

Understanding the knowledge gaps in whistleblowing and speaking up in health care: narrative reviews of the research literature and formal inquiries, a legal analysis and stakeholder interviews

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Scientific summary

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Scientific summary

Background

Recent inquiries and reports into poor standards of NHS care have highlighted the vital role that employee whistleblowing and speaking up can play in the detection and prevention of harm to patients. Although many concerns about poor or unsafe care are dealt with satisfactorily, there is compelling evidence to suggest that some staff (perhaps many) may feel unable to speak up, and that even when they do, their organisation may respond inappropriately. Against this background, we wanted to strengthen the theoretical and empirical evidence-base underpinning whistleblowing policy and practice in the NHS.

Objectives

The overall purpose of this study was to identify theoretically grounded and evidence-informed lessons for the design and implementation of employee whistleblowing policies in the NHS. The specific objectives were to:

1. explore the main strands of the academic and grey literature on whistleblowing and related concepts such as employee silence, and to identify the key theoretical and conceptual frameworks that can inform an understanding of employee whistleblowing
2. synthesise empirical evidence from different industries, sectors and countries with regard to the organisational processes, incentives and cultures that serve to facilitate (or impede) employees raising legitimate concerns
3. examine the UK legal framework(s) for whistleblowing in relation to health care, and review alternative approaches to whistleblowing in other European Union member states, considering what lessons can be learnt at a domestic level from such comparisons
4. distil the lessons for whistleblowing policies and practice from the findings of formal Inquiries into serious failings in NHS care
5. ascertain the views, expectations and experiences of a range of key stakeholders, including service user and carer representatives, about the development of effective whistleblowing policies in the NHS
6. on the basis of findings relating to points 1–5, develop theoretically grounded and evidence-informed practical guidance for policy-makers, managers and others with responsibility for implementing effective whistleblowing policies in the NHS.

Methods

The study comprised four distinct but overlapping and interlocking strands.

1. A series of linked narrative literature reviews of the theoretical and empirical literature related to raising concerns, speaking up and whistleblowing across a range of sectors and contexts. We adopted a narrative and interdisciplinary approach to reviewing, which sought to produce a synthesis that embraced the complexities and ambiguities associated with developing an understanding of whistleblowing.
2. An overview of the legal issues related to whistleblowing in an international context. Literature searches of primary legal sources (statutory and case law materials) were conducted and secondary literature searches of legal databases were undertaken.
3. A review of formal Inquiries and government documents related to previous failings of NHS care; in addition, we examined the responses of the main stakeholders to the corresponding Inquiry reports. Electronic searches of the documents were performed using thematic coding in a deductive and inductive manner via keywords generated by emerging findings arising from other strands of the study.

4. Interviews with 16 key informants comprising a mix of representatives of user and carer groups, policy advisors, academics, employee organisations, trade unions and the Royal Colleges. The interviews ascertained the views about current whistleblowing policies in the NHS and how these could be improved, and were used to inform and develop the other strands noted above.

Members of the research team liaised throughout the literature review process to discuss and synthesise the emergent findings and ensure that insights were shared and integrated across the work packages. For example, the review of conceptualisations and theories of whistleblowing informed the analysis of the Inquiry reports and the content of the key informant interviews.

Results

This section takes each of the research objectives in turn. We take the first two objectives together as they are informed by the same literature review; and we do not separate out the findings from objective 5 as these were used to shape and inform the wider work.

Research objectives 1 and 2: key conceptual issues and empirical findings

The key conceptual and empirical issues uncovered by our review with practical import for understanding, designing and improving whistleblowing and speaking up policies in the NHS include those detailed in the following sections.

Silence and voice

Policy prescriptions have tended to conceive the issue of raising concerns about unsafe care as a simple choice between deciding to 'blow the whistle' and determining to remain silent. Yet research suggests that such simple dichotomies are unhelpful; for example, health-care professionals may raise concerns internally within the organisation in more informal ways before (or instead of) utilising whistleblowing processes. Such a view highlights the different routes through which health-care employees are able to articulate their 'voice', and challenges the pejorative notion, often promoted in the media, that health-care professionals are culpable bystanders who tolerate poor standards of care and are 'silent witnesses' to malpractice and mistreatment.

Hearing and acting

The effective voicing of concerns is but the first stage in reshaping better, safer health care: those with influence have to hear, and they have to act. In this regard, we discuss the 'deaf effect', a concept that has been used in the management and organisation literature to describe the reluctance of senior managers to hear, accept or act on concerns about care raised by employees lower down the hierarchy. Our conclusion is that we need as sophisticated an understanding of these response dynamics as we do of the dynamics of whistleblowing itself.

Interactional processes

Linked to the above is the recognition that whistleblowing is a situated and interactional process and not just a one-off act by an identifiable whistleblower. Most previous research and policy around whistleblowing has focused on the whistleblower, in particular the factors that inhibit whistleblowing and determine who has 'the courage' to speak up and under what circumstances. However, policy prescriptions need to better acknowledge the complexity and ambiguity of speaking out, and a greater research focus needs to be placed on why some managers respond effectively to concerns raised and others do not.

Whistleblowing, or bell-ringing?

As conceived in both the academic literature and wider public understanding, whistleblowing usually describes internal organisational members raising concerns to those who can effect action. However, 'bell-ringing', or outsider whistleblowing, is also a possibility: the reporting of care failings by those other than employees (e.g. patients themselves, relatives, or professionals from other agencies, such as social

workers). Potentially, this is a more significant issue for health care than for any other sector. As the NHS becomes ever more diverse in terms of collaboration with other sectors, and as social media and information-sharing technologies become more developed, external staff and other stakeholders are increasingly exposed to, and in a position to speak up about, poor-quality care. This is a key area for future research.

Personal factors in raising concerns

There is mixed evidence on the role and impact of personal factors in raising concerns. For example, in terms of length and security of tenure, some studies have found that the more embedded and socialised into a particular culture staff are, the less likely they are to spot poor practice and report it (perhaps because of personal and social links with colleagues). Similarly, the evidence is mixed on whether nurses who, over time, become more socialised and integrated members of the organisation become less likely (through de-sensitisation) or more likely (through better organisational knowledge and developed networks) to detect and report poor care.

Research objective 3: the legal frameworks for whistleblowing

Here, we consider alternative approaches that may be taken in relation to the statutory basis and regulation of whistleblowing.

Oversight from an independent agency

As part of a review of the law in this area, one approach is the creation of a specific national independent whistleblowing agency, a free-standing body or within an existing agency. Such a body could receive and investigate whistleblowing disclosures, collect information on workplace disclosures and have the power to obtain information from regulators for subsequent action. It could issue penalties when organisations have not followed up on information disclosure, order the cessation of retaliation against a whistleblower and be able to order compensation and reinstatement.

Statutory requirement to establish whistleblowing procedures

The establishment and maintenance of whistleblowing procedures could be made a legal requirement. In the Republic of Ireland, the Protected Disclosures Act 2014 (Republic of Ireland. *Protected Disclosures Act 2014*. Dublin: Government of Ireland; 2014) places a specific requirement on public bodies to create and maintain procedures for employees to make protected disclosures and provide them with information concerning this.

Early-stage protection for whistleblowers

Whistleblowers should be able to apply for whistleblower status to receive early-stage protection. Currently, an employee can apply under section 128 of the Employment Rights Act (Great Britain. *Employment Rights Act 1996*. London: The Stationery Office; 1996) to an employment tribunal and ask for an order that they can remain employed. This will maintain the contractual arrangement while waiting for the whistleblower's case to be determined. However, this has limited utility: whistleblowers must act within 7 days, it is expensive and employers cannot be forced to allow the whistleblower to continue working.

Incentives for whistleblowing

One possible approach that can be taken to encourage whistleblowers to come forward is the provision of financial incentives, whether in the form of proportion of fines levied or other financial benefits obtained as a result of their disclosure. Incentives have been used in other contexts, notably in the USA, where the Dodd–Frank Wall Street Reform and Consumer Protection Act (United States of America. *Dodd–Frank Wall Street Reform and Consumer Protection Act*. Washington, DC: Library of Congress; 2010) provides substantial incentives of between 10% and 30% of monies of > US\$1M recovered by the government.

Confidentiality/'gagging' clauses

Confidentiality or so-called 'gagging' clauses may be seen as valid and appropriate from an employment law perspective, but considerably less so from a freedom of speech approach to whistleblowing or from a regulatory approach. It remains very questionable as to the extent to which such clauses are ever

appropriate in the public sector, and in the past the Secretary of State for Health has indicated that these would be banned. Further work and/or guidance in this area may be necessary.

Using the criminal law to protect whistleblowers

The legislation in England and Wales does not provide for criminal penalties against those who commit reprisals against whistleblowers. In contrast, such provisions do apply in relation to certain other jurisdictions. For example, the US Sarbanes–Oxley Act {Sarbanes–Oxley Act [2002] (Pub.L. 107–204, 116 Stat. 745, enacted July 30, 2002)} states that it is an offence to ‘knowingly and with intent’ take actions harmful to another person.

None of the potential avenues for legal innovation laid out above offers simple or swift remedial action to a patched and patchwork legal system. Nonetheless, they do lay out avenues for future discussion, consultation and empirical research.

Research objective 4: learning from the findings of formal inquiries

There have been numerous formal Inquiries into care failings in the NHS, and we reviewed what these had to say about whistleblowing, from the Kennedy inquiry up until the latest round of Francis Reports following the care failures in Mid Staffordshire NHS Foundation Trust.

Few specific recommendations on whistleblowing

It is perhaps surprising given their subject matter, but there is little specific discussion of, or recommendations concerning, whistleblowing across these Inquiries. The Inquiries focus (perhaps disproportionately) on patient complaints rather than on employee voice. Of some 820 recommendations across all of the Inquiries reviewed, only eight are directly concerned with whistleblowing.

Diverse definitions of whistleblowing

There appear to be three dimensions to whistleblowing contained with formal Inquiry reports: (1) whether or not the person works for the organisation, (2) whether they raise concerns internally or externally (or escalate from internal to external, if the internal route produces no results) and (3) whether or not they are a whistleblower in the strict legal sense of the term and are making a ‘qualifying statement’.

Cultural change over legal safeguards

It was notable that most Inquiry accounts focused on the ‘system’ rather than on the people within it. The most consistent system remedy drawn out from Inquiry recommendations is cultural reform and renewal rather than legal safeguards. By finding fault with culture and providing prescriptions for change, several Inquiry reports make assumptions that require examination. First, they presuppose that we can identify and assess common aspects of culture, as well as identify which aspects are supportive of, or inimical to, high-quality care. Second, they assume that these aspects of culture can be purposely changed, that any changes will lead to improvements, and that the costs and dysfunctions from such prescriptive changes will be outweighed by the benefits. However, much research shows more complex and nuanced relations between cultures, practices and outcomes than implied by Inquiry reports.

Reinvention and retreads

Evident from the Inquiry reports is a high degree of reinventing the wheel, with some return to similar solutions over time: a situation that has been described as ‘Groundhog Day’ as recommendations from previous Inquiries become recycled. The clearest example of this is the repeated identification of culture as both a culprit of and a solution to periodic failings in the quality of care in the NHS.

Optimism over improvements

Many of the reports appear to be somewhat optimistic that ‘things are getting better’: that institutions, policies and procedures are in place that will not allow earlier problems to recur. Governments typically tend to argue that ‘much has changed’ since the incidents took place, and that remedial policies have been put in place. However, although there have been some positive changes, there remains a concern

that the deep-rooted and diverse challenges exposed by these Inquiries have yet to be fully addressed, and that the potential for effective whistleblowing policies has yet to be fully exploited.

Conclusions

Taken together, the arguments emerging through the various strands of this work highlight the need for a new socially situated research agenda, not just of whistleblowing as aberrant activity, but of the full range of organisationally embedded communications, sense-making, judgement-forming and responses. Although some form of whistleblowing – and the social, legal and structural arrangements in support of it – may always be necessary, a better understanding of these organisationally situated dynamics may, paradoxically, enable a diminution of its prominence.

Current policy prescriptions that seek to develop better whistleblowing policies and nurture open reporting cultures are in need of better evidence. Although we have set out a wide range of issues that need consideration in the development of whistleblowing policies, it is beyond the remit of this research to convert these concerns into specific recommendations of the ways in which current policies can be improved: that is a process that needs to be led from elsewhere, in the light of this new evidence summary, and in full partnership with the service. It is our view, however, that there is still much to learn regarding this important but under-researched area of health policy and management practice, and to this end we have highlighted a number of important gaps in knowledge that are in need of more sustained research.

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