developed by [Coughlan et al. \(2007\)](#) was used (see [Table 2](#) for The Coughlan, Cronin and Ryan appraisal tool). The [Coughlan et al. \(2007\)](#) tool is specific to quantitative research and divides the critique into two sections for clarity. In the first section of the appraisal, it incorporates elements prompting the credibility of the research concentrating on the information of the authors and the purpose of the study. While the second section mixes the elements prompting the robustness of the research, this tool was chosen for the clear, thorough and comprehensive steps presented by [Coughlan et al., 2007](#).

Table 1 Critical appraisal skills programme

<i>Qualitative journals</i>	<i>Ciasullo et al. (2017)</i>	<i>Jackson et al. (2010a, 2010b)</i>	<i>Attree (2007)</i>	<i>Peters et al. (2011)</i>	<i>Jones and Kelly (2014)</i>
Was there a clear statement of the aims of the research?	Yes	Yes	Yes	Yes	Yes
Is a qualitative methodology appropriate?	Yes	Yes	Yes	Yes	Yes
Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes	Yes	Yes
Was the recruitment strategy appropriate to the aims of the research?	Yes it was	Yes	Yes	Yes	Yes
Was the data collected in a way that addressed the research issue?	Yes	Yes	Yes	Yes	Yes
Has the relationship between researcher and participants been adequately considered?	Yes	Yes	Yes	Yes	Yes
Have ethical issues been taken into consideration?	Can't tell, however, the case studies are anonymous	Yes, ethical consideration was clearly stated	Yes, approval has been sought by the ethics committee	Yes, approval has been sought by the ethics committee 18 Nurses also consented to join the study	Yes, ethics and governance approvals were obtained
Was the data analysis sufficiently rigorous?	Yes, it was thorough	Yes, it was thorough	Yes	Yes	Yes
Is there a clear statement of findings?	Yes	Yes, transferable, credible and authentic	Yes	Yes	Yes
How valuable is the research?	the researcher identified areas needing more research	the researcher identified an area of limitation	The samples were not statistically representative	This study proved to be very valuable and adds significance to the clinical practice	Very valuable

Source: [Critical Appraisal Skills Programme \(2017\)](#)

Table 2 Coughlan *et al.*'s (2007) appraisal tool

Section 1. Elements influencing the believability of the research					
Quantitative journals	23	20	21	22	19
Writing style	Written well and organised	Written well and organised	Not clearly written little presence of subheadings to guide the reader	Written well and organised	Written well and organised
Author	Qualify and knowledgeable	Knowledge of authors not clear	Knowledge of authors not clear	Qualify and knowledgeable	Qualify and knowledgeable
Title (10–15 words)	9 words, and clearly identifies purpose of study	13 words, and clearly identifies purpose of study	11 words, and clearly identifies purpose of study	11 words, and clearly identifies purpose of study	13 words, and clearly identifies purpose of study
Abstract	Purpose is clear (exploring the factors that act as barriers and their likelihood to be modified)	purpose was clear	purpose was clear	purpose was clear	purpose was clear

Data extraction

Two of the reviewers (1 and 3) performed the data extraction for this study. Information was extracted from eligible articles based on predefined criteria. Information such as the author's name, year of publication, research aim, the study design, sample size, data analysis methods and their key findings. Extracted data from the included articles are summarised in [Table 3](#).

Synthesis

In the included studies themes in the qualitative and quantitative data were incorporated in the text, differing methods were used. The findings are therefore summarised in a narrative manner rather than using direct comparison.

Results

Characteristics of studies

These studies were published between 2000 and 2019. Out of these, 11 studies included in the final review of this study originated from five countries: the USA ($n=3$), the UK ($n=2$), Australia ($n=2$), Italy ($n=1$), the Netherlands ($n=1$), Finland ($n=1$) and Wales ($n=1$) respectively. Five of the included studies were qualitative in design (Ciasullo *et al.*, 2017; Jackson *et al.*, 2010a, 2010b; Attree, 2007; Peters *et al.*, 2011; Jones and Kelly, 2014) using varied data collection methods, and six quantitative studies (DesRoches *et al.*, 2010; McAuliffe and Moore, 2012; King and Scudder, 2013; King, 2001; Uribe *et al.*, 2002; Pohjanoksa *et al.*, 2019) using questionnaires.

The included studies presented clear statements of their aims and most studies identified their research designs and were suitable to address the aims of the research. The aims were all aligned to the findings. The authors used plain and short aims, allowing the reader to recognise what the authors are investigating, giving their studies a centre.

The absence of a clear statement of aims would mislead the reader, leads to a lack of focus and affects the concepts behind the research (Cochrane and Puvanewaralingam, 2012). Additionally, the background of the articles included a clear link to the research aims and why the research was required. Contextual information proposes that the topic has been carefully explored and aids the construction of the research procedures and objectives (Blaxter *et al.*, 2006). Within these studies, possible barriers of whistleblowing have been

Table 3 Data extraction table

Authors and year	Country	Study	Research design, methodology and method	Sample size/participant	How the results were analysed	Limitations discussed by authors
1. Ciasullo <i>et al.</i> (2017)	Italy	Improving health-care quality: the implementation of whistleblowing	<p>A <i>qualitative analysis</i> based on three explorative case studies in health-care organisations, operating within the Italian National Health Service (INHS).</p> <p>→ Unstructured interviews (were audiotaped and then verbatim transcribed)</p> <p>→ Structured interviews</p> <p>→ Questionnaire</p> <p>→ Face to face interviews or via the telephone</p>	<p>15 unstructured interviews of key informants (five for each unit of analysis)</p> <p>The key informants were selected from those employees who had directly and indirectly experienced whistleblowing initiatives in the previous three years or from those who were assigned with specific responsibilities to handle the whistle-blowing processes</p>	<p>All data gathered were carefully studied. First, a research report was written for each unit of analysis. Then, the findings for each health-care organisation were compared and a final comparative report was written.</p> <p><i>Results</i></p> <p>This study suggested that whistleblowing effectiveness is strictly related to managerial ability to build a sense of safety and commitment towards the organisation</p> <p>Others felt fear of retaliation</p>	<p>This research paper was limited by the analysis of three Italian public health-care organisations, which did not allow the generalisability of findings.</p>
2. Uribe <i>et al.</i> (2002)	America	Perceived barriers to medical-error reporting: an exploratory investigation	<p><i>Quantitative –</i></p> <p>Nominal group sessions-</p> <p>Focused groups</p> <p>→ Questionnaire was developed (Survey design)</p>	<p>Non-probability sample → a quota sample was obtained</p> <p>Nurses and physicians at a large academic medical centre located in the Midwest United States. The final sample consisted of 56 physicians and 66 nurses.</p>	<p>A statistical analysis was conducted using SPSS statistical software. One-sample T tests were performed by comparing the mean scores for each factor against the mid-point value of 3 to determine statistical significance.</p> <p>Independent-sample T tests were performed to examine differences between physicians and nurses</p> <p><i>Results</i></p> <p><i>Most likely factor</i> to act as a barrier was: Time involved in documenting an error, extra work involved in reporting and hesitancy regarding "telling" on somebody else</p> <p><i>Less likely factors</i></p> <p>Fear of losing a job, not knowing who is responsible for reporting the error and forms or computer locations not available to report medical errors</p>	<p>The inability to consider potential significant variables in analysing study results</p> <p>Potential source of bias → the study reports apparent barriers rather than real barriers</p> <p>There is a concern of non-respondent bias</p>

(continued)

Table 3

<i>Authors and year</i>	<i>Country</i>	<i>Study</i>	<i>Research design, methodology and method</i>	<i>Sample size/participant</i>	<i>How the results were analysed</i>	<i>Limitations discussed by authors</i>
3. McAuliffe and Moore (2012)	The UK	To report or not to report? Why some nurses are reluctant to whistleblow	An exploratory quantitative research design A total of 575 anonymous questionnaires were distributed The nurses were asked to respond using a five-point Likert scale of "strongly agree" to "strongly disagree" to the accounts that might encourage them to report an event of low care	The sampling framework adopted was a cluster random sample Data from eight acute hospitals in the Health Services Executive (HSE) regions in Ireland – two hospitals from each of the four regions and nursing staff on three wards within each hospital – provided the sample. The target participant population was 575 in total. A total of 152 or 26% responded	Physicians perceive more factors as barriers for reporting than nurses The variances among reporters and non-reporters of deprived care were explored in an attempt to identify the particular attitudes and beliefs amongst nurses that might be contributing to unwillingness to report. <i>Results</i> The nurse managers were significantly more likely to whistle blow than staff nurses. In exploring factors that might encourage nurses to report poor care. Two most common beliefs and fears amongst non-reporters are both fear of retribution and "wouldn't want to cause trouble"	No limitations were stated
4. King and Scudder (2013)	America	REASONS REGISTERED NURSES REPORT SERIOUS WRONGDOINGS IN A PUBLIC TEACHING HOSPITAL.	<i>Quantitative</i> - A survey instrument consisting of 10 factors was constructed	241 registered nurses agreeing to participate In the current study, but three did not complete even the most basic contact information. Of those 238 respondents, 72 had observed a wrongdoing over the previous year that they believe merited reporting, but only 68 of those nurses said they had reported it. The 68 individuals reporting the incident were used as the basis for the current study	Mean scores and standard deviations were calculated for each factor <i>Results</i> There was no statistically significant difference In both groups there was a strong tendency to overlook a wrongdoing by a friend who had a reputation of being a competent nurse.	Nurses had to select from the list of 10 items provided by the researchers and could not add their own personal reasons for reporting the wrongdoing. Not-allowing them to add more to indicate other concerns Additionally, little is known about The many nurses in the bigger pool who did not choose to participate. The amount of participants was also small because only those who actually had reported a wrongdoing were included. Nurses were enrolled from only one medical site (i. e., a

(continued)

Table 3

Authors and year	Country	Study	Research design, methodology and method	Sample size/participant	How the results were analysed	Limitations discussed by authors
5. King (2001)	Netherlands	Perceptions of intentional wrongdoing and peer reporting behavior among registered nurses.	Quantitative study using Surveys using a five-point Likert scale (that is, from definitely report to definitely not report)	Three hundred seventy-two registered nurses (N= 372) responded to a survey consisting of both intentional and unintentional wrongdoings that could occur by a nurse	Results of a paired t-test were as predicted. <i>Results</i> The severity of the wrongdoing performed a significant role in determining whether or not an incident should be reported Respondents indicated they would not report the unintentional wrongdoings Findings were clustered into four main themes, namely: Leaving and returning to work-The staff do not like you.; Spoiled collegial relationships-Barriers between me and my colleagues; Bullying and excluding-They've just closed ranks; and, Damaged inter-professional relationships-I did lose trust in doctors after that <i>Results</i> Whistleblowing resulted in hostility in the workplace. Analysis of the data revealed that whistleblowing had a deep and overwhelmingly bad effect on working relationships. For these participants, the loss of collegial relationships was by far	hospital), which reduces the external validity of the study The response rate of 20% may have affected the reliability coefficient in this study. Possibly using a larger sample of registered nurses, follow-up letters, and conducting a pilot study beforehand would have enhanced both the reliability coefficient and the response rate of the study. It is uncertain whether the sample used in this study is representative of the experiences of all nurses directly involved in whistle-blowing incidents
6. Jackson <i>et al.</i> (2010b)	Australia	Trial and retribution: A qualitative study of whistleblowing and workplace relationships in nursing	a qualitative narrative inquiry design → via face-to-face and telephone and → Semi-structured interview	18 participants with direct experience of whistleblowing were recruited into the study		

(continued)

Table 3

Authors and year	Country	Study	Research design, methodology and method	Sample size/participant	How the results were analysed	Limitations discussed by authors
7. Attree (2007).	The UK	Factors influencing nurses? decisions to raise concerns about care quality	A <i>qualitative</i> study -Grounded theory was used to enable exploration, clarification and elaboration of participants' insights and involvements. →Semi-structured interviews were implemented The initial interview themes included Nurses' perceptions of and concerns about standards of nursing practice, and how they handled concerns. Interviews were audio-taped, with participants' permission	142 practicing nurses theoretically sampled from three Acute NHS Trusts in England.	the most upsetting aspect of their experience Grounded theory was used to collect and analyse data <i>Results</i> RN nurses described experiencing dilemmas and difficulty deciding how to handle their concerns. Whilst some described these as regular daily occurrences, others spoke of infrequent incidences. Professional dilemmas were identified because of conflict between nurses' duty to raise concerns and their fear that negative consequences would result. Indecision and hesitancy were attributed to fear of repercussions, retribution, labelling and blame for raising concerns Final themes were developed using a thematic analysis. <i>Results</i> Three themes were identified: These are: 'I felt sad and depressed'; overwhelm- ing and persistent distress; 'I was having panic attacks and hyperventilating'; acute anxiety; and 'I had all this playing on	The samples were not statistically illustrative. Further study is required using a larger and more representative samples.
8. Peters <i>et al.</i> (2011)	Australia	The emotional sequelae of whistleblowing: findings from a qualitative study	A <i>qualitative</i> study – a narrative inquiry research design was developed with recorded Face to face and phone interviews.	18 female nurses consented to participate however, 14 were chosen.	No limitations stated This study proved to be very valuable and adds significance to the clinical practice	

(continued)

Table 3

Authors and year	Country	Study	Research design, methodology and method	Sample size/participant	How the results were analysed	Limitations discussed by authors
9. Jones and Kelly (2014)	Wales	Whistleblowing and workplace culture in older peoples' care: qualitative insights from the health care and social care workforce	A qualitative study including semi-structured interviews or focus groups. The interviews lasted between 35 and 65 min and the focus groups between 43 and 67 min. The interviews and focus groups were held away from parts of direct clinical care, to increase privacy. Four telephone interviews took place with one representative of the NMC, and three representatives of the Welsh police (who are involved if reports of mistreatment are made directly to them)	60 participants took part, 17 RNs, 23 care assistance, 4 regulators/police and 16 year 2 students.	my mind': nightmares, flashbacks and intrusive thoughts The results were obtained by analysing themes generated by the participant's responses A Peer review of data analysis, was also undertaken in the research team to, advance The thoroughness of the study <i>Results</i> term whistleblowing was perceived negatively by most interviewees The term whistleblowing was also perceived as reporting behaviour related to observing severe misconduct or mistreatment of patients. Managers strove to instill in staff the importance of concerns being discussed openly	No limitations have been stated
10. DesRooches et al. (2010)	America	Physicians' Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues	<i>Quantitative</i> - Nationally representative surveys focus groups	2938 eligible physicians practicing in the United States in 2009 in anaesthesiology, cardiology, family practice, general surgery, internal medicine, paediatrics, and psychiatry. Overall, 1891 physicians (64.4%) responded	To test for significant differences between groups, 2-sided t-tests (continuous variables) or χ^2 tests (categorical variables) were used as appropriate. A multivariable model was constructed based on the bivariate analysis Separate multivariable logistic regression models were fitted to evaluate the association of outcomes The results were obtained by collating data formulating this to percentages <i>Results</i> 64% (1120) agreed with professional commitment to report physicians who are significantly incompetent.	First, because of reliance on voluntary disclosure of failure to report impaired and incompetent colleagues, these failures may be viewed as negative, and the results likely represent a lower-bound estimate of the actual frequency of non-reporting Second, although the response rate was relatively high for a physician survey, nonresponse bias might exist Third, the accuracy of the respondents' beliefs about whether their colleagues were, in

(continued)

Table 3

<i>Authors and year</i>	<i>Country</i>	<i>Study</i>	<i>Research design, methodology and method</i>	<i>Sample size/participant</i>	<i>How the results were analysed</i>	<i>Limitations discussed by authors</i>
					69% (1208) reported to be prepared to effectively deal with incompetent colleagues and 64% (1126) reported being so prepared to report. 17% (309) had direct personal knowledge of a physician who is incompetent to practice in their hospital or practice, off those with this knowledge 67% (204) reported this colleague to the relevant authority 19% (58) believed someone else was taking care of it, followed by the belief nothing would be happen as a result of the report 15% (46) and fear of retribution (12% = 30)	fact, impaired or incompetent cannot be verified

evident. Many publications have identified factors that lead to a whistle-blowing barrier including the ten articles used for this study.

Emerging themes

The themes found within the 11 articles revealing barriers for whistleblowing are discussed below, and divided into cultural, organisational and individual to establish the significance of the barriers of whistleblowing in health care. The charts displaying the themes for the included studies can be found in [Table 4](#).

Culture

The sub-themes under culture includes hesitance and fear of retribution and repercussions. The cultural influences of whistleblowing were identified by understanding first the meaning of culture, according to [Maull et al. \(2001\)](#) this is a learned character, which represents either the way people think about things or the way they do things ([Williams et al., 1994](#)). In this case, the theme culture refers to the employees and employers of health care that may have developed a negative culture that as a result becomes a barrier to whistleblowing. These negative cultural barriers were identified by analysing the way people think of whistleblowing and what they would do in the case of a whistle-blowing incident.

Hesitance

The hesitance to carry out a report on a colleague is because of issues related to the belief that others will report it, and it will be dealt with ([Attree, 2007](#); [DesRoches et al., 2010](#)). According to [Attree \(2007\)](#) and [DesRoches et al. \(2010\)](#) stated that people have found it difficult deciding how to handle their concern. Nurses have described facing dilemmas because of the conflict between their professional duty to raise concerns about care quality and their expectations that adverse consequences would result from raising their concerns ([Attree, 2007](#)). [King \(2001\)](#) found that a nurse who observes or confronts a wrongdoing being committed by another nurse would find it tough to decide whether he or she should reveal the wrongdoing or stay silent. [Attree \(2007\)](#) also found that nurses perceived raising concerns as a difficult and risky action leading to a bad reputation. The clear indecision and hesitancy were attributed barriers because of fear of repercussions among nurses ([Uribe et al., 2002](#); [McAuliffe and Moore, 2012](#); [Attree, 2007](#); [DesRoches et al., 2010](#)). Nurses' predictions about the low likelihood of positive action resulting from raised concern were major considerations in decision-making ([Attree, 2007](#)). The system and culture in health care was characterised as being unresponsive with no positive action to reported concerns ([Attree, 2007](#)). Furthermore, raising a concern was labelled as a disloyal act, and registered nurses feared corrective measurements and promotional difficulties ([Attree, 2007](#)). In [Attree \(2007\)](#) study, nurses stated that the lack of positive management was a barrier for reporting, leading to lack of confidence in the individuals and the system.

Table 4 Main and sub-themes generated from both the qualitative and quantitative studies

Themes	Qualitative articles	Quantitative articles
Main theme 1: Culture	1, 16,17	19, 20, 21, 22, 23,
Subthemes:		
Hesitance and indecisiveness		
Fear of retribution and repercussions	16, 17	19, 20, 23
Main themes 2: Organisational and Individual	16	20, 21, 23
Subthemes:		
Lack of anonymity reporting		
Negative effects of whistleblowing	5, 17, 18	

Unfortunately, nurses were also found to overlook a mistake or an unintentional wrongdoing by a nurse and withhold reporting concerns (King and Scudder, 2013; King, 2001). King and Scudder (2013) revealed nurses had the tendency to overlook serious life-threatening mistakes protecting nurses who were their friends and known to be generally competent. These actions can be a result of avoiding hostility by others. Nevertheless, King and Scudder (2013) also revealed that nurses would in other cases report a wrongdoing for their moral professional responsibility holding them accountable with a strong endorsement of 82% out of 68 individuals that have reported incidents in the past.

However, registered nurses can differentiate perceptions of intentional wrongdoing across various situations of patient care (King, 2001). Besides, King (2001) found that the individual's view of the severity governs whether a wrongdoing is deserving of action. Although what one nurse may perceive as intended wrongdoing another nurse may perceive as poor judgement or carelessness on the part of the wrongdoer.

Ciasullo *et al.* (2017) revealed that the apparent lack of managers and colleagues' support was also a significant stimulus that encouraged health-care professionals and administrative employees to remain silent. This raises the question as to why it seems to be less supported to raise concerns openly in a field of health care that should be promoting honesty and openness. Yet, the term whistleblowing has been perceived by some as negative (Jones and Kelly, 2014; Attree, 2007). Similarly, the less experienced individuals interviewed by Jones and Kelly (2014) also shared that whistleblowing would be like grassing and telling tales.

Conversely, Jones and Kelly (2014) directed a qualitative study and found that managers strove to instil in staff the importance of concerns being discussed openly. Managers have had open attempts to create workplace culture encouraging staff to communicate openly about issues (Jones and Kelly, 2014). All managers need to be re-educated about having open communication and not going all-defensive when someone complains. However, McAuliffe and Moore (2012) highlighted that nurse managers are more likely to whistle blow than staff nurses. In McAuliffe and Moore (2012) study, staff nurses' responses versus the manager nurses' responses indicated that 88% of 26 nurse managers would report an observed incident, whereas only 65% of the 107 staff nurses would do so.

Fear of retribution and repercussions

A fear of retribution has been found more commonly within the lower hierarchy than in management (McAuliffe and Moore, 2012). Fear of workplace retaliation has shown to have influence on non-reporting (Ciasullo *et al.*, 2017; Jackson *et al.*, 2010a, 2010b; Attree, 2007; Pohjanoksa *et al.*, 2019). Attree (2007) found that because of fear of repercussions nurses who raised concerns before would not take their concerns further unless they deemed the concern serious. However, with the guarantee that their careers would not be affected, nurses would come forward to reporting wrongdoings by their colleagues. Attree (2007) study further shared that a nurse wanted to take a concern further, but the manager said no you are not, followed by the statement that the concern will not go anywhere. Evidently, Individuals do not feel confident that their concerns will be taken serious or even supported, conflicting one to blow the whistle.

Understandably, individuals working in health care feel they may be risking their jobs with the belief that nothing would happen to rectify their concerns (DesRoches *et al.*, 2010; McAuliffe and Moore, 2012; Uribe *et al.*, 2002). Following a whistle-blowing experience individuals would leave their work areas and in some cases even be dismissed and strongly encouraged to remove themselves from the site of the complaint according to Jackson *et al.* (2010a). Key informants in one of the case studies by Ciasullo *et al.* (2017) also stated that they would not feel confident and safe when reporting malpractices and wrongdoings. Sometimes, the fear of retaliation is stronger than the willingness to blow the whistle.

Organisational and individual

The organisational and individual themes were identified by analysing the results linked to the influences of organisational actions and inactions on health-care individuals when necessary to whistle-blow. The following sub-themes (lack of anonymity reporting and negative effects of whistleblowing) were gathered by considering the results within the qualitative and quantitative primary studies used for this study. The results revealed that many health-care individuals would describe their organisation as unsupportive and one of a possible blaming nature. As a result, health-care workers lack the confidence to report openly within their organisation, as some are affected because of whistleblowing. [Tsai \(2011\)](#) highlights that organisational values and principles mirror the standards, views and behavioural customs that are used by employees in that organisation giving them meaning to the circumstances that they meet, which can influence the attitudes and conduct of the staff. This further state that organisational values have a considerable effect on individual's behaviour towards reporting. [Pohjanoksa et al. \(2019\)](#) also reported that organisation-related wrongdoing was the most common type of wrongdoing in health care with suspected and observed wrongdoing being 70% and 60%, respectively.

Lack of anonymity reporting

An Italian study based on three explorative case studies by [Ciasullo et al. \(2017\)](#) found that health professionals who either directly or indirectly experienced whistleblowing would excuse raising concerns because of the inability for their anonymity to be guaranteed and the ineffectiveness in preventing retaliation as the main barrier. [Uribe et al. \(2002\)](#) also found that lack of anonymity reporting was a most likely factor to discourage raising a concern. In an attempt to understand how important anonymity might be for reporting behaviour, [McAuliffe and Moore \(2012\)](#) also conducted a quantitative study in the UK and found that 56% out of 152 respondents believes that concerns should be raised anonymously, with 37% stating that concerns should not be reported anonymously.

However, based upon the issue of anonymous reporting in past research, [King and Scudder \(2013\)](#) predicted anonymous reporting would be related to higher likelihood of reporting a wrongdoing. Yet, in [King and Scudder \(2013\)](#) quantitative study, the endorsement for anonymous reporting had the lowest rate of 10%. The logical connections are clear, for instance, if a wrongdoing is reported anonymously, the problems of reprisal or others thinking badly about the reporting nurse disappear ([King and Scudder, 2013](#)). However, this would take away the validity of the report with no means to gather evidence to support claims.

Negative effects of whistleblowing

There is a reason to believe whistleblowing could result in hostility in the workplace ([Jackson et al., 2010a](#)). [Jackson et al. \(2010b\)](#) revealed that whistleblowing had a profound and overwhelmingly negative effect on working relationships. [Attree \(2007\)](#) study also described negative social outcomes, alienation and withdrawal of peer support following raising concerns. Raising concerns carried the label troublemaker and whistleblowing threatened those in power. Individuals would withhold the whole truth from management to save their reputation and to keep their jobs ([Attree, 2007](#)).

[Peters et al. \(2011\)](#) found that among 14 female nurses' their emotional health was also considerably compromised because of a whistle-blowing event. However, not much is identified about the degree and strength of emotional symptoms and about the duration of emotional distress experienced because of whistleblowing. Additionally, those accounts that do exist are all based on whistleblowers or non-whistle blowers ([Peters et al., 2011](#)). However, the experiences of subjects of whistle-blowing events remain ([Peters et al., 2011](#)).

Pohjanoksa *et al.* (2019) in their study reported that reluctance to blow the whistle might be because of lack of courage and fear of the possible negative consequences for oneself.

Discussions

Health-care professionals in the current study expressed lack of confidence in the organisational system, which was combined with a belief that nothing would be done about their raised concerns (Ciasullo *et al.*, 2017; Uribe *et al.*, 2002; McAuliffe and Moore, 2012; Attree, 2007; DesRoches *et al.*, 2010; Jackson *et al.*, 2010a, 2010b; Peters *et al.*, 2011; Jones and Kelly, 2014; King and Scudder, 2013; King, 2001; Pohjanoksa *et al.*, 2019). This dilemma was associated with a negative structural environment, characterised by fear of personal retribution, labelling and blame for raising concerns, causing the observer to be hesitant to report the wrongdoing (McAuliffe and Moore, 2012; Attree, 2007; DesRoches *et al.*, 2010). The fear of retaliation from management and other employees resulted as one of the main barriers against whistleblowing in health care. This is similar to the discovery by Alleyne, Weekes-Marshall and Arthur (2013), which also found this to be a factor effecting whistleblowing among accountants in Barbados. The fear of the likely job loss was an influential factor that was considered when deciding whether to blow the whistle (Alleyne *et al.*, 2013). Also, it is understood that deciding whether to blow or not to blow the whistle can have an enormous amount of pressure on an individual making stress a developing risk factor (Peters *et al.*, 2011). Corley *et al.* (2005) also identified experiences of ethical stress related to professional's failure to take moral action to maintain patient safety.

Furthermore, it is suggested that an authority figure in health care such as nurse managers were significantly more likely to report incidents of poor care (McAuliffe and Moore, 2012; Ciasullo *et al.*, 2017), putting nurse managers in an important position to influence nurses' decision to raise concerns (Jackson *et al.*, 2010a, 2010b; Ciasullo *et al.*, 2017). Nonetheless, health-care professionals at all levels are aware of their ethical responsibilities to report concerns especially those that effect patient care. This was expressed in most of the studies found. Additionally, Ulrich *et al.* (2010) found that nurse's main priority evolved around protecting patients' rights. However, the constant conflict of a nurse's ethical duty to patients, reliability to colleagues and consideration of their own employment and career remains a reality in Europe, America and Australia. The literature has directed that there is a need to develop an ethical culture and provide the structures to support staff to raise concerns. Moreover, the reduction of error in health care is dependent on a culture of zero acceptance and full admission. Establishing the underlining views of nurses to reporting poor care is a needed stage in conveying the required cultural change away from one of silence.

The findings underpin the fact that whistleblowing is a demanding issue (Jones and Kelly, 2014). Furthermore, the findings raise the issue of the absence of organisational protection. The hierarchy professionals and managers in the National Health Service and wider health care have a duty to listen to whistleblowers and provide them with protection from ill-treatment for raising concerns openly. This protection also exists under the [Public Interest Disclosure Act \(1998\)](#) and is reinforced in the National Health Service by executive guidance, issued in 1999, demanding appropriate local policies and procedures.

Consequently, the hierarchy management in health-care establishments should regularly analyse the various factors that may affect or influence an individual's whistle-blowing decision or behaviour. As significance, a framework could be developed which not only encourages whistleblowing but also satisfies the whistleblower and all parties to the whistle-blowing event. Management needs to delve further into the stigma associated with whistleblowing to understand how to implement procedures to prevent retaliation, promote a positive organisational culture and increase personal benefits or incentives to whistleblowing. As organisational cultures are generally learned and transferred by individuals, it delivers the guidelines for behaviour within the organisations (Yang, 2007).

However, even with the delivery of guidelines wrong practices may remain, as will the need to report concerns within health-care organisations and, in some cases, to whistle blow externally. Nevertheless, every Individual should improve their professional knowledge necessary to speak up and to reflect on their own reasons with a view to ensuring the actions taken are appropriate.

Review limitations

This study only comprised of 11 journals both qualitative and quantitative because of the limited time available to complete this study. The use of more studies would be more significant, future research should consider using larger numbers of literatures. It would be noteworthy to further explore whether factors such as the level of success of the hierarchy health-care profession or organisation influence the success of the whistle-blowing report, determining how far or how much influential change occurs.

Conclusion

The whistle-blowing barriers revealed in the literatures proved that health-care workers are not being heard or supported enough as the management and organisations frequently lack supportive measurements, to listen to staff reports. Health-care professionals are open to pressures that lead them to priorities their own well-being or those of the organisation over those of patients. Additionally health-care organisations may priorities financial reasons and executive values over patient care and staff well-being.

This study provided the realities of those working in health care and their experiences of whistleblowing. Future studies would be beneficial addressing leadership models including advanced repeated teaching strategies such as, the importance of quality improvement to ensure the safety of all health-care professionals and patients applying change. Because the main guidelines of an organisation begin with the leader, it is also vital to include a comprehensive leadership model that will change.

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