



Whistleblowing over patient safety and care quality: a review of the literature

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Single sentence summary: This paper reports the findings of a systematic review of the empirical research on whistleblowing over issues of patient safety and care quality.

Abstract

Purpose

To review existing research on whistleblowing in healthcare to develop an evidence base for policy and research.

Design/methodology/approach

A narrative review, based on systematic literature protocols developed within the management field.

Findings

We identify valuable insights on factors that influence healthcare whistleblowing, and how organizations respond, but also substantial gaps in the coverage of the literature, which is overly focused on nursing, has been largely carried out in the UK and Australia, and concentrates on the earlier stages of the whistleblowing process.

Research implications

The review identifies gaps in the research on whistleblowing in healthcare, and draws attention to an unhelpful lack of connection with the mainstream whistleblowing literature.

Practical implications

Despite limitations to the existing literature important implications for practice can be identified, including enhancing employees' sense of security and providing ethics training.

Originality/value

This paper provides a platform for future research on whistleblowing in healthcare, at a time when policymakers are increasingly aware of its role in ensuring patient safety and care quality.

Keywords: whistleblowing, raising concerns, speaking up, patient care, quality healthcare

INTRODUCTION

Whistleblowing continues to bring healthcare scandals to light, reports into poor standards of care highlight its contribution to the detection and prevention of harm to patients (Kennedy, 2001; Francis, 2015), and it has emerged as a central issue in debates over quality and safety in many health systems (Braithwaite et al., 2015). Yet compared to many other sectors there remains relatively little research on whistleblowing in healthcare. In this article we review existing research on whistleblowing in healthcare, to identify what insights it offers for policy and practice, and develop a healthcare-specific research agenda. Focusing on situations where the issues relate primarily to the delivery of healthcare, we define healthcare whistleblowing as the raising of concerns about unsafe, unethical or poor quality care to persons able to effect action.

This definition of healthcare whistleblowing is intentionally broad, reflecting the current state of the field. Definitional debates tend to feature extensively in the earliest work in the field,

indeed these debates often continue even as the field matures. Whistleblowing research is relatively unusual in that a single definition, developed in the early days of work in this area, quickly became the standard definition and has remained so. By the time healthcare whistleblowing research began to emerge in the late 1990s the Near & Miceli (1985) definition of whistleblowing was used almost universally – not just in the management field, but also by legal scholars, psychologists etc. It is thus striking that healthcare whistleblowing research almost never cites Near and Miceli, tending instead to use either Ahern & MacDonald (1999) – whose definition of whistleblowing is almost identical to Near and Miceli – or a ‘common sense’ definition. This created a difficulty for us, in that adopting the definitional precision which one would normally expect in a systematic literature review risks misrepresenting the reviewed studies (i.e. representing the authors as working with a definition which they might not recognise). Mannion et al. (2018) note that in healthcare the terms raising concerns, speaking up and whistleblowing are at times being used interchangeably, and that is certainly evident here. However all the studies reviewed were examining behaviour encompassed by the Near & Miceli definition of whistleblowing, namely ‘the disclosure by organization members...of illegal, immoral or illegitimate practices under the control of their employers, to persons or organizations that may be able to effect action’ (1985: 4).

Professional body codes of conduct require healthcare professionals to act in ways which ensure no harm comes to patients, which includes taking action in cases where they observe unsafe or unacceptable practice; failure to act may lead to them being sanctioned. This logically requires professionals to blow the whistle on unacceptable practice, yet there has been a reluctance to accept healthcare organizations and/or professionals might need to have the whistle blown on them (Dixon-Woods, Yeung & Bosk, 2011). Research has provided greater understanding of the ways in which healthcare professionals can respond when faced with instances of unsafe and/or poor quality care, without blowing the whistle (e.g. Tarrant et al., 2017). Such approaches are appealing to both individuals and policymakers, as they hold the possibility of more palatable alternatives to whistleblowing, based on culture change within healthcare. However, as Tarrant et al (2017) highlight, these approaches are not always effective, as staff may choose to go only so far in trying to address problems. Whistleblowing remains a crucial ‘last resort’ – Vandekerckhove & Phillips (2017) found whistleblowing tends to occur only after other avenues for raising concerns have been exhausted. There is thus a need for understanding the whistleblowing process in a healthcare context.

The obvious corollary to the need for staff to be willing to raise concerns is that organizations need to respond positively to these concerns, learn from any mistakes and put effective policies in place to prevent them from happening again. Unfortunately, there are many high profile examples in healthcare where serious concerns raised by front-line staff were dealt with inadequately. Writing in the context of the UK NHS, but making a point of universal relevance, Francis lamented a culture “which deters staff from raising serious and sensitive concerns and which not infrequently has negative consequences for those brave enough to raise them” (2015, p1). Many healthcare professionals believe they will be victimized, ostracized or bullied if they raise concerns (Medical Protection Society, 2012), leading some, particularly junior staff, to remain silent in the face of poor care or wrongdoing (Delk, 2013): “The junior needs a reference and a recommendation; nurses want to keep their jobs. This is a powerful motive for keeping quiet” (Kennedy Report, 2001). Disquiet about speaking up is perhaps unsurprising. Local discursive practices (e.g. on the nature of success, failure, risk and performance) and local operational contingencies (e.g. resource constraints, service

rivalries, competition and stakeholder pressure) will have a powerful influence on the willingness of employees to raise concerns and the ability and willingness of employers to respond appropriately.

In this article we review empirical research on whistleblowing in healthcare. We begin with a description of the methodology used to undertake the review, then present a thematic narrative analysis of the identified literature, focusing on factors that influence whistleblowing, and on organizational responses to whistleblowing. We explore the policy and practice implications of the evidence gathered, before turning to a consideration of the research agenda needed to enhance our understanding of healthcare whistleblowing.

METHOD

The literature on whistleblowing in healthcare is widely dispersed and divergently-framed research, so we undertook a systematic, narrative review. That is, we used a systematic literature review protocol to select the papers to be reviewed, and the selected papers were then subject to a conventional narrative literature review. Our goal was to identify all empirical studies relating to whistleblowing in healthcare. We began by collating papers from the bibliographies of three recent literature reviews on speaking up or raising concerns in healthcare (Milligan et al. 2016; Okuyama et al., 2014; Kelly & Jones, 2013). We then undertook keyword searching of the mainstream whistleblowing literature (using the terms whistleblowing, “whistle blowing”, and “whistle-blowing”) using SCOPUS and EBSCO databases (see Figure 1). Further healthcare papers were added via ‘snowballing’ (cf. Contandriopoulos, Lemire, Denis & Tremblay, 2010) which produced an initial list of 741 records. We reviewed this list and removed duplicates, papers not based on empirical research, or not relevant to healthcare. This left a much shorter list of 33 papers, which we reviewed to see whether they cited (or had been cited by) studies not previously identified by the review process. This led us to add a further 22 papers, giving a total of 55 studies for review. We then reviewed each paper to identify its key findings. To structure our analysis of the selected papers we drew upon the model proposed by Near and Miceli (1985), who suggest the whistleblowing process can be conceptualized into five ‘stages’, from recognizing an event or situation as problematic; through decisions to take action (or not); the actions taken (internally or externally); the organizational responses to these actions; and, finally, the whistleblower’s assessment of those responses (and, potentially, future actions by the whistleblower). The stage model thus implicitly captures a continuing cycle of response, interpretation and action.

<<<< INSERT FIGURE 1 ABOUT HERE >>>>

FINDINGS

We began this review anticipating that studies of whistleblowing in healthcare would be a sub-set of the general whistleblowing literature. In fact these studies are almost entirely separate from the general literature, yet do not themselves constitute a recognisably coherent body of work. They are dispersed across a very broad range of journals (the 55 studies reviewed here were published in 42 different journals), and there is only limited evidence of studies building upon previous research. The field is dominated by the UK (29% of papers published) and Australia (27%). Just 9.5% of the papers published originated in the USA, which is surprising given the size and influence of US healthcare, and in marked contrast to the mainstream whistleblowing literature. The mainstream whistleblowing has its roots in the

work of a handful of US-based scholars, notably Near and Miceli, and though the field is now global US scholars continue to make important contributions. The dominance of British and Australian research is a limiting factor in terms of gaining insights into ways in which different healthcare systems approach the issue. A further limitation is that the healthcare literature uncovered relates primarily to whistleblowing by nurses (52.5%) and student nurses (28.8%), who together account for over 80% of participants in the studies.

We found surprisingly little overlap between the mainstream and healthcare whistleblowing literatures. It is not that the healthcare literature on whistleblowing is substantially different – indeed in one of the few direct comparisons Lewis, D’Angelos & Clark (2015) suggest findings from the mainstream literature to apply equally well to healthcare – but it remains the case the literatures are very separate, with almost no cross-citations. Our search of the mainstream whistleblowing literature identified over 350 articles published since 1983, only 15 were related to healthcare of which just six reported original empirical research. Healthcare whistleblowing research began in the late 1990s and developed separately from the mainstream field, rarely drawing upon its theoretical and empirical insights. This may be because the mainstream field has focused largely on fraud and corruption. There is clearly a qualitative difference between whistleblowing on financial wrongdoing and whistleblowing on clinical matters. Although fraud and corruption can be hard to identify and even harder to prove, in principle it can be legally determined whether or not they have occurred. By contrast, there is greater scope for debate (or dispute) within healthcare about what is ‘safe’ and what counts as good quality of care. In a similar vein, the extent to which whistleblowers are heroes or villains is also contested.

Whistleblowing is a complex phenomenon (Grube et al., 2010; Firtko & Jackson, 2005; Ion et al., 2015), influenced by a broad range of factors. Ohnishi et al. (2008) note the huge personal challenge of blowing the whistle, and the complexity of social, ethical, and personal forces at work in these situations. As noted above we used the Near & Miceli stage model to structure our analysis but mapping the selected papers onto the model shows research is concentrated mainly on the decision making stage (see Appendix 1). We have therefore adopted a structure better suited to the actual profile of the reviewed studies, clustering the findings under four headings – individual and role characteristics, culture and climate, responses to whistleblowing, and leadership and management.

Individual and role characteristics

Whistleblowing is not generally done lightly, and indeed may be viewed as a supererogatory act (Edwards, 1996). Many studies highlight the importance of nurses’ self-image and perceived duty as patient advocates (Ahern & McDonald, 2002; Bickhoff et al., 2016; Black, 2011; Jackson et al., 2010b; Firtko & Jackson, 2005). This advocacy role has been recognized as being a crucial part of a nurse’s training (Stevanin et al., 2015; Law & Chan, 2015; Tella et al., 2012), and perceived as fundamental to helping nurses recognize when care is poor. Peternelj-Taylor (2003) suggests it is naïve for nurses to think organizations will respond to reports of wrongdoing in an ethical matter; consistent with their ‘nurse as patient advocate’ ideals they need resilience, confidence and moral courage to be able to speak out about wrongdoing in the healthcare sector (Bickhoff et al., 2016; Ion et al., 2016; Monrouxe et al., 2014). However Schwappach & Gehring, (2014a) suggest nurses are concerned about *how* to raise concerns, rather than *whether* to raise them, opening up the possibility that with the right processes more staff would be willing to speak up.

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3 Studies highlight differences in the willingness to speak up between individuals in different
4 roles and positions within healthcare organizations. In critical situations, nurses rarely
5 challenged potentially dangerous decisions made by those in more powerful positions (St
6 Pierre et al., 2012). Clinical staff in management roles appear more willing to speak up when
7 confronted with poor or unsafe care (Moore & McAuliffe, 2009; Schwappach & Gehring,
8 2014b), which may be associated with demographic characteristics such as age, tenure,
9 seniority, and experience providing them with greater confidence in their assessment of what
10 is unacceptable, ability to communicate their concerns effectively etc. This is consistent with
11 findings in the mainstream literature on the impact of such demographic factors, though
12 Throckmorton & Etchegaray (2007) found error reporting was more likely to come from
13 nurses who were operationally closer to the patient, and *less* well established in their roles.
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16 **Culture and climate**

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18 Hooks et al. (1994) suggest organizational culture has a greater influence on the decision to
19 blow the whistle than all other factors. Exploring these issues in healthcare, Hutchinson &
20 Jackson (2015) report many nurses experienced a contrast between the espoused mission of
21 the organization articulated by senior management, and the actual culture/climate
22 encountered in the workplace. Jones & Kelly (2014) highlight how formal procedural
23 approaches to encouraging open reporting of concerns gave way to “[a] process of
24 socialization and habituation in the workplace”, meaning organizational culture has a far
25 stronger influence than organizational procedures in determining whether staff feel it is safe
26 and useful to report concerns about the quality of care. Prang & Jelsness-Jorgensen (2014)
27 found organizational culture was perceived as a barrier to reporting concerns. St Pierre et al.
28 (2012) found that a reluctance to challenge decisions believed to be dangerous was justified
29 with reference to a lack of knowledge of whistleblowing procedures and a perceived inability
30 to challenge superiors, which they suggest points towards a culture that suppresses voice and
31 erodes the confidence of nursing staff in their own judgement.
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35 *Occupational cultures*

36 For healthcare organizations the cultures of specific occupations and professions can also be
37 an importance influence on employee behaviour. Kingston et al. (2004) nursing culture
38 encourages compliance with formal rules and protocols, whereas medical culture encourages
39 dealing with incidents informally and ‘off-the-record’. Ahern & McDonald (2002) found that
40 nurses who blew the whistle on wrongdoing had a belief system that privileged their role as
41 ‘patient advocate’, whereas those who did not report were more likely to believe they were as
42 responsible to their colleagues and their employer as they were to the patient. The existence
43 of clear professional standards and guidelines has been found to be an important factor in
44 supporting whistleblowing in healthcare in a number of empirical studies (Firth-Cozens et al.,
45 2003; Ion et al., 2015, Jackson et al., 2010a; Kingston et al., 2004; Orbe & King, 2000).
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49 *Socialization and training*

50 Placement students may be aware of unsafe clinical practices (Killam et al., 2012; 2013),
51 having been trained to identify good and poor practice, and not yet being socialized into a
52 particular organizational culture (Bradbury-Jones et al., 2010), or having the influence of the
53 workplace environment cloud their judgement of what constitutes unsafe care (Tella et al.,
54 2015). Despite this they may be unlikely to raise concerns – Ion et al. (2016) suggests a
55 ‘blame culture’ exists within student nursing, while Bradbury-Jones et al. (2011) note fear of
56 failing their placement often deters healthcare students from speaking up about poor quality
57 care, and they lack the experience and confidence necessary to raise concerns with their
58 superiors (Kent et al., 2015). Training and education can address this, by increasing
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3 confidence and willingness to report and challenge poor practice (Bradbury-Jones et al.,
4 2010). Bellafontaine (2009) notes that a strong student-mentor relationship and supportive
5 university representatives are key to giving student nurses the personal confidence and
6 information necessary to facilitate speaking up about concerns around patient safety. Law &
7 Chan (2015) emphasize the value of mentoring nurses in order to enhance their understanding
8 of what constitutes good (and poor) quality care and to raise their confidence in reporting
9 concerns. Johnstone & Kanitsaki (2006, p.374) suggest nurses and others need to ‘learn from
10 practice errors and to use the lessons learned to help prevent future errors from occurring’,
11 and urge educators to present raising concerns in a positive light.
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14 *Climate and financial context*

15 The financial context will have an important influence on climate. McCann et al. (2015)
16 highlight the impact of financial austerity measures on whistleblowing, and more specifically
17 on voice: given the difficulties of meeting more challenging targets with fewer resources,
18 staff often resort to ‘under-the-radar’ tactics to deliver the quality of care they feel meets their
19 professional standards, while avoiding the potential risks associated with ‘speaking up’.
20 Similarly, pressure to meet *business* targets begins to undermine nurses’ confidence in their
21 judgement on what is an acceptable level of care, and they modify their behaviours in
22 response (Hyde, 2016; Leary & Diers, 2013). When financial constraints throw job security
23 into sharper relief, staff are less likely to blow the whistle when doing so brings them to the
24 attention of management, which may result in retaliatory action (McDonald & Ahern, 2000).
25 The culture and climate of an organization will influence (and be influenced by) the
26 development and application of clear whistleblowing policies and procedures. These are
27 generally perceived to increase the likelihood of internal reporting of wrongdoing (e.g. Seifert
28 et al., 2010), but in healthcare the situation may be more ambiguous. Klaas et al. (2012)
29 suggest formal whistleblowing policies and processes are likely to make whistleblowing
30 appear to be a strategy of last resort. Entrenched behavioural patterns within healthcare
31 organizations are often at odds with the officially espoused organizational approach
32 (Hutchinson & Jackson, 2015), and formal procedural approaches can be ‘neutralized’ by
33 organizational cultures that opposed ‘voice’ (Jones & Kelly, 2014). Interestingly, Newton et
34 al. (2012) found nurses often took independent action to address poor care rather than pursue
35 official channels of complaint. McCann et al (2015) observed a similar phenomenon, where
36 in response to more challenging performance targets amid a reduction in resources, both
37 frontline and mid-level management employees resorted to “a form of “street-level
38 bureaucracy” – a situation in which traditional professional norms are reasserted informally
39 in ways that often transgress prescribed performance systems” (p.773).
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45 *National cultures*

46 National culture too may be an important influence (King, 2000). There has been a great deal
47 of work on the relevance of national culture to whistleblowing (e.g. Park et al., 2008), and
48 given the multi-national nature of the healthcare workforce in many developed countries it
49 will be important for healthcare employers to take into account that staff coming from other
50 countries may have different beliefs about if and how one should raise concerns. Ohnishi et
51 al. (2008) note the significant impact of national culture in their research with psychiatric
52 nurses in Japan, and Cheng et al. (2015) comparing British and Chinese healthcare students
53 noted that “individuals from collectivist cultures are less likely to be whistle-blowers, and
54 less accepting of whistleblowing behaviour, than individuals from individualistic cultures”
55 (p.15). Tella et al. (2015) found UK nursing students considered themselves better prepared
56 for reporting on problems in relation to patient safety than their Finnish counterparts, and
57 Tabak et al (1997) note that knowledge of the concept of whistleblowing was relatively
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3 underdeveloped in Israel compared to the UK, albeit the same moral imperative to care for
4 patients existed in both countries.
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6 **Responses to whistleblowing**

7 *Organizational response*

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9 An organization's response to whistleblowers (whether positive and negative) has great
10 bearing on the entire whistleblowing process. Indeed, the *lack* of response (i.e. no subsequent
11 change in practice, or addressing of wrongdoing) is widely cited as a key reason for a
12 decision not to report (Jackson & Raftos, 1997; Kingston et al. 2004; Moore & McAuliffe,
13 2009 & 2012). While this could be seen as an attempt to justify lack of action by non-
14 reporting observers worried about the risks associated with whistleblowing (cf. 'cues for
15 inaction', Blenkinsopp & Edwards, 2008), one would expect that seeing positive response
16 from the organization would support further reporting of wrongdoing (McDonald & Ahern,
17 1999). Fear of retaliation by the organization emerges as a significant barrier to speaking up
18 (Attree, 2007; Delk, 2013; Bradbury-Jones, et al. 2011), and what evidence we have suggests
19 this fear may be justified (e.g. Francis, 2015), yet there has been a dearth of research
20 exploring what proportion of whistleblowing actually results in retaliation versus positive
21 responses to the raising of concerns.
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26 *Response from peers*

27 Whistleblowers also report the potential for reprisals from peers as a major factor in their
28 decision-making process, with McDonald & Ahern (2000) reporting 'unofficial' (i.e. not
29 initiated by the organization) reprisals on whistleblowers from colleagues taking the form of
30 pressure to resign, social rejection, being treated as a traitor, and having their career
31 progression halted. Some whistleblowers experience "negative social outcomes, alienation
32 and withdrawal of peer support" (Attree, 2007, p.397), and report bullying and exclusion
33 from social groups (Peters et al., 2011; Bickhoff et al., 2016). Jackson et al. (2014) suggest
34 nurses' desire to fit in leads them to conform to group norms, including norms on whether or
35 not to report wrongdoing, so the development of group norms in favour of reporting might
36 increase whistleblowing propensity. Law & Chan (2015) highlights the importance of
37 whether peers naturally support colleagues who report wrongdoing, and consider the use of
38 peers as mentors in these situations.
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42 *Impact on well-being*

43 It is perhaps not surprising then that whistleblowers (both internal and external) often suffer
44 deterioration in their relationships with their peers, irrespective of whether the concerns
45 reported are genuine and legitimate (McDonald & Ahern, 2000; Beckstead, 2005; Delk,
46 2013). The formal process of investigating a concern is often traumatic for both complainants
47 and the subjects of complaints, as well as bystanders (Attree, 2007; Jackson et al., 2010a &
48 2010b; McDonald & Ahern, 1999 & 2000; Moore & McAuliffe, 2010; Peters et al., 2011;
49 Prang & Jelsness-Jorgensen, 2014). Jackson et al (2014a) interviewed both whistleblowers
50 and targets of whistleblowing, and found that "whistle-blowing had a profound and
51 overwhelmingly negative effect on working relationships" (p.37), with collegial and inter-
52 professional relationships damaged, and those involved suffered bullying and exclusion.
53 Bystanders were not immune to the impact of poorly managed whistleblowing, and can suffer
54 from a decline in peer relationships (Jackson et al., 2014a).
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Leadership & Management

In the mainstream literature a number of studies highlight the importance of leadership in promoting ethical behaviour, including whistleblowing (Culiberg & Mihelic, 2017), and they are important in healthcare too. Goldberg (2007) notes that negative or even hostile reactions to whistleblowing result in a loss of “*moral leadership*” from healthcare organizations (p.10). In most countries the public sector is an important player in the healthcare system, and Hutchinson & Jackson (2015) suggests the very nature of the public sector predisposes organizations to favour an authoritarian leadership style in which bullying and intimidation can thrive and leads to a punitive culture that discourages employees from whistleblowing. Mannion et al. (2017) explored the relationship between hospital board governance and patient safety in the NHS. They found a significant relationship between particular (self-reported) board competencies and whistleblowing related questions in the annual NHS staff survey, notably an association between board competencies and staff willingness to report errors and incidents as well as staff perceptions that their organization would take positive action if they did report. This draws attention to the wider governance context as well as the influence of local management and leadership in supporting the reporting of front-line concerns.

There is a sharp contrast between the positive perceptions of senior executives regarding the ease of reporting wrongdoing and subsequent action, compared to the actual difficulties reported by nurses (Cleary & Doyle, 2016; Dean 2014). Many studies find nurses lack confidence in the reporting systems, which acts as a barrier to reporting poor care (Attree, 2007; Black, 2011; Ion et al., 2015). Jackson et al. (2010a) report that healthcare managers were often perceived to have not dealt with complaints appropriately, and suggest a more responsive and inclusive style of management would improve standards of care (cf. Blenkinsopp & Snowden, 2016). Jackson & Raftos (1997) highlight nurses’ perceptions of barriers and obstacles put in place by management that discourage the reporting of concerns internally. Such defensive behaviour among managers can drive some nurses to report externally (though probably more often simply to remain silent). The perception that management will fail to respond positively to concerns is frequently cited as a key reason why healthcare workers do not to speak up when faced with unsafe care (Attree, 2007; Black, 2011; Firth-Cozens et al., 2003; Jackson & Raftos, 1997; Kingston et al., 2004). Milligan et al (2016), drawing on research by Espin & Meikle (2014), note that some of the unintended barriers created by senior managers could be overcome by creating a more clearly defined “*reporting ladder*” (p.27) that facilitates the recognition of a clear path through which concerns could be raised in organizations.

DISCUSSION

Implications for policy and practice

We noted above that the bulk of healthcare whistleblowing research has been undertaken with samples from nursing, and clearly this has implications for the generalisability of the findings for other professions in healthcare. Nurses work in teams, have more opportunities to observe the wrongdoing of other professionals than vice versa, are more likely to observe certain types of wrongdoing and less likely to observe others, have a strong occupational culture etc. All of these factors mean that we need to be cautious in assuming that research on nursing whistleblowing will read across readily to other healthcare professions.

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3 Yet despite this limitation there are key messages for policy and practice which come out of
4 the literature. First, we need to pay greater attention to workers' sense of security when it
5 comes to blowing the whistle. We know whistleblowers are more likely to be in positions of
6 relative security (e.g. through role, tenure, position in the hierarchy, experience etc.), but
7 many healthcare workers are in innately insecure positions (e.g. locums, agency workers,
8 students, trainees etc.), and those in ostensibly secure positions are still anxious about the
9 possible consequences of raising concerns (Medical Protection Society, 2012). If we are to
10 encourage a wider range of employees to raise concerns we need to consider how they can be
11 made to feel more secure (cf. Yanchus et al., 2014). In debates about whistleblowing in
12 healthcare we observe an assumption that staff (especially clinical professionals) should be
13 willing to go on the record with their concerns. By contrast many other industry sectors
14 operate with expectations that workers may be very wary of putting their concerns on the
15 record, and will only do so if there are mechanisms for raising concerns that are protective of
16 them, which may include anonymity. Whilst healthcare organizations can and should
17 consider how to move towards a culture in which open discussion, feedback and the raising
18 of concerns are encouraged and supported, we also need an acknowledgement that many
19 whistleblowers are 'speaking truth unto power', and an inconvenient truth at that, and thus
20 are taking a risk for which they need to feel there is some degree of support and protection.
21 Whilst many territories have so-called whistleblower protection legislation, in most cases this
22 provides post-hoc compensation for discrimination rather than protection from dismissal. In
23 his review of UK whistleblowing protection legislation Lewis (2017: 1137) argues that
24 employers should have "a statutory duty to make a risk assessment when a person raises a
25 concern and to have in place a process for checking that reprisals do not occur". Yet adopting
26 such risk assessment processes need not wait for legislation, employers can and should make
27 this part of their existing whistleblowing policies and procedures. This would provide
28 reassurance for potential whistleblowers. More broadly this points to the importance of
29 understanding how whistleblowing policies and procedures are developed and applied (cf.
30 Ciasullo et al., 2017).

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37 Second, there is evidence that healthcare workers' ability to identify poor care and
38 willingness to speak up about it is compromised by organisational factors which cloud their
39 judgement, as they attempt to juggle the interests of various stakeholders. By contrast
40 workers who view themselves as having a primary responsibility to the patient above all other
41 stakeholders appear more likely to raise concerns (Ahern & McDonald, 2002). We might
42 draw an analogy with health and safety – organisations with strong safety records tend to
43 emphasise a safety first approach, making clear that other considerations (e.g. production
44 targets and deadlines) will not be allowed to overrule safety concerns. A similar 'patients
45 first' message in healthcare organisations would seem uncontroversial, but in many cases
46 staff are not confident this is a primary organisational value in all situations. It seems clear
47 that leadership sets the tone. There is a need to encourage staff to treat their obligations to the
48 patient as primary. Healthcare professionals respond to a range of stakeholders in undertaking
49 their duties, and can experience conflict in attempting to reconcile their differing demands.
50 Healthcare organizations can reinforce the message that in the final analysis the patient must
51 come first, and staff will be supported for acting in the interests of the patient, even if this
52 causes conflict with colleagues, short-term reputational damage to the organization etc.

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56 Finally, the studies point to a need for training, especially as part of induction. There are
57 several aspects to this. Perhaps surprisingly, there appears to be a need for training which
58 clarifies ethical expectations (Park & Blenkinsopp, 2013). Simple information giving on
59 policies and procedures is also required; staff are not routinely involved in raising concerns,
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3 and when they encounter a problematic situation they may be unfamiliar with the processes
4 involved. Skills development on how to challenge colleagues constructively, how to raise
5 concerns in a manner likely to have a positive impact etc. would be useful. The training needs
6 to cover both rank and file staff (who are in a position to observe problems) and more senior
7 staff (who are likely to be the recipients of whistleblowing).
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10 Many prescriptions for change emphasise the importance of culture change, without
11 acknowledging how difficult this can be to achieve. The changes we describe above can
12 contribute to a gradual culture change, but will also have a significant immediate impact.
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15 **Directions for future research**

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17 The studies vary in terms of three dimensions – the occupational group(s) from which
18 participants are drawn, the national healthcare system in which the study is undertaken, and
19 the stage(s) of the whistleblowing process examined. It is striking how similar many of the
20 studies are on these three dimensions – involving nurses or student nurses, in the UK (or
21 Australia), and examining the factors involved in deciding whether to blow the whistle. The
22 current literature is thus skewed in terms of occupations and locations. The mainstream
23 literature on whistleblowing clearly shows that though many of the issues surrounding
24 whistleblowing are universal, there is also potential for considerable variation, and we need
25 research across a greater range of locations and healthcare professions if we are to gain
26 insights that can inform the development of policy and practice relevant to all healthcare
27 organizations, in particular expanding the scope of research to include healthcare professions
28 other than nursing. Although there are commonalities within healthcare, there are also
29 considerable variations between settings. The bulk of research has been undertaken in
30 hospital settings, so there is a need for work in other contexts with their own specific features
31 e.g. mental health, nursing homes, primary care. As healthcare becomes more global in scope
32 there is a need to explore the interaction of occupational, organisational and national cultures,
33 all of which influence whistleblowing.
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38 Given the limited number of studies from the USA there is an obvious need for further
39 research in this location, but (following the idea of the dog that did not bark) it is also worth
40 considering whether the lack of attention from scholars may reflect differences in the US
41 context. There is certainly no lack of whistleblowing cases, but they tend to be focused on
42 fraud and corruption rather than issues of care quality and patient safety¹. The mainstream
43 whistleblowing literature reveals that the issues first researched in the USA in the mid-1980s
44 have proven to be relevant and similar in other countries, notwithstanding cultural and legal
45 differences. By contrast for healthcare whistleblowing the suggestion is that the USA may be
46 different from the territories studied to date, in ways which are interesting and may offer
47 important insights for policy and practice. Exploring the issue with US scholars in healthcare
48 management we encountered two possible explanations. First, the US healthcare system has
49 potentially more external stakeholders, meaning there is greater scrutiny. Second, and related
50 to this, these external stakeholders may be more ‘enthusiastic’ recipients of whistleblowing
51 reports; insurance companies in particular want to ensure that they are paying for safe, quality
52 care. In short, it may be the US system has more eyes looking for potential problems, and
53 more ears willing to listen to concerns. This possible explanation warrants further
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58 ¹ The US website Healthcare Finance News keeps an annual ‘running list’ of the biggest healthcare frauds. For
59 2017 the list ran to 70 separate cases involving sums up to \$1.3 billion, resulting in fines and prison sentences of
60 various lengths.

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3 investigation, as it offers potentially crucial insights for the healthcare systems of other
4 countries.
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7 The idea that whistleblowers frequently experience retaliation is well-established in the
8 public mind, partly because highly publicized but isolated incidents of mistreatment of
9 whistleblowers may have a disproportionate impact on the level of apprehension experienced
10 among employees. This underlines the need for a clearer picture of what healthcare
11 professionals (and the public) understand by the terms such as whistleblowing, speaking up
12 or raising concerns, and a clearer sense of what might happen as a consequence. Clearer
13 procedures make a difference, but staff need also to be confident that they work and things
14 will change. Some cases cannot be discussed because of confidentiality issues, but in others it
15 ought to be possible to create anonymised 'case studies' to demonstrate how the process
16 works and that management will act. In the UK context the creation of freedom to speak up
17 (FTSU) guardian roles in the NHS is an important development, which warrants ongoing
18 research.
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22 Healthcare is more likely to encounter situations of outsider whistleblowing (Culiberg &
23 Mihelic, 2017), where concerns are raised by individuals not directly employed by the
24 organization. Whereas problems within an organization like a bank or a car manufacturer
25 might be hidden from view, in healthcare a whole range of people (patients, visitors, social
26 workers, suppliers, clinicians from other organizations, students etc.) engage with the
27 organization in ways that might allow them to notice problems. Much whistleblowing
28 research, and whistleblower protection law, envisages the whistleblower as an employee of
29 the organization. For healthcare there is a pressing need to gain greater insights into the issues
30 surrounding outsider whistleblowing.
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33 CONCLUSION

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35 We have identified a number of areas in which further research is urgently needed, and
36 outlined proposals for actions that could be taken to make it more likely that staff will speak
37 up. Healthcare is slowly beginning to recognize that whistleblowing is not a problem, rather it
38 is part of the solution to problems with the safety and quality of care, though the present
39 review highlights that we still have a long way to go. Previous research has focused on the
40 decision to blow the whistle and not enough on organizational response, yet the latter
41 ultimately determines whether the issues affecting patients are addressed. Mainstream
42 whistleblowing research has begun to focus on this more in recent years (Vandekerckhove,
43 Brown & Tsahuridu, 2014). There needs to be more attention paid to encouraging a positive
44 response to whistleblowing. Although much of the research focus has been on how
45 whistleblowing in the public interest can be encouraged and supported, there is less emphasis
46 on the response of managers and organizations to whistleblowing. In part this is a process of
47 reframing, helping managers to understand that concerns raised by staff, just like complaints
48 made by patients, are a valuable source of information from which the organization can learn
49 and improve.
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54 We noted earlier a marked separation between healthcare whistleblowing research and the
55 rest of the field. This separation is both unnecessary and unhelpful for both – healthcare is
56 failing to gain valuable insights from a large body of research on other sectors and
57 professions, and the main field is missing an opportunity to explore nuances of
58 whistleblowing in some of the most complex and contested research sites available. In short,
59 we need to encourage mainstream whistleblowing researchers to expand their scope to
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include healthcare, as the best of way of ensuring the development of an evidence base which can inform the pressing debates about how to encourage and support healthcare workers to raise concerns.

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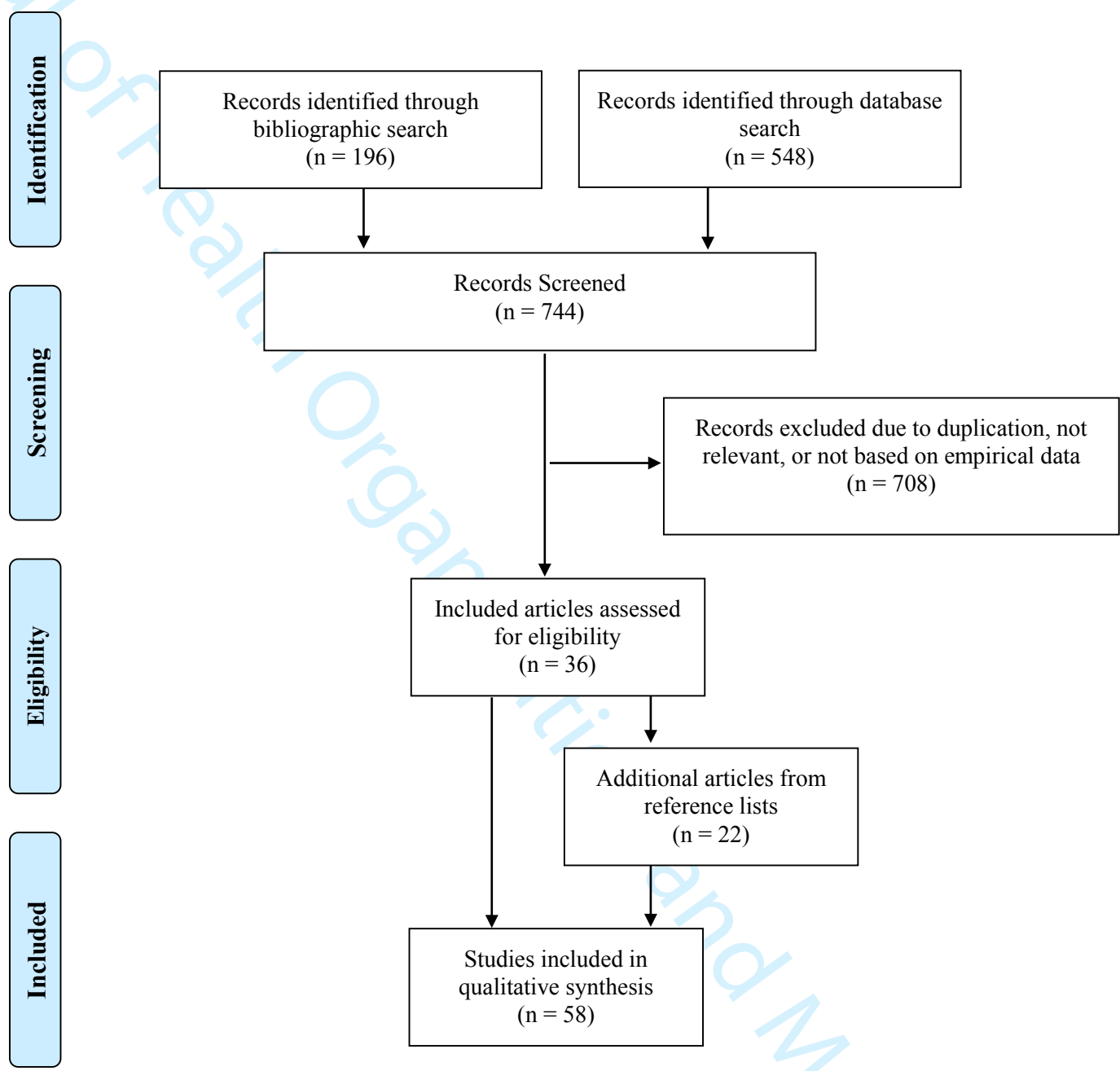
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26 <<<< INSERT APPENDIX 1 HERE >>>>
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Figure 1: PRISMA Flow Diagram



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Appendix 1: Mapping healthcare related studies onto a stage model of whistleblowing

Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Potential whistleblower recognises event as problematic	Decides on action to take	Takes action (or not) to report internally or externally	Organisation (or other stakeholders) responds to whistleblowers actions	Whistleblower assesses organisational response and decides on what (if anything) to do next.
Ahern & McDonald (2002)				
	Alinaghian et al. (2018)			
	Andrew & Mansour (2014)			
	Attree (2007)			
Beckstead (2005)				
	Bellafontaine (2009)			
		Bickhoff et al. (2016)		
		Black (2011)		
	Bradbury-Jones et al (2010)			
		Bradbury-Jones et al (2011)		
	Espin & Meikle (2014)			
	Firth-Cozens et al (2003)			Firth-Cozens et al (2003)
Fledderjohnann & Johnson (2012)				
Gould & Drey (2013)			Gould & Drey (2013)	
			Greaves & McGlone (2012)	
	Grube et al (2010)			
	Ion et al. (2015)		Ion et al. (2015)	
	Ion et al. (2016)			
				Jackson & Raftos (1997)
			Jackson et al. (2010a)	
	Jackson et al. (2010b)			
			Jackson et al. (2014a)	
		Jones & Kelly (2014)		
		Jones et al (2016)		
Kent et al. (2015)				
Killam et al. (2012)				
	Killam et al. (2013)			
	Kingston et al. (2004)		Kingston et al. (2004)	

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3	Ko & Yu (2017)			
4	Law & Chan (2015)			
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6		Levett-Jones & Lathlean (2009)		
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8		Lewis & Vandekerckhove (2015)		
9	Loewenbrück et al. (2016)			
10				
11		McCann et al (2015)		
12				
13		McDonald & Ahern (1999)		
14			McDonald & Ahern (2000)	
15		Mansbach & Bachner (2010)		
16		Mansbach et al. (2012)		
17				
18	Monrouxe et al. (2014)			
19	Monrouxe et al. (2015)			
20	Moore & McAuliffe (2010)			Moore & McAuliffe (2010)
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22	Moore & McAuliffe (2012)			Moore & McAuliffe (2012)
23				
24		Newton et al. (2012)		
25				
26		Ohnishi et al. (2008)		
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28		Orbe & King (2000)		
29				
30		Peternelj-Taylor (2003)		
31				
32				Peters et al. (2011)
33		Pohjanoksa et al. (2019)		
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35		Prang & Jelsness-Jorgensen (2014)		
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37		Schwappach & Gehring (2014a)		
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39	Stevanin et al (2015)			
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41		St Pierre et al. (2012)		
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43		Tabak et al. (1997)		
44				
45		Tarrant, et al (2017)		
46	Tella et al. (2015a)			
47	Tella et al. (2015b)			
48				
49		Throckmorton & Etchegaray (2007)		
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Response to Reviewers' Comments

Reviewer 1

<p>The article purports to be “a review of the evidence” and the Method section refers to “relevant articles”. It is not explained why the extensive quantitative and qualitative research for the Francis Freedom to Speak Up Review is ignored [see detailed Appendices to the report].</p>	<p>We can only apologise if it seems as if we had ignored the Francis review, as it was in many ways the inspiration for the project. However using normal SLR protocols it is difficult to treat the data presented in the report in the same way as peer-reviewed academic articles. The research which informed Francis is nevertheless captured in our review, as it has been subsequently published in articles now covered in the review (Lewis & Vandekerckhove, Lewis et al.).</p>
<p>Indeed, give the number of responses to the surveys conducted for Francis it might be argued that it is unfair to say (about the UK at least) that “there remains relatively little research on whistleblowing in healthcare”.</p>	<p>Francis has certainly made a contribution to remedying the gap in our knowledge, but compared to many sectors healthcare remains relatively under-researched. And surprisingly so, given the volume of healthcare scandals brought to light by whistleblowers (Powell et al., 2019).</p>
<p>On page 7, it might be argued that the research for Francis provides clear evidence about the extent to which whistleblowers suffer retaliation.</p>	<p>It does provide some evidence, and we have amended the sentence to reflect that (see below), but across healthcare we still have limited research on the scale and frequency of retaliation.</p> <p>“Fear of retaliation by the organization emerges as a significant barrier to speaking up (Attree, 2007; Delk, 2013; Bradbury-Jones, et al. 2011), and what evidence we have suggests this fear may be justified (e.g. Francis, 2015), yet there has been a dearth of research exploring what proportion of whistleblowing actually results in retaliation versus positive responses to the raising of concerns.”</p>
<p>On page 8, the issue of job security is raised. The authors might want to discuss whether whistleblowers can ever be legally protected or merely compensated if they suffer discrimination/discrimination. Protection may require employers to take pro-active steps to avoid reprisals being taken e.g. conducting risk assessments.</p>	<p>We have added the following to develop this point:</p> <p>“Whilst many territories have so-called whistleblower protection legislation, in most cases this provides post-hoc compensation for discrimination rather than protection from dismissal. In his review of UK whistleblowing protection legislation Lewis (2017: 1137) argues that employers should have ‘a statutory duty to make a risk</p>

	<p>assessment when a person raises a concern and to have in place a process for checking that reprisals do not occur'. Yet adopting such risk assessment processes need not wait for legislation, employers can and should make this part of their existing whistleblowing policies and procedures. This would provide reassurance for potential whistleblowers.”</p>
<p>On page 10, mention is made of “a marked separation between healthcare whistleblowing research and the rest of the field”. In fact, financial services is another sector where critical issues are at stake and where employers are under regulatory pressure to demonstrate that they have adequate policies and procedures in place .</p>	<p>Reviewer 2 makes a similar point, which seems to reflect a weakness in how we have phrased this. Our point is not that healthcare is unlike all other industries, but that researchers investigating whistleblowing in healthcare have almost entirely ignored research done in other industries. Research on whistleblowing in healthcare started in earnest almost 15 years after the mainstream field was established, and from the outset drew almost literally nothing from this earlier work – not even the standard Near & Miceli definition of whistleblowing. We have added the following:</p> <p>“It is not that the healthcare literature on whistleblowing is substantially different – in one of the few direct comparisons Lewis, D’Angelos & Clark (2015) suggest findings from the mainstream literature to apply equally well to healthcare – but it remains the case the literatures are very separate, with almost no cross-citations.”</p>
<p>Indeed, is it a coincidence that in both industries in the UK whistleblowing ‘champions’ have been introduced. Surely, the functioning of ‘champions’ in the NHS should be a subject for future research (see page 9)?</p>	<p>This was an oversight on our part, probably because we are aware of current projects already starting to examine the role of FTSU guardians, including a large NIHR funded study. However, you are right that this should be highlighted as a topic for further research, and we have added material to that effect.</p>

Reviewer 2

<p>The topic for the article is timely and produces interesting findings. The most noticeable are i) the lack of overlap between mainstream research on whistleblowing and whistleblowing in healthcare, ii) the relatively small amount of papers written on the topic based on empirical data, iii) that the main focus within this area of research has been on the decision making stage of Near and Miceli's (1985) five stages of whistleblowing model, iv) that almost 60% of the articles is written in the geographical context of the UK and Australia, and v) that the healthcare literature primarily relates to whistleblowing by nurses and student nurses.</p> <p>It is welcome that the authors have a discussion on implications for policy and practice as well as a section on directions for future research in the Discussion part of the paper. This adds to the contribution of the paper beyond the empirical findings mentioned above making it more relevant.</p>	<p>Thank you.</p>
<p>The paper is called 'Whistleblowing over patient safety and care quality: a review of the evidence'. The second part of this title implies there is evidence for something in the study, leading to the assumption by the reader that there is some kind of testing of a hypothesis or similar design in the study that will come to a clear conclusion on something, e.g. that there are evidence that prove that whistleblowing improve quality in health care services. Perhaps this was the original intention of the author/s, something that is also indicated by the mentioning of 'meta-analysis' in the methods section. However, since the paper does not have such an ambition, focus on such evidence or draws meta-analytical conclusions the title ought to be changed to better reflect the content of the paper.</p>	<p>We did initially hope to uncover more of an evidence-base to evaluate, and you are right in guessing the title is a legacy of this. We have re-titled the paper to read "...: a review of the literature".</p>
<p>On page 1, line 54-56, there is a definition of 'healthcare whistleblowing'. It would be preferable to have a more developed discussion on the definition of whistleblowing in earlier research that the definition in the paper relates to, e.g. Near</p>	<p>Thank you, we added the following as the second paragraph of the Introduction to explain this:</p> <p>"This definition of healthcare whistleblowing is intentionally broad,</p>

and Miceli (1985) that seems to be the inspiration for the definition in the paper. Also, the definition is quite vague. This may be to allow for a broad range of perceptions on whistleblowing in the studied literature, but if so, this needs to be discussed in the paper. The vagueness of the definition and the discussion of whistleblowing as a 'last resort' (p. 2, line 15) make it unclear when, where and how whistleblowing occurs. Are for instance all types of 'raising concerns' whistleblowing or does it entail more? This needs to be clarified or it needs to be clarified that the material for the study are unclear on the matter.

reflecting the current state of the field. Definitional debates tend to feature extensively in the earliest work in the field, indeed these debates often continue even as the field matures. Whistleblowing research is relatively unusual in that a single definition, developed in the early days of work in this area, quickly became the standard definition and has remained so. By the time healthcare whistleblowing research began to emerge in the late 1990s the Near & Miceli (1985) definition of whistleblowing was used almost universally – not just in the management field, but also by legal scholars, psychologists etc. It is thus striking that healthcare whistleblowing research almost never cites Near & Miceli, tending instead to use either Ahern & MacDonald (1999) – whose definition of whistleblowing is almost identical to Near & Miceli – or a 'common sense' definition. This created a difficulty for us, in that adopting the definitional precision which one would normally expect in a systematic literature review risks misrepresenting the reviewed studies (i.e. representing the authors as working with a definition which they might not recognise). Mannion et al. (2018) note that in healthcare the terms raising concerns, speaking up and whistleblowing are at times being used interchangeably, and that is certainly evident here. However all the studies reviewed were examining behaviour encompassed by the Near & Miceli definition of whistleblowing, namely 'the disclosure by organization members...of illegal, immoral or illegitimate practices under the control of their employers, to persons or organizations that may be able to effect action' (1985: 4)."

In addition, since one of the findings in the paper is the lack of overlap between mainstream research on whistleblowing and whistleblowing in healthcare as well as a lack of drawing between the two regarding theoretical and empirical insights, a review of mainstream research on whistleblowing would be expected in the Introduction in

Linked to the point above about definitions, the lack of overlap between the two fields is in one sense bibliometric – they simply don't cite each other. That does not mean the concerns of the two fields have no points of overlap, but it does mean they are not learning from each other. Since reviewer 1 raises a similar concern about our claim of separation it is clear we have not explained

<p>order for the reader to know on what grounds comparisons are made.</p>	<p>ourselves well, so we have added the following:</p> <p>“It is not that the healthcare literature on whistleblowing is substantially different – in one of the few direct comparisons Lewis, D’Angelos & Clark (2015) suggest findings from the mainstream literature to apply equally well to healthcare – but it remains the case the literatures are very separate, with almost no cross-citations.”</p>
<p>The first two lines of the methods section (p. 2, line 51-52) talk about ‘evidence base’ and ‘meta-analysis’. As discussed above (see under Title) the study does not engage with the collected material in such a way that the terms seem relevant. My recommendation is to get rid of this, and focus on what has been done, rather than what has not been done.</p>	<p>Done, thank you for the suggestion.</p>
<p>The method for analysis named in the paper is ‘narrative systematic review’ (p. 2, line 54). However, there is no discussion on what method entails beyond the brief mentioning of ‘reviewed each paper to identify its key findings’ (p. 3, line 11). In my opinion, the authors seem to have done a qualitative content analysis. If so, there is no real need to describe it as something else unless there is a particular method for analysis used that differs from a qualitative content analysis. If so it needs to be discussed in more detail, otherwise a few sentences on the coding process would suffice.</p>	<p>With hindsight the terminology is potentially confusing, as the term is used in different ways. We undertook a narrative review, but the process for identifying the papers involved a systematic protocol. The section now reads:</p> <p>“...so we undertook a systematic, narrative review. That is, we used a systematic literature review protocol to select the papers to be reviewed, and the selected papers were then subject to a conventional narrative literature review.”</p>
<p>There is a lack of discussion on why the search for relevant articles is only done in the two selected databases (SCOPUS and EBSCO) beyond that the keyword search is done in the ‘mainstream whistleblowing literature’. This raises two questions question. First, on what grounds are the selected databases chosen to be the place to look for ‘mainstream whistleblowing literature’? Second, why is the focus on ‘mainstream whistleblowing literature’ if the goal is to ‘identify all empirical studies relating to whistleblowing in healthcare’ (p. 2, line 55)? A search on the term ‘whistleblowing’ in Medline generated 1205</p>	<p>Searching for the term whistleblowing does indeed produce a lot of hits, but most of the papers thus found are not reporting empirical studies. In developing our search we did a lot of ‘range-finding’ searches in a wide variety of databases (including Google Scholar, CINAHL, Medline etc.) but we found that all empirical studies could be found in either SCOPUS or EBSCO. We have updated our search but identified just 3 further papers (now included in the revised submission), which have similar findings to the papers already reviewed.</p>

<p>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15</p> <p>results, compared to the 741 results in the study. The choice of databases needs to be discussed with reference to a clear research question that motivates this delimitation. Alternatively, and perhaps also the better course of action, would be to actually use also other databases that will either generate more material for the study or confirm that the material collected is indeed ‘all empirical studies relating to whistleblowing in healthcare’.</p>	
<p>16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43</p> <p>At the end of the section it is stated that the analysis of the selected papers were structured according to the five stage model proposed by Near and Miceli (1985). This is true for Appendix 1 but not the Findings section. The structure of the Findings section needs to be discussed in the Methods section, preferably as a concluding remark concerning the coding of the material. It was a bit of a surprise that this section [Findings] did not follow the five stages model by Near and Miceli since this is indicated in the Method section.</p>	<p>The Findings section was originally structured according to the stage model, but the preponderance of studies focusing on the decision making stage meant this produced a skewed structure (four very short sections and one very long section). We have amended the phrasing in the Methodology to explain this (see above). We have added a short paragraph to the start of the Findings section explaining why we didn’t structure the Findings following the 5-stage model:</p> <p>“As noted above we used the Near & Miceli stage model to structure our analysis but mapping the selected papers onto the model shows research is concentrated mainly on the decision making stage (see Appendix 1). We have therefore adopted a structure better suited to the actual profile of the reviewed studies. The first and largest section examines the factors affecting whistleblowing, before we turn a consideration of responses to whistleblowing.”</p>
<p>44 45 46</p> <p>The last sentence in the Methods section (p. 3, line 21) is not about methods. This is a finding.</p>	<p>Good point, we have moved this.</p>
<p>47 48 49 50 51 52 53 54 55 56 57 58 59 60</p> <p>The themes identified in the Findings seem relevant and reasonable, but needs to be presented in a more structured way to better help the reader take in the amount of information provided. In addition to the named categories and themes, the sub-themes under each theme could be named and listed.</p> <p>Following the discussion above regarding the selection of the material for the study, there may have to be a reflection on of if</p>	<p>We have revised the structuring of the Findings to draw out the sub-themes more clearly, simplifying the main headings and adding sub-headings to guide the reader.</p>

<p>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60</p> <p>this affects the findings and conclusions of the study.</p>	
<p>The first paragraph of the Discussion section is findings rather than discussion. These findings are of a character that you would like to see them in the beginning of the Findings section as a backdrop to the qualitative content analysis.</p>	<p>Thank you, we have moved this paragraph accordingly.</p>
<p>The paragraph also contains a claim that mainstream whistleblowing literature is dominated by US scholars (p. 7, line 55), but there is no sources referenced to support this claim.</p>	<p>We have revised this to state “The mainstream whistleblowing has its roots in the work of a handful of US-based scholars, notably Near and Miceli, and though the field is now global US scholars continue to make important contributions.”</p>
<p>The section on Implication for policy and practice seem to follow well from the findings. However, since the overwhelming material analyzed relates to nurses as participants in the studies, there ought to be a discussion on the potential limitation this set for the recommendations.</p>	<p>We have added a discussion of this limitation.</p> <p>“We noted above that the bulk of healthcare whistleblowing research has been undertaken with samples from nursing, and clearly this has implications for the generalisability of the findings for other professions in healthcare. Nurses work in teams, have more opportunities to observe the wrongdoing of other professionals than vice versa, are more likely to observe certain types of wrongdoing and less likely to observe others, have a strong occupational culture etc. All of these factors mean that we need to be cautious in assuming that research on nursing whistleblowing will read across readily to other healthcare professions.”</p>
<p>The first paragraph in the Directions for future research section includes a good discussion on a number of areas for further research that follows well from the findings. However, if the findings are skewed due to the selection of material (see discussion under Method above) this would also affect this discussion.</p>	<p>See point above in response to your comment on the search protocol. The findings are skewed by the literature rather than the selection; research on nurses does dominate.</p>
<p>In the second last sentence of the first paragraph (p. 9, lines 23-25) we learn that the ‘bulk of research has been undertaken in hospital settings’. This is a finding and should therefore go in the findings section, preferably together with the findings moved from the Discussion section (see comment above).</p>	<p>Thank you, we have moved this to the start of Findings.</p>

<p>The second paragraph under the future research heading (p. 9) calls for further research on whistleblowing in the US. Why the US is singled out as a named country where more research is needed is unclear especially since the first paragraph in the section ends with the recognition of the global scope of healthcare and asks for exploration of whistleblowing in different national cultures. The brief examples in the findings relating to countries like Finland, China and Israel could serve as an entry to a more relevant discussion on future research.</p>	<p>We have added the following paragraph to elaborate on this: “The mainstream whistleblowing literature reveals that the issues first researched in the USA in the mid-1980s have proven to be relevant and similar in other countries, notwithstanding cultural and legal differences. By contrast for healthcare whistleblowing the suggestion is that the USA may be different from the territories studied to date, in ways which are interesting and may offer important insights for policy and practice.”</p>
<p>No comments beyond that the conclusions of the study may be affected by revising the paper in accordance with previous comments.</p>	<p>The comments helped us clarify some key points and generally tighten up the paper, but as our revised search did not reveal additional relevant papers the changes did not significantly alter our conclusions.</p>

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