

Does the risk of reprisal prevent nurses in the NHS from blowing the whistle on bad practice?

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Nurses are often exposed to the dilemma of whistleblowing. A literature review was undertaken to identify the barriers to speaking out against unsafe practice

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Abstract

Whitehead B, Barker, D (2010) Does the risk of reprisal prevent nurses in the NHS from blowing the whistle on bad practice? Nursing Times; 106: 43, early on-line publication.

Background Despite the introduction of legislation to protect people who report poor or unsafe practice, [whistleblowing](#) can still have serious consequences for nurses.

Aim To review the literature on whistleblowing in healthcare, and explore the barriers to reporting poor practice.

Method Studies focusing on whistleblowing in healthcare were used to assess the safety of incident reporting, and to determine what prevented nurses from reporting poor practice.

Results Four major themes were identified as the main barriers to whistleblowing in healthcare: experience of the nurse; confidentiality and reporting processes; incident severity; and personal beliefs.

Conclusion Reprisal for whistleblowing remains a major concern for nurses. [Patient safety](#) could be improved by prioritising confidentiality and creating an environment where nurses feel safe to report poor practice.

Keywords Whistleblowing, Incident, Reporting, Poor practice, Unsafe practice

- This article has been double-blind peer reviewed

Practice points

- Numerous factors, including the severity of the incident, the confidence of the nurse, and personal beliefs, all influence a nurse's decision on whether to blow the whistle on poor practice.
- Reprisal for whistleblowing remains a major issue for nurses. Organisations should create an environment where nurses feel able to report incidents safely.
- Incident reporting processes can be very complex.
- Simplifying the process and making it more accessible could improve reporting rates.

Introduction

Health service employers will have to pledge to support whistleblowers under proposed changes to the NHS constitution. The amendment was announced by health secretary [Andrew Lansley](#) who identified that staff have a legal right to raise concerns.

Recent cases of whistleblowing include that of nurse Margaret Haywood, who blew the whistle on poor care at a Brighton Hospital in 2005. Ms Haywood was struck off the [Nursing and Midwifery Council](#) register in April 2009 for breaching patient confidentiality but was reinstated seven months later after a battle, backed by the Royal College of Nursing. Ms Haywood's case prompted an outpouring of support from the public, with more than 43,000 signing a petition which successfully called for the [NMC](#)'s decision to be reversed (RCN, 2009).

This inspired us to explore in more depth the safety of whistleblowing in healthcare.

The UK Public Interest Disclosure Act 1998 (tinyurl.com/disclosure-act) aims to protect people who blow the whistle on poor or unsafe practice. However, whistleblowing can still have serious consequences for healthcare professionals and the patients they care for.

Aim

The aim of this [study](#) was to review the literature regarding the appropriateness and safety of whistleblowing by nurses, and explore what hinders them from reporting poor or unsafe practice.

Method

To familiarise ourselves with literature reviews and provide a general overview of the topic, we assessed a range of literature focusing on whistleblowing in healthcare.

This gave us a methodological framework and general background within which to contextualise and explore the issue.

Literature review

Using the Elton B Stephens Company (EBSCO) portal, we carried out a systematic search of the following databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL); Medline; the Allied and Complementary Medicine Database (AMED); and the British Nursing Index (BNI). A separate search of Elsevier Science Direct was also conducted.

The search was limited to research carried out between 1998 and 2010, after legislation to protect whistleblowers was introduced in the UK. Using the key words “whistleblowing”, “whistle blowing”, “nurs*”, “NHS” and “whistleblower”, we found almost 20,000 articles.

After further analysis, 403 studies remained, 271 of which we discarded because they did not meet the criteria of empirical research or primary studies. According to Aveyard (2007), empirical studies refer to research that has been undertaken by means of an accepted scientific method, developing a research question, identifying a methodology, and presenting and discussing the results.

Of the remaining 132 articles, six were included in the final analysis. These articles, which are outlined in Table 1, were most closely aligned to the original research question of the literature review.

TABLE 1. EMPIRICAL RESEARCH ARTICLES USED FOR FINAL ANALYSIS

| Source | Title | Aims | Research method | Study characteristics | Additional analysis | Findings | Limitations |
|---------------------------------------|---|---|--|--|--|---|---|
| Bellorizaine (2009) (UK) | Exploring whether student nurses report poor practice they have witnessed on placements | To explore what influences student nurse's ability to report unsafe practice in clinical placements | Qualitative, purposive sampling, six individual semi structured interviews | One mental health, three children's and two adult student nurses; four x second and two x third year students at inner London hospitals | Content data analysis through process of coding and identifying four main themes | Indicated that unsafe practice is going unreported. Four main themes emerged as to why they did not report poor practice | No first year students expressed an interest. Small sample size not a true representative of all student nurses |
| Athre (2007) (UK) | Factors influencing nurse's decisions to raise concerns about care quality | To explore factors that influence nurses' decisions to raise concerns on poor practice | Qualitative, semi structured interviews | Registered practising nurses – 66 medical, 55 surgical and 21 from other people's wards – from three NHS acute trusts | Grounded theory. Interviews were taped. Constant comparative analysis used to identify theoretical codes and identify three main themes for guided interviews | Fear of repercussions, attribution, labeling and blame. Nurses lacked confidence in reporting system | While there was a high degree of consensus between the nurses, the sample was not statistically representative |
| Kingston et al (2004) (Australia) | Attitudes of doctors and nurses towards incident reporting: a qualitative analysis | To examine attitudes of medical and nursing staff to reporting incidents | Qualitative, purposive sampling, semi structured interviews to five focus groups | Fourteen medical staff and 19 nurses from three public hospitals. The focus groups represented consultant, registrars, resident medical officers, senior nurses and junior doctors | Iterative approach to data categorisation. 'Rands theory of social behaviour used'. Transcripts generated from audiotapes and independently coded by two researchers, with a third person adjudicating. Seven themes on barriers | Cultural differences between doctors and nurses. Nurses reported more habitually than doctors | The voluntary nature of participants meant there was the potential for more motivated and opinionated people to attend than if random sampling had been used |
| Ahern and McDonald (2002) (Australia) | The beliefs of nurses who were involved in a whistleblowing event | To explore the beliefs of nurses who wrestled with whistleblowing ethical dilemmas | Qualitative, descriptive survey design, postal questionnaire, the port Likert scale used | Five hundred nurses from register, known to be whistleblowers and non whistleblowers; only 95 responses received in time for inclusion | Parson's correlation matrix and a one way ANOVA. To further explore, factor analysis was run with varimax rotation. Four themes identified | Whistleblowers agreed more strongly with traditional statements | Low response rate of 20% and the post hoc power analysis indicated a 33% chance of type II error being made. Higher proportion of whistleblowers (three quarters) than in most workplaces |
| Orbe and King (2000) (US) | Tension between policy and reality: exploring nurses' communication about organisational wrongdoing | To explore the ways in which nurses communicate wrongdoing | Qualitative, administered surveys, with two questions on critical incidents | A random sample of 1,900 working nurses, provided by state board, were sent surveys; only 202 critical incidents received in time for inclusion | Phenomenological techniques, bracketing, self reflexivity and inductive free variation. Collective reviewing of each step to reveal the five themes | It provided a foundation of information on what nurses perceive as organisational wrongdoings as well as factors that guide their responses to such | It does not propose to represent all nurses' or others' responses to policy violations in the workplace |
| King and Hemmion (2000) (US) | Peer reporting of coworker wrongdoing: a descriptive analysis of observer attitudes in decision to report versus not report unethical behaviour | To examine factors that may affect peer reporting of questionable behaviour by colleagues | Qualitative, two open ended postal survey questions | 197 nurses responded to a survey regarding reports of unethical behaviour by coworkers; 89% were employed by hospital/in health hospital system; 93% were female | A number of coding procedures. Responses were divided into two. Each then described the wrongdoing which was separated from the transcript and placed under Tenhofs three categories – individual, situational or organisational | Numerous individual, situational and organisational issues may affect an employee's decision to report or not report unethical behaviour | Majority of respondents worked in a hospital or multi hospital, so limited or no response from nurses in positions such as school health, office and day care, and other professionals outside the hospital |

Source: empirical research articles

The terminology used in the articles to represent an act that warrants reporting included wrongdoing, unsafe or poor practice, and raising concerns.

To offer a comparison of whistleblowing cultures outside the UK, we included articles from Australia and the US. We acknowledge that the different legal, professional and social environments in these countries may make it difficult to compare the studies.

To assess the qualitative research methods used in the articles, and to ensure the research question was properly addressed, we conducted a critical appraisal skills programme (CASP) ([Public Health](#) Resource Unit, 2006).

The preferred reporting items for systematic reviews and meta-analysis (PRISMA) guidelines were also followed (Moher et al, 2009).

Results

All the articles reviewed had an in depth understanding of the reasons for whistleblowing, and the meaning of human behaviour with regard to whistleblowing.

In addition, four studies (Bellefontaine, 2009; Attree, 2007; King and Hermodson, 2000; Orbe and King, 2000) used a phenomenological approach to explore how the research participants viewed their lived experiences and attitudes related to the topic.

The literature review suggested numerous factors could prevent nurses from whistleblowing, but four common themes emerged. These were: the experience of the nurse; confidentiality and reporting processes; severity of the incident; and personal feelings and beliefs.

Experience of the nurse

King and Hermodson (2000), who surveyed 197 nurses about unethical behaviour by coworkers, found being new to an organisation could affect whether or not a nurse reported wrongdoing.

Bellefontaine (2009) and Orbe and King (2000) agreed, suggesting it was experience that has an impact on how, or if, incidents are reported. However, the study by Kingston et al (2004) found that, although nurses were more likely to report incidents than doctors, experienced nurses were complacent when it comes to incident reporting.

Three studies suggested a previous negative response, such as complaints not being upheld or investigated, could make nurses unwilling to report incidents (Attree 2007; King and Hermodson, 2000; Orbe and King 2000).

Confidentiality and reporting processes

Kingston et al (2004) studied the attitudes of 19 nurses and 14 doctors towards incident reporting. Both professions said simplifying the reporting process would make it easier for them to comply with their professional duty to report. The researchers also suggested that clarification of what constitutes an adverse event or near miss could help improve incident reporting rates.

Bellefontaine (2009), who studied student nurses working in London hospitals, found that difficulties in using reporting processes influenced students' decisions on reporting incidents.

Orbe and King (2000), who studied 202 critical incidents, suggested staff were more likely to use internal disclosure channels to report incidents in organisations that were supportive of these channels.

The study by Attree (2007) found that nurses feared negative consequences of raising concerns, such as being labelled a troublemaker or being seen as disloyal by colleagues. This study of 142 registered nurses from three NHS trusts revealed the reporting culture was seen as "closed, concealing and blaming".

In their Australian study, Ahern and McDonald (2002), who questioned 95 nurses involved in a whistleblowing event, found nurses wanted to take morally correct action and report adverse incidents, but often felt unable to for a variety of pragmatic reasons. Barriers included bureaucratic policies, paternalism, procedures promoting "traditional roles", autocratic [management](#) management styles and "the doctor-nurse game" where nurses are culturally subordinate to doctors.

Incident severity

According to the NMC, all nurses have a duty to voice concerns if poor practice is witnessed (NMC, 2008).

However, Ahern and McDonald (2002) argued it was the severity of the poor practice that dictated whether nurses reported incidents or not. King and Hermodson (2000) and Orbe and King (2000) agreed that some errors, such as those involving medication where there had been no harm to the patient, went unreported. Orbe and King (2000) identified substantial evidence suggesting that numerous near misses were being under reported.

Attree (2007) and Bellefontaine (2009) suggested the level of confidence of the individual nurse could have an impact on incident reporting rates. In the study by Bellefontaine (2009), students' degrees of professional knowledge and previous experience was shown to be a contributory factor in the reporting of incidents.

According to Orbe and King (2000), "politics" had a significant influence on one nurse's decision to report in their study. As the participant said:

"I did not report these incidents because my husband's father was the patient and my husband is a local nursing administrator. Politically he said he could not afford to report this. I know this

was not appropriate for two healthcare professionals but we're by no means perfect people.” (Orbe and King, 2000)

However, it could be argued that, as this statement is representative of only one participant, it merely suggests one individual's view rather than an overall consensus.

Feelings and personal beliefs

The six studies in this literature review acknowledge that whistleblowing is an emotive subject with thoughts, feelings, morals and personal beliefs entrenched within it.

According to Kingston et al (2004), attitudes, values of peers, roles, ideals and norms all have an impact on an individual's decision to perform an act of whistleblowing.

An alternative view is put forward by Ahern and McDonald (2002), whose study suggested that whistleblowers operated on two different belief systems. The “rational advocacy role” concerns nurses who know whistleblowing is risky but put patient safety ahead of their personal considerations. The “traditional role” concerns nurses who lack autonomy and are obliged to follow orders from more senior members of staff.

Some of the researchers acknowledged that nurses faced personal, ethical dilemmas on a regular basis with regard to the decision to whistleblow (Attree, 2007; King and Hermodson, 2000; Orbe and King, 2000). Some nurses felt it was difficult trying to perform their duties in a “less than ideal world”, and characterised the process of raising concerns as a difficult journey they were reluctant to begin. Others felt that experiencing dilemmas led to problems in deciding how to handle their concerns (Attree, 2007).

Kingston et al (2004) suggested that nurses' concerns were often related to personal protection and possible punitive repercussions, and Ahern and McDonald (2002) offered evidence supporting nurses' fear of reprisals and repercussions within whistleblowing dilemmas.

Discussion

The literature review revealed many different aspects and beliefs of the whistleblowing experience.

However, as no single definition of whistleblowing was agreed by all of the researchers, it is unclear what actually constitutes a whistleblowing act.

The articles reviewed presented several themes that appear to hinder nurses from whistleblowing.

Reporting processes

The study findings suggest the complexity of the reporting process is a barrier to whistleblowing.

In recognition of this, Australia, the US and the UK have all initiated national healthcare incident reporting systems (Attree, 2007). However, it is unclear which studies were completed before these systems were put in place.

Negative experiences

Bellefontaine (2009) indicated that negative experiences could act as a deterrent to whistleblowing and nurse [educators](#) may need to take this into consideration as nurses appeared to be disillusioned.

However, as Bellefontaine acknowledged, this study has possible limitations because of its small sample size, suggesting that further research was needed in this area. According to Attree (2007), and Ahern and McDonald (2002), whose sample sizes exceeded Bellefontaine's (2009), future research should review the support nurses receive when dealing with organisational reporting systems.

Morals and [ethics](#)

The review raises questions over the ethics and moral judgement of nurses, along with the possible legal implications of whistleblowing.

The inconsistencies in the studies make it difficult to determine which major factor could make a nurse blow the whistle.

However, there does appear to be a definite link between the professional obligation – reflected in the nursing codes of conduct in the three countries studied – to report and the ethical or moral response to reporting.

This response is that nurses feel obliged but not always empowered to report even where they are empirically disadvantaged in doing so. The lack of empowerment can, unfortunately, lead to nurses pragmatically failing to report where they feel professionally and ethically that they should do.

Policymakers may need to address this as it could affect the development processes that influence and inform relevant policies, reduce risks and ensure robust clinical governance.

Risk of reprisal

All six research articles indicated that nurses who experience whistleblowing suffer some form of reprisal or repercussion, along with individual ethical dilemmas.

Nurses recognised patient safety was a priority but personal protection remained a priority too. The Public Interest Disclosure Act 1998 was identified as being the most important protection for whistleblowers, although this was only mentioned in one article (Attree, 2007). This act applies in Britain, but all countries represented in this review have laws in place (Bowden, 2005).

Patient safety

Evidence from five out of six articles indicated that most nurses would report if the severity of the incident warranted it. Examples included if a patient's rights or safety were jeopardised (Bellefontaine, 2009; Attree, 2007; Ahern and McDonald, 2002), or if the act was seen as having criminal consequences (Orbe and King, 2000; King and Hermodson, 2000).

Although Kingston et al (2004) touched on this subject – patient safety and welfare were expressed as a concern – other factors were identified as more significant to incident reporting.

Conflict between their professional duty to report and the risk of negative consequences, along with the complexities of the reporting process, appear to be the main obstacles discouraging nurses from whistleblowing.

Conclusion

Reprisal for whistleblowing remains a major concern for nurses. Future research should concentrate on developing an environment where nurses feel able to report incidents safely. Confidentiality should be given priority, thereby reducing the fear of reprisal or future repercussions.

The reporting process could be simplified and made more accessible, with an integrated support mechanism included. This would further enable all healthcare professionals to feel protected and supported while facing the dilemma of having to perform an act of whistleblowing.

The nature of the job means nurses are more frequently exposed to the dilemma of whistleblowing than other clinical staff.

These recommendations could go a long way towards making nurses feel more confident to speak up, facilitating a more effective and safe healthcare environment for patients and healthcare professionals alike.

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