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**Speaking out in organisations – a broader perspective.**

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Setting the scene:

Recent inquiries into care settings have raised serious concerns about care provision (Francis 2010, 2013). Between 2005 and 2009 up to 1,200 patients are believed to have died prematurely as a result of poor care at Mid-Staffordshire NHS Foundation Trust. The public Inquiry into care at the Trust (Francis 2013) made 290 recommendations with an aim to provide a basis for improvement. In its description of failings at the Trust (Francis 2010; 2013) many issues relating to nursing care were outlined such as:

* Failures responding to call bells
* Not ensuring frail patients’ meals were in reach
* Ignoring patients lying in soiled beds, sometimes for hours
* Nurses with attitude problems who were dismissive of patients and relatives
* Nurses exposing patients to a loss of dignity

The above points relate primarily to individual action/ non action, but broader issues relating to structural and organisational failings were also highlighted. Both of the inquiries cited above highlighted numerous issues such as multi- agency failings and a culture focussed on:

* “Doing the system’s business, not that of the patients.”
* “An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern.”

(Francis 2013:4).

It is hard to imagine that all staff were at ease with the above situation but ‘speaking out’ about what one thinks might be wrong is a difficult thing to do. Previous research in the nursing arena (Melia 1982; Levett-Jones and Lathlean 2009) has shown for example, that there has been pressure for student nurses to fit in, conform and comply, even in the face of moral distress and a conflict with their own values (Gallagher 2011). In the process they become socialised into an ‘acceptable way of being’. Qualified staff face similar pressures and the Patients First (2014) submission to ‘The Freedom To Speak Up’ chaired by Robert Francis indicates that there were many staff who did speak out, but some were ostracised and made vulnerable for doing so. The literature indicates that there is not a simple dichotomy between speaking out and not speaking out, and this is something that will be explored within this paper.

Wright - Mills (1959) commented on ‘personal troubles and public issues’. To apply this to the above situation: if one nurse ignores a call bell or leaves a patient in a soiled bed it is his or her particular problem. If many are doing it then it becomes an organizational issue – and the art of the sociological imagination is to explore some of the ‘taken for granted assumptions’ and ask why? Given that the Public and Independent Inquires discussed above point to more than just ‘a bad apple’ or the ‘individual’ as being the cause / source of the issues, there is a need to explore some broader aspects of the situation, in particular why some people do speak out, whilst others do not, and the circumstances of this. Also, the nursing profession has a code of conduct (NMC 2015) which indicates that nurses are under a professional duty to raise concerns[[1]](#footnote-1) but this in itself obviously did not enable all those who should have spoken out to do so (Francis 2014).

The issues raised by the Inquiry are to some extent not new issues, and inquiries into health and social care provision have a long history (Robb 1967, Martin 1984, Stanley and Manthorpe 2004, Mandelstam 2011), with the subject of staff not ‘speaking out’ or being ‘open’ when there were obvious problems, being a central theme. Sheppard (2004) outlines 152 inquiries from 1985-2003 into the care and treatment of people with mental health problems and/or learning disabilities, but what appears to be relatively new is the increasing number of inquiries into care provided in acute general hospitals and primary care settings. This could be seen as a positive thing (more people raising concerns that have always been there but not spoken about) or a negative thing (more issues of concern happening).

Of the 290 recommendations that were made as a result of the 2013 report (Francis 2013), there are two key areas cited by him which will be discussed 1) the need to ensure openness, transparency and candour about matters of concern (or a variation of this); and 2) the need to enhance education, training and support, particularly for those in nursing (and leadership) positions. It is the intention of this paper to review and critically analyse some key theories and concepts that relate to these issues, and to consider how these might apply to the educational programmes that are delivered to student nurses. The underpinning theory used in support of this paper will range from the broad (i.e. structural and organisational factors that may silence us) to the narrow (i.e. the individual reasons why people may or may not speak out), and educational theory that may best fit with an attempt to enable a voice for those who identify a concern.

The issues

One key issue that emerges from the Independent and Public Inquiries (Francis 2010, 2013) and which fits with ‘asking why’ (Wright- Mills 1959) is the concept of human devaluation and Social Role Valorisation (SRV) – a theory outlined by Wolfensberger (1998), Race (2006), and Osburn (1998). This theory asserts that people who are perceived to be of a lower value in our society (eg the mentally ill, old, learning disabled, and other vulnerable groups) will be more at risk of being devalued, and are at risk of having bad things happen to them. These groups are more likely than other members of society to be treated badly and be subject to a systematic pattern of negative experiences such as:

1. Being construed as "deviant," due to their negatively-valued differentness (by virtue of physical or functional impairments, low competence, certain behaviours or associations).
2. Being rejected by community, society, and even family and services.
3. Being cast into negative social roles, some of which can be severely negative, such as "subhuman," "menace," and "burden on society."
4. Being put and kept at a social or physical distance, the latter most commonly by segregation (eg placing children in ‘special schools’ or older adults in ‘care homes’).
5. Having negative images (including language) attached to them.
6. Being the object of abuse and violence (adapted from Osburn 1998).

This theory is explored with students in their first module, and has some empirical support (Fiske 2012; Harris and Fiske 2009), who outline how our social structures and our stereotypes of whether we perceive other people to be emotionally ‘warm’ and / or competent, influence our emotions (namely disgust, envy, pity or pride) which result in helping / harming behaviours towards those other people. This could be argued to be borne out in the Francis Independent Inquiry of 2010, where the majority of people suffering indignities and poor care were devalued in some way as defined above, and were older adults, possibly deemed to be lacking competence. This would be particularly so of institutionalized individuals where their access to the everyday sites of life (Wolfensberger 1996) and to some extent their access to other people, is limited by the very people caring for them. Staff speaking out in this context is essentially something that helps to protect and safeguard the vulnerable who would otherwise be ‘captive’ within a service (Wolfensberger 1996).

Another issue that is important to recognise, is that some of the published work on ethics, values and ‘doing the right thing’ will fit into the framework here because how we teach this and talk about it with students is *supposed* to form a basis for how they will behave in the future. Values have been defined in the literature (Rokeach 1973) as everything from eternal ideas to behavioural actions. They are affectively laden thoughts about people, objects, ideas and conduct etc. that guide our behaviour. Within educational theory, and within nursing education, there has been a distinction made between knowledge (the cognitive), skills (the observable behaviour) and attitudes (the values or affective qualities) that students may possess (Krathwohl et al 1956). Within the nursing arena knowledge and skills have been generally recognised as elements of learning that are perhaps more readily assessable than affective or attitudinal ones (Duffy 2003).

The third key issue is that within the literature it is possible to identify six key concepts / definitions that are framed in such a way as to describe the issue of whether people speak out or remain silent about things which concern them:

1. Open disclosure (or a duty of candour)
2. Speaking out
3. Whistleblowing
4. Silencing
5. Acquiescence
6. Willful blindness

Whist there are some similarities and degrees of inter relatedness between these, it is important to distinguish their differences in order to provide a clear focus for any subsequent research.

1) **Open Disclosure**: One of the recommendations from the Francis Report (2013) has resulted in a new policy which came into force in 2014 (Department of Health 2014a,b,c).It will be focused on being truthful and not covering up issues, as well as speaking openly. This ‘duty of candour’ will require all health and adult social care providers registered with Care Quality Commission (CQC) to be open with people when things go wrong. The regulations will impose a specific and detailed duty of candour on all health and social care providers where any harm to a service user from their *care* or *treatment* is above a certain harm-threshold (though how harm will be defined may prove problematic). The duty of candour will be a legal requirement and the CQC will be able to enforce penalties if it finds breaches. The concept of ‘open disclosure’ has been on the agenda for some time, and in 2009, the National Patient Safety Agency relaunched its ‘Being Open’ framework (NPSA 2009) to try to enhance open disclosure in the UK. A review of the international literature on open disclosure since 1980 (Birks et al 2014) indicated that the principle of truthfulness was widely supported but not always upheld. This was primarily because of uncertainties over what should be disclosed, by whom, when and how. Being truthful and open about mistakes was supported in theory but was reported as being difficult to put into practice. As a result of this review it was suggested that open disclosure should be seen as a process and not a one-off event as it is often described. The key message seemed to be that while open disclosure is widely considered as the right thing to do, creating a *culture of* *openness and a good work environment* rather than *blame of an individual* was a central requirement to facilitate this. This again is something that is not new, and indeed the aviation industry has a culture of reporting near misses and anything which is of concern in a non- punitive way (Aviation Safety Reporting System 2014) to enhance safety. This is something which was outlined as a good idea for the NHS eighteen years ago (Department of Health 2000). The report stated that:

*“When things go wrong, whether in health care or in another environment, the response has often been an attempt to identify an individual … who must carry the blame. The focus has tended to be on … the human acts or omissions immediately preceding the event itself.*

*It is of course right in health care… that individuals must sometimes be held to account for their actions …yet in the great majority of cases, the causes of serious failures stretch beyond the actions of the individuals immediately involved.” (DOH 2000 p vii – ix)*

2) **Speaking Out**: Another result of the Francis Inquiry (Francis 2013) has been the review resulting in ‘Freedom to speak up’ - an independent review again chaired by Robert Francis (gov.uk 2014a), which was appraisal of creating an open and honest reporting culture in the NHS. Patients First (2014) have submitted a document to this review indicating that speaking out still appeared to be a problem, and in a separate review, staff have reported problems raising patient safety concerns in seven of fourteen acute trusts investigated in a recent major review ( cited by Ford 2013).

3) **Whistleblowing**: Whistleblowing is when a worker reports suspected wrongdoing at work. Officially this is called ‘making a disclosure in the public interest’ (gov.uk 2014b). A worker can report things that are ‘not right’, are illegal or if anyone at work is neglecting their duties. Whistleblowers are protected in the law as long as certain criteria are met [[2]](#footnote-2).An extensive research literature exists on so called ‘whistleblowing,’ which often involves major exposure of serious wrong doing including such things as physical and sexual assaults on patients by staff, fraud, medical incompetence and bullying, but the Francis inquiry report documents at length (see Francis Report 2010, Vol.2) what might be described as a ‘drip drip’ of low level violations which over time and with increasing frequency leave patients, feeling devalued, angry, stressed and with a loss of dignity and trust. A salient aspect of this situation is not why it failed to lead to ‘whistleblowing’ at the time in a more concerted way (because a small number of staff did in fact ‘whistleblow’) but why so many staff remained silent? Malstrom and Mullin (2014) provide an summary of why they believe whistleblowing does not work, primarily based on empirical evidence outlining why loyalty within a team who are working together is easier to enforce than honesty.

4) **Silencing:** Silencing is often about being ‘silently silenced’ and feeling uneasy, unwilling, or lacking the courage to voice an opinion, sometimes not being aware that you are being silenced (Mathiesen 2004). Modern panoptical and synoptical devices function as silencing systems in that they are silencing large groups, even whole populations (Mathiesen 2004; Bauman and Lyon 2013). Silencing is structural in that it is part of our everyday lives, it passes us by unnoticed, and it is unbounded because it is difficult to pinpoint its limits. So in simple terms, structures, organisations and processes may silence us despite what we may feel. Mathiesen (2004) argues that the pressures to not speak out outweigh the desire to do so. He highlights five main features which are typical of the ways silencing takes place:

* Absorption - attitudes and actions are integrated into the prevailing order, and are made unthreatening to the prevailing order. Administrators and leaders become carriers of messages which then become an integrated part of the state, and criticism against the state is avoided.
* System placement - in work life, and in large groups, people are exposed to a ‘place in the system’ and role assignment which essentially subordinates people in a hierarchy. Individuals are exposed to a long series of pressures which put the brakes on transcendence.
* Professionalization – persons and groups who might otherwise have represented transcending attitudes are sucked into the professions in society. Mathiesen (2004) argues that no society brings forth professions which take a revolutionary or critical stance. He maintains that the subordination which professionalization entails takes place initially during the training period. To apply this to nursing would be to consider the way that students have to ‘fit in’ in order to pass assessed practice elements of a programme.
* Legislation – law and jurisprudence offer a specific way of silencing. This is in part because the distinctive form of talk used by the apparatus of law, resulting in intimidation / refraining from opposition. One could add to Mathiesen’ s definition here, that the language of professionalization (medical and nursing) results in a similar situation.
* Masking – this is about an outward change of name or a shedding of a previous ‘skin’. This contributes to silencing because the ‘old thing’ which has bad associations suddenly becomes something else (adapted from Mathiesen 2004). An example might be Windscale being renamed Sellafield, and Stafford Hospital being re-named County Hospital from 1st November 2014 (BBC News 2014).

5) **Acquiescence**: Mathiesen (2004) describes this as a process of quiet, unseen, unnoticed, non-physical silencing, or fitting in. It happens when a person knowingly stands by without raising objections to infringements on their rights, but it is generally seen to be a type of permission or agreement given by being passive.

6) **Willful Blindness**: The legal concept of wilful blindness originated in the 19th century. The judge in the case of Regina v Sleep (1861) ruled that an accused could not be convicted for possession of government property unless the jury found that either he knew the goods came from government stores or he had "wilfully shut his eyes to the fact"(Heffernan 2011a,b). Cases of willful blindness are not about hindsight. They feature contemporaneous infor­mation that was available but ignored (Heffernan 2011a,b). It could be argued that much of what was not ‘spoken out’ about but was reported on in both of the Francis Inquiries (Francis 2010, 2012) amounted to willful blindness. In Terms of action on this point, The Department of Health has introduced a new criminal offence of ill treatment and Willful neglect from 2015 (Nursing Times 2014).

Questions for education and future research

As a practitioner working to train and educate future nurses within a modularized pre-qualifying nursing degree, I run an existing module entitled: Professional Values, Attitudes and Behaviour in year one of the programme. Some of the questions raised for us as educators of future / current nursing practitioners are in order to support the supposed values that nursing operates, how can we foster ‘speaking out’ in a constructive way, that does not threaten the person doing the ‘voicing of the opinion’? And how can we foster an awareness of the broader circumstances that influence our voicing of these opinions? Will this make a difference to behaviour or simply to awareness?

One theory which fits well here is Bandura’s concept of self-efficacy (Bandura 1963,1977a,b) which outlines how persistence in activities that may be perceived as threatening (but are relatively safe) enhance self –efficacy and reduce defensive behaviour – and provide mastery. This concept of self-efficacy was developed as part of a larger Social Learning Theory, and the later Social Cognitive Theory (Bandura 1986). Social Cognitive Theory highlights how cognitive, behavioural, personal and environmental factors interact to determine motivation and behaviour in people. According to Wood and Bandura (1989) there are many factors that play a part in human behaviour but these are not of equal strength and do not always occur simultaneously. For example, how people behave (behavioural factors) in the workplace will be influenced by how the person is affected (cognitive factors) by organisational and environmental factors (which thus fits in with Mathiesen’s (2004) ideas about silencing). Empirical work by VanSandt et al (2006) provides evidence to support that an ethical work climate is a primary predictor of individual moral awareness, and that the influence of social factors often override the effects of individual moral / ethical differences in a work group setting.

In support of the idea that practising something may enable one to be more effective at dealing with it, Gentile (2010) has developed a curriculum called **‘***Giving Voice to Values*’ which aims to enable people to effectively stand up for their values in the face of opposition. It is not aimed changing people who are ‘unethical’ into ‘ethical’. Rather, it is premised on the assumption that within any group of students there will be “opportunists” (those who claim they pursue their own self-interest regardless of Values) “idealists” (those who attempt to adhere to adhere to their values) and “pragmatists” (those who would like to adhere to their values as long as it does not put them at a disadvantage – see also Malstrom and Mullin 2014). Her educational intervention focusses mainly on the pragmatists to provide skills, tools, insights and the “rehearsal” to prepare for speaking out. Incorporating aspects of Gentile’s work into a future study or educational provision would enable use of previously well explored concepts in a new setting, given that her initiatives have focussed mainly in a business setting. This coupled with an exploration of issues faced by those who do speak out; those who do not; or those who feel as if they may have ‘acquiesced’ would be a starting point for future research that would aim for us to explore and embed these skills into our curricula.

Following on from this, nurses have a duty to raise concerns (Nursing and Midwifery Council 2013), but there is a need to explore how easy or difficult this can be for individuals who work in an already bureaucratic and often large organisation. Greenberg and Edwards (2009) provide conceptual insights into voice and silence in organisations. They move beyond the issue of whistleblowing and address some of the ‘ordinary’ situations about employees being able to speak out, actually speaking out, knowing what to say, and considering the consequences of this. Many of these ordinary situations raise ethical concerns, but it is the premise of the author that they may not be viewed as such– for example – would a nurse who decides not to take a thirsty patient a cup of tea because they are ‘too busy’ see this as an ethical issue? It is also the premise of the author that when confronted with dilemmas such as those described in the Mid Staffordshire Hospital Public Inquiry (Francis 2012) many nurses (despite thinking they would stand up for their ethical principles and values) would in fact remain silent, especially in the case of such so called ‘low level’ ethical transgressions because of the complex nature of silencing in organisations.

In addition to the requirement to comply with the requirements of a Code of Professional Conduct (NMC 2015) all nurses will have had some instruction on healthcare ethics and values as part of their pre-qualifying training because it is a requirement stemming from the educational standards set out by the governing body concerning nursing values (NMC 2010), and is one of the ways that ethical/ moral/ legal issues are set out as needing to be covered in the curriculum. So the requirement to speak out is essentially embedded, and often couched in terms of ‘ethical behaviour’, as well as sticking to a deontological/ virtue based code of conduct (NMC 2015). Despite this being the case, the experience at Mid Staffordshire indicate that giving nurses education in healthcare ethics and values, and expecting them to comply with a code of conduct has not, and arguably will not prevent such failings occurring either now or in the future.

The ‘standard’ model of teaching ethics and values, often based on a Kohlbergian approach (Rest et al 2009) has been that when individuals are faced with such decisions they go through the following phases: Moral Awareness - Moral Deliberation – Moral Judgment – Moral Intention – Moral Action. These phases imply a linear flow and cognition, and the model appears to presume that: Awareness is needed for a decision to have moral implications; An individual’s reasoning determines judgment; Moral intention is required for the actor to understand her moral action. But there is evidence that this model may be incomplete and misleading, and criticisms have arisen from psychologists (particularly calling for changes in methodology) and philosophers (criticising Kholberg’s normative and deontological theory) (see Rest et all 2009). Some of the aforementioned linear assumptions, which can be at the core of training in ethics and professional values, appear to ignore some of the mounting evidence to the contrary. For example Haidt (2001) asserts that research on moral judgement has been dominated by rationalist models where this judgement is thought to be *caused* by moral reasoning. He points out that this appears *not* to be the case, and in fact moral reasoning is usually a post hoc confabulation / construction, generated after a judgement has been reached (i.e. that people will have a gut reaction as to whether something is right or wrong almost immediately, and will then provide a rationale for their actions or thoughts afterwards). Haidt (2001) postulates an intuitionist model which states that moral judgement is usually the result of quick, automatic evaluations or intuitions. This fits well with recent work by Kahneman (2012) who asserts that there are two types of thought, one being fast, intuitive, sub conscious and emotional; the other being slow, rational and more deliberative and within conscious control.

There is also wide variation in how ethics / values (and as such ‘doing the right thing’ or speaking out about this) are featured and taught in Nursing Curricula across the country (based on a review by Holt 2006) – but mostly it is based on *normative* and somewhat idealistic views of the world, which does not really take into account how people actually are. For example, empirical work by Zimbardo (2006, 2008) highlights how people may behave when they have some degree of power or authority over others, which would be an aberration from their usual behaviour. Arendt (1994) reports on how behaviours which may appear to be shocking, arise out of ‘simply following orders and processes’. People are often irrational and fallible (Ariely 2009) – and can be prone to dishonesty if they feel they are not going to be caught out (Ariely 2009), but the way we teach them may be based on exhorting them towards ideals that many practitioners may not be able to live up to. Simply being taught about what is the right thing to do, or knowing what this might be, may not be a good predictor of future behaviour. Indeed, recent studies have examined whether ethicists themselves are more moral in their ethical behaviour than other people with similar education, gender and background, and have found no evidence that this is the case. Even studies looking at Professors of Ethics and Morals fail to demonstrate that they are any more ethical than the rest of us (Schwitzgebel, E., Rust, J., 2011).

To conclude; a small pilot study was undertaken with a first year and a third-year student nurse (available on request). This was a qualitative open-ended interview approach

Analysis of the two interviews so far has been thematic and is ongoing but has already revealed some interesting results. Some of these are tabulated below, but this is an initial ‘sense’ of the discussion.

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| **Table 3- some key themes emerging from interviews** | |
| **Key theme (initial reading of transcript)** | **Wider discussion – my notes to self** |
| Complaining about a real issue seen as whingeing and moaning | i.e. seen in a negative way reflecting on the student rather than standing up for someone in a positive way. |
| Mentors in placement have the power to ‘not sign your book’ i.e. not pass your placement if you rock the boat – so you weigh up whether the thing you want to raise can wait until after you have passed your placement.  There are tensions between speaking out and fitting in. Fear of being ostracised. | Graham Pink – Stockport – research indicates that people who speak out or whistle blow are more likely to be loners rather than team players  But we select and encourage team players rather than dissenters or people who have resilience? |
| Staff want to do things ‘right’ in order to keep their PIN (registration as a nurse) – they are terrified of losing their PIN. | Issues of being loss averse and having an instrumental orientation to care. Doing things because they fear the consequences rather than because it is the morally right thing to do? |
| Would speak out about a BIG thing but can sometimes let the LITTLE things go. | Note to self – When we teach ethics in health professions we almost always focus on BIG ethics - Abortion, End of Life, Double Effect, codes of conduct etc. … but is it the *small ethics* that will probably make most difference ? – see essay (Beeston 2014 – theory in educational research) |

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1. Eg the NMC code (2015) states that:

   You must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practising

   You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk

   You must inform someone in authority if you experience problems that prevent you working within this code or other nationally agreed standards

   You must report your concerns in writing if problems in the environment of care are putting people at risk [↑](#footnote-ref-1)
2. **Types of whistleblowing eligible for protection:** that someone’s health and safety is in danger; damage to the environment; a criminal offence; that the company is not obeying the law; that someone is covering up wrongdoing.

   **Who is protected:** **Employees;** agency workers; people that are training with an employer, but not employed; self-employed workers, if supervised or working off-site; A worker will be eligible for protection if: they honestly think what they’re reporting is true; they think they’re telling the right person; they believe that their disclosure is in the public interest .(Whistleblowing- gov.uk (2014b) . [↑](#footnote-ref-2)