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Commentary

Whistleblowing Need not Occur if Internal Voices Are Heard: From Deaf Effect to Hearer Courage

Comment on "Cultures of Silence and Cultures of Voice: The Role of Whistleblowing in Healthcare Organisations"

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Abstract

Whistleblowing by health professionals is an infrequent and extraordinary event and need not occur if internal voices are heard. Mannion and Davies' editorial on "Cultures of Silence and Cultures of Voice: The Role of Whistleblowing in Healthcare Organisations" asks the question whether whistleblowing ameliorates or exacerbates the 'deaf effect' prevalent in healthcare organisations. This commentary argues that the focus should remain on internal processes and hearer courage.

Keywords: Whistleblowing, Whistleblowers, Internal Reporting, Deaf Effect, Hearer Courage

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Mannion and Davies'[1] editorial on "Cultures of Silence and Cultures of Voice: The Role of Whistleblowing in Healthcare Organisations" asks the question whether whistleblowing ameliorates or exacerbates the 'deaf effect' prevalent in healthcare organisations.

The deaf effect phenomenon has been described as what occurs when a person who can perhaps effect action (decision-maker) does not hear or ignores reports of bad news, resulting in inaction.[2,3] Understanding the critical features of what is a 'deaf effect' is important when considering the impact that inaction can take in a healthcare environment when health practitioners raise concerns that they perceive as essential for patient safety. It is clear from many well-known whistleblowing cases (some that have resulted in large public Commissions of Inquiry both in the United Kingdom – *Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995*, *The Mid Staffordshire NHS Foundation Trust Inquiry* and Australia *Queensland Public Hospitals Commission of Inquiry and the Special Commission of Inquiry into Campbelltown and Camden Hospitals in New South Wales)* that inaction by management internally to address the concerns does set the health practitioner on a path to becoming a whistleblower.[4] The deaf effect and its impact on potential whistleblowers (those who choose to report outside) is not only evident in health services. Researchers who have examined this complex phenomenon have repeatedly found that internal inaction and a lower level of trust in, and support from, management can be a significant motivating factor to report to an external body who may be able to affect action.[5-7]

Prior to examining the vexed question of the impact of the deaf effect on whistleblowing it is prudent to first examine the definition of whistleblowing. Whistleblowing is a contested notion with a variety of definitions used depending on disciplinary focus.[8] Social science researchers for instance focus on the whistleblowers' choice of recipient (both internally and externally) and readily use the well-recognised general definition posed by Miceli and Near[9] 'the disclosure by organization members (former or current) of illegal, immoral, or illegitimate practices under the control of their employers, to persons or organizations that may be able to effect action.'[9] Within this definition, the whistleblowing act includes internal reporting as well as external disclosure outside the organisation. This appears to be the stance taken by Mannion and Davies[1] who see whistleblowing as a part of a 'wide spectrum of formal and informal behaviours that are embedded in local organisational context and cultures, and enmeshed in both formal and informal governance arrangements and practices.'

Research by healthcare professionals and specifically nurses has shown that whistleblowing is considered to have occurred only when referring to external disclosures. Additionally prior to reporting externally, the would-be whistleblower should have exhausted all the internal reporting mechanisms in order to effect action to bring to an end to the offending practice.[10-13] The clear distinction in health service literature that whistleblowing only includes external disclosures arises from the need to value internal reporting of error and misconduct as a 'normal' organisational process (clinical governance), which does not involve a breach of confidentiality commonly associated with reporting to an unauthorised external authority.[10,11,14-17] This is supported by the World Health Organisation (WHO) *Draft Guidelines for Adverse Event Reporting and Learning Systems*[18] which identifies that the primary function of internal reporting is to 'enhance patient safety by learning from failures' and for the identification of gaps and weaknesses within the system.

Whistleblowing to an external source is an infrequent and extraordinary event, however despite the pro-social intent

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of the whistleblower, they are often viewed as disloyal or disaffected members of staff who expose damaging information, thus betraying the organisation.[19-22] The whistleblower wants to reveal the truth, while the organisation will seeks to conceal it.[23] In the process, many whistleblowers have become victimised, where the message they are trying to deliver is overlooked and the ability to effect action for public good or to protect public safety risks being lost. Personal and professional retaliation against whistleblowers has been well-recognised and involves damaging processes that attempt to deal with the disclosure by discrediting the whistleblower rather than dealing with the information disclosed.[24-31]

Mannion and Davies[1] like others have posed the argument that whistleblowing need not occur if those responsible in an organisations respond positively to concerns raised and begin a process of learning from mistakes as well as implementing effective policies to prevent future harm. However, to achieve this there needs to be a recognition that a culture of silence will remain in health services if the following dual processes continue to occur when staff raise concerns internally. First is inaction to address the concern and second is when the investigation and later action (often retribution) are focussed towards the messenger rather than those identified in the message. Research into the reasons why healthcare professionals, in this case nurses, are reluctant to report malpractice have been linked to both apathy, tied to an assumption that no action will be taken, and fear of retribution to their professional standing or personal lives, which have included both negative physical and emotional affects.[27,30,32-34]

In a recent UK National Health Service (NHS) survey of more than 2000 managers and clinicians a disparity of opinion emerged on the 'culture of voice.' Here, staff were invited to report on the quality of leadership, transparency, and whistleblowing. When asked about raising concern '94% of executive directors thought staff could raise concerns' compared to 'only 57% of nurses' and when asked if 'such concerns would be handled appropriately' 90% of executive directors thought so, whereas 'only 26% of nurses agreed.'[35] Further evidence that healthcare staff lack faith in actions being taken from concerns raised emerged in the 2014 National survey of NHS staff. In this survey of over 624 000 staff, 93% indicated that knew how to report concerns, however, only 57% expressed the view that they were confident that their concerns would be addressed.[36]

The solution therefore is to ensure that the focus should be on the culture within an organisation to ameliorate the need for disaffected staff to take the courageous step of reporting outside to effect action and bring to a close the offending practice or practices. When health service managers are faced with reports of failure and particularly issues that raise concerns about patient safety, they will demonstrate a human response. What seems to be unknown at this time are the human factors involved in the behaviours of healthcare managers who distance themselves from staff who raise concerns about patient safety.

In an examination of management and executive action in the United Kingdom's NHS, Dixon-Woods et al[37] found that while considerable time and resources had been invested into data collection and monitoring systems, the degree to which this was 'translated into actionable knowledge, and then into effective organisational responses' relied on the particular human responses of managers and or executive. Dixon-Woods et al[38] large mixed method research program involved 7 substudies which included data from 107 interviews with senior level stakeholders involved in quality and safety, 197 interviews with executive, board members and frontline clinicians, 715 surveys, 2 focus groups, and 10 interviews with patients and the public, patient and staff satisfaction survey data from 2005-2011 and 621 clinical teams assessed using Aston Team Performance Inventory.

Dixon-Woods et al[38] classified senior management's responses into two categories of behaviour: 'problem-sensing' or 'comfort-seeking.' Problem-sensing was thought to occur when senior managers actively sought out weaknesses in their organisations, using not only the formal incident reporting systems, but also 'softer intelligence.' Softer intelligence was suggested to be any activity that demonstrated active listening to staff and patients as well as making 'unannounced visits to clinical areas,' and having consumers engage in the review of services. Comfort seeking was suggested to have occurred when management sought data from only limited sources, these managers were pre-occupied with compliance, external expectations and positive news, they actively sought sources of data that provided 'reassurance that all was well.' In order to avoid negative feedback there was a demonstrated tendency to distance themselves from frontline staff, in addition concerns raised or critical comments were perceived as merely as 'whining or disruptive behaviour.'[37] What is clear is that the 'deaf affect' to internal reporting is certainly prevalent in healthcare and as speculated by Mannion and Davies[1] the 'more unpalatable the message' the less likelihood of action. It is further speculated that this will be particularly prevalent with those who use what Dixon-Woods et al describes a using comfort seeking behaviours or those who have what Mannion and Davies describe as a vested interest in 'narratives of success.'

Mannion and Davies[1] are correct in their call for a strategy to deal with the resistance to bad news by those in a position of power. However, this should be considered as part of an overall strategy to improve patient safety and clinical governance and not framed as whistleblowing strategy. Critical to ensuring that the deaf effect does not exacerbate the incidence whistleblowing is a clear understanding of the factors that influence managers. Understanding why some managers display not only the courage to hear what is being said and take appropriate action, but also the courage to refrain from inappropriate action such as targeting the bearer of the news. Vandekerckhove et al[39] suggest future research should examine the variables that determine courage on the part of the recipient of the bad news, specifically on 'hearer courage' to understand why some managers 'have the courage to hear,' under what circumstances and with regard to what type of reported wrongs.

It is now time to specifically examine the human factors involved in the behaviours of healthcare managers, particularly those who distance themselves from staff who raise concerns about patient safety. There is an urgent need to uncover the variables that determine hearer courage for managers. Organisations who have managers who

display courage to actively hear the messages of failure and adequately address them in a culture of transparency, trust and accountability will prevent the need for staff to resort to whistleblowing.[4]

Ethical issues

Not applicable.

Competing interests

Authors declare that they have no competing interests.

Authors' contributions

SRC: corresponding and primary author; KED: review of manuscript, development, and critique of central argument.

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