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Reporting misconduct : A descriptive study of whistleblowing in nursing

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Reporting Misconduct

A Descriptive Study of Whistleblowing in Nursing

By

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Abstract

This research examined the effects of whistleblowing and non-whistleblowing on nurses in Western Australia. A descriptive survey design was used to explore the physical, emotional and professional effects experienced by nurses who blew the whistle and nurses who did not blow the whistle on misconduct. This study also examined the effective and ineffective coping behaviours reported by participants. A questionnaire was developed based on Lazarus and Folkman's Stress/Coping model and mailed to 500 nurses in Western Australia. Of these, 100 returned the completed questionnaire, indicating a response rate of 20%. Ninety-five respondents were included in the study; 70 were self-identified as whistleblowers and 25 were self-identified as non-whistleblowers. Results indicated that nurses experienced stress-induced physical and emotional problems from being involved in a whistleblowing situation. Data also suggested that severe professional reprisals occurred if the nurse reported misconduct, but there were few professional consequences if the nurse remained silent. A majority of whistlebowers tried *problem-focused* coping behaviours and reported four of them to be effective. A majority of non-whistleblowers tried *emotion-focused* coping behaviours and reported all of them to be ineffective. The conclusions reached from this research are: (1) Whistleblowing situations are stressful and may cause physical and emotional problems *whether one blows the whistle or not*. (2) Blowing the whistle on misconduct can be professionally damaging, whereas remaining silent will probably not affect one's career. (3) Blowing the whistle on misconduct will probably not change, or stop, the misconduct. (4) Remaining silent may result in more feelings of unworthiness and guilt than speaking up. (5) Problem-focused behaviours are the most effective coping behaviours in whistleblowing situations.

Declaration

"I certify that this thesis does not incorporate without acknowledgement, any material previously submitted for a degree or diploma in any institution of higher education and that, to the best of my knowledge and belief, it does not contain any material previously published or written by another person except where due reference is made in the text or contain any defamatory material."

Signature [redacted]

Date 1 July 1999

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Chapter One

Introduction

This study examined the phenomenon of whistleblowing in the field of nursing. Whistleblowers are people who disclose information about misconduct in their workplace which they feel violates the law, or endangers the welfare of others (De Maria, 1994). Nurses who identified misconduct at work were asked to describe the physical, emotional, and professional effects of reporting the incident ("whistleblowing") or not reporting the incident ("non-whistleblowing"). Both whistleblowers and non-whistleblowers were asked to describe how they coped with their whistleblowing experience and which coping behaviours they considered most effective.

Patients who are hospitalised for physical or mental illness experience varying degrees of vulnerability (Irurita, 1996). Their illnesses have often robbed them of self-care capabilities, autonomous movement, and rational decision-making. They must depend on the competence of their carers and trust that their care is motivated by good will, beneficence and high ethical standards. Nursing organisations around the world recognise this vulnerability in ethical codes which direct nurses to protect patients from abuse, incompetence, exploitation or harm (Johnstone, 1994).

The Nurses Code of Practice 1995, issued by the Nurses Board of Western Australia, states that "a nurse who is caring for a client who is in a vulnerable physical or emotional state should ensure, to the extent practicable, that no unfair advantage is taken of the client" (Section 3.3). This ethical code clearly binds a

nurse to patient advocacy, and contains principles that nurses are taught to uphold. However, if patient advocacy requires the nurse to report incompetence or misconduct, there could be personal and professional risks involved. Studies of whistleblowers in other professions reveal that speaking out can cause serious personal and professional problems. De Maria and Jan (1994) found that all of the whistleblowers in their study suffered official or unofficial reprisals for reporting misconduct, including such punitive measures as dismissal, demotion, harassment, ostracism and/or referral to a psychiatrist. Lennane (1993) studied the health effects of whistleblowing, and found that the majority of whistleblowers suffered physical and emotional ill health.

Such research clearly indicates that reporting misconduct in the workplace causes physical, emotional and professional consequences for those who blow the whistle (De Maria, 1994; Hunt, 1995; Lennane, 1993). However, an extensive search of nursing literature could find no studies that examined the effect of reporting misconduct in nursing. Furthermore, no studies have examined whether nurses who do **not** report misconduct are affected physically, emotionally or professionally. Since the Nurses Code of Practice (1995) compels nurses to protect patients from abuse, exploitation, incompetence or harm, it is important to investigate if nurses experience physical, emotional and/or professional effects for reporting, or not reporting, such misconduct. Reporting misconduct in the workplace is known as 'whistleblowing'. Therefore, this study examined how nurses in Western Australia were affected when they blew the whistle, or decided not to blow the whistle, on misconduct they encountered at work.

Background

Reporting a situation that endangers the welfare of others would seem to be a good thing to do. However, a paradox exists, for organisations do not like members who report events that reflect negatively on the organisation. Managers expect employees to accept company protocol and follow majority rule (Davis & Aroskar, 1991). Speaking out when the rest of the group remains silent is widely regarded as a breach of loyalty and a betrayal of those who conform. This is particularly true of hospital corporations, where there is a history of paternalistic control (Johnstone, 1994). Pressure to keep information within the group is reinforced by the fear of being labelled a "traitor" or "trouble-maker". In Australia, the term "whistleblower" has negative connotations because it invokes the repellent idea of "dobbing in your mates", or telling on your colleagues. There is such a strong emphasis placed on belonging to the group, that to engage in a behaviour which threatens the group norm is to risk rejection and ostracism (Anderson, 1990).

However, this paradox places nurses in a difficult situation. Their Code of Ethics compels them to safeguard the interest of their patient, yet such action could put them in direct conflict with their organisation (group). Anderson (1990) goes so far as to state, "Every act of patient advocacy is a potential whistleblowing incident" (p.10).

There are disparate opinions regarding the issue of patient advocacy. Some nursing scholars believe that patient advocacy is the foundation of nursing (Bandman & Bandman, 1990; Kelly, 1996), while others believe that nurses are not in the best position to be patient advocates (Allmark & Klarzynski, 1992; Kendrick, 1994). Those opposing views will be examined more closely in the literature review. However, the controversy regarding patient advocacy does not alter the fact that

nurses must adhere to current ethical codes of practice and are legally bound to protect patients from harm. There are times when that could mean blowing the whistle on misconduct.

Unethical conduct has occurred in hospital settings in the UK, the United States and Australia. Martin's book *Hospitals in Trouble* (1985) describes patient neglect and staff brutality that occurred in UK hospitals in the 1960s and 1970s. Gross misconduct was also uncovered at Rampton Hospital in 1980, and at Ashworth Special Hospital in 1991 (Hunt, 1995). British nurse, Graham Pink, complained that staff shortages at Stepping Hill Hospital caused a poor quality of care for the patients, and his employment was terminated for exposing the situation. However, other nurses across Britain confirmed similar patient neglect on their geriatric wards (Lunn, 1995).

In the United States in 1990-1992, U.S. state, federal and media investigations uncovered widespread fraud, patient abuse and unethical conduct in mental health facilities in Texas, California, Alabama, Florida and New Jersey (Mohr, 1995a). Some of the complaints investigated were:

- Excessive medication and therapy
- Unnecessary hospitalisation of patients
- Coercion and threats to detain voluntary patients
- Holding voluntary patients against their will
- Falsifying diagnoses to match insurance benefits
- Questionable and abusive therapies

In Australia, a 1961 Royal commission looked into allegations of cruelty and neglect in Callan Park Mental Hospital (Schizophrenia Care Foundation Report, 1994). Other "scandals" were investigated at Chelmsford and Townsville hospitals

(De Maria, personal communication, March 19, 1997) and recently there was news of "irregularities" found at Baillie Henderson Hospital which included reports of physical and sexual assault of psychiatric patients (Fagan, 1996). In Western Australia, a government investigation closed Hillview Psychiatric Hospital in 1995 for reasons that included gross mismanagement and sexual abuse of young patients (Gibson, 1997).

Since nurses account for a large proportion of hospital employment, it is reasonable to assume that many nurses were aware of offences taking place in their hospitals. Yet with few exceptions (Hunt, 1995; McDonald, 1994; Mohr, 1995b; Mohr & Mahon, 1996) nursing literature has remained silent on the issue of hospital misconduct. What nursing scholars have documented is the distress nurses feel when confronted with moral dilemmas. A study by Wilkinson (1987/88) found that when nurses are involved in situations where they feel unable to act morally, they suffer "psychological disequilibrium" resulting in "moral outrage".

In summary, it is clear that the health care environment is not immune to engaging in illegal or unethical activities. When such misconduct occurs where nurses are employed, they are faced with an ethical dilemma. Their Code of Ethics compels them to assume the role of patient advocate, and to protect their patients from harm. But when patient advocacy involves reporting misconduct, it could place nurses in direct conflict with their employing agency, and put them at risk for personal and professional consequences. Patient advocacy literature offers clear evidence that when nurses assume the role of patient advocate, they encounter risks and difficulties requiring conviction and courage (Chafey, Rhea, Shannon & Spencer, 1998; Holly, 1993; Segesten, 1993; Watt, 1997). Those studies indicate that one of the most difficult aspects of patient advocacy is maintaining an ethical

stance when faced with opposition. If there are elements of incompetence, or misconduct involved, the issue becomes a potential whistleblowing situation, and the nurse must decide whether to report it or not. This dilemma causes high levels of stress and risk for the nurse (Anderson, 1990; Holly, 1993; McDonald, 1994; Segesten, 1993). The aim of this research is to help nurses understand the implications involved in reporting, or not reporting, misconduct.

Research Problem

Ethical codes of conduct bind nurses to the role of patient advocate. However, clinical case studies and a review of the literature reveal that this role can put nurses in direct conflict with employers or colleagues. Studies of whistleblowers in professions other than nursing show that whistleblowers suffer high levels of stress resulting in physiological and psychological ill health (De Maria, 1994; Lennane, 1993). Nursing literature reveals that nurses experience "moral outrage" when they are prevented from acting morally (Wilkinson, 1987/88). However, there were no data on the physical, emotional or professional effects of reporting misconduct in the profession of nursing. The aim of this research was to examine how nurses in Western Australia were affected when they blew the whistle or decided not to blow the whistle, on misconduct they encountered at work. The study also examined the coping behaviours used by nurses in the study and defines which coping behaviours they considered effective and ineffective.

Significance

The profession of nursing relies on a system of checks and balances to ensure the delivery of good patient care. It places great emphasis on the ability of nurses to make sound judgements and to be able to identify a situation that jeopardises patient safety. For this reason, whistleblowing in nursing takes on the added dimension of patient advocacy, and has profound implications for the profession and for individual nurses. Since the significance of this subject affects several areas, each area has been discussed separately.

Significance to the Literature

Nursing literature is beginning to address the manifestations of whistleblowing, including patient advocacy, moral decision-making, and nursing ethics studies (Anderson, 1990; Curtin, 1993; Fiesta, 1990; Forchuk, 1991; Kelly, 1996; Wilkinson, 1987/88). Most of the nursing literature related to whistleblowing has been theoretical rather than empirical, and no studies were found that examined nurse whistleblowers. Many authors describe the risks involved in whistleblowing (Anderson, 1990; Fahy, 1992; Kiely & Kiely, 1987) or offer legal advice for nurse whistleblowers (Fiesta, 1990; Fry, 1989; Johnstone, 1994; Lunn, 1995), but again those papers are mostly theoretical, and provide no empirical data for practical application. For example, Kiely and Kiely (1987) completed a review of the literature and found that there was little information on the occurrence of whistleblowing among professional nurses and Anderson (1990) confirmed this by stating that there was no data on the frequency or effect of whistleblowing in nursing.

Patient advocacy is a subject that is related to whistleblowing, and there are studies that examine the experience of nurses who risked opposition to act as patient advocates (Chafey et al., 1998; Holly, 1993; Segesten, 1993; Watt, 1997). Some nursing scholars have documented the moral decision-making process of nurses (Carpenter, 1991; McAlpine, Kristjanson & Poroch, 1997; Uden, Norberg, Lindseth & Marhaugh, 1992), but those studies do not discuss ethical decision making in the context of reporting misconduct or risking professional censure.

Lennane (1993) and De Maria (1994) profiled whistleblowers in various professions in Australia, and their studies have made an important contribution to the knowledge of whistleblowing. Although their results do not discuss whistleblowing in relation to nursing, they are included in the literature review because they define the risks and complexities involved in whistleblowing. The significance of this study is that it extends knowledge of whistleblowing to the discipline of nursing, where there is no information on how the experience of being in a whistleblowing situation affects nurses physically, emotionally and professionally.

Significance to the Patient

People who require nursing care are often compromised by pain, fear and physical and/or psychological dysfunction. They must trust that their care will be competent and in their best interest. Nurses in several recent studies have described the vulnerability of ill patients, and have expressed the belief that there are times when patients may require nurses to act as their advocates. (Chafey et al., 1998; Watt, 1997). Nurses described the need for advocacy when "the client was vulnerable, being intimidated, taken advantage of, neglected or complaining" (Chafey et al., 1998, p. 47). However, there are times when nurses are discouraged from acting as a patient advocate. Some of the reasons given by nurses in various

studies include physician anger, time constraints, lack of autonomy and power hierarchies within the work environment (Chafey et al., 1998; Holly, 1993; Segesten, 1993). In situations where nurses are prevented from giving good patient care, their most frequently employed coping behaviour is avoidance of the patient (Wilkinson 1987/88; Diaz & McMillin, 1991).

Vulnerable patients require consistent and diligent care, and nursing studies have indicated that patient advocacy is the most highly valued nursing standard (Mallik, 1996; Wilkinson, 1987/88). Therefore, if factors such as misconduct or incompetence jeopardise patient advocacy, those factors need to be investigated.

Significance to the Nurse

A consensus exists in the nursing literature that nursing stress is increased if nurses are prevented from acting in the best interest of their patients (Anderson, 1990; Gunning, 1983; Jameton, 1984; Kelly, 1996; Wilkinson, 1987/88). However, nurses who speak out about misconduct within their organisation may do so at considerable risk to their professional career and health (Anderson, 1990). De Maria's (1994) study of whistleblowers warns that reprisals for whistleblowing often include dismissal, transfer, harassment, social ostracism and personal attacks on the whistleblower's moral integrity. Lennane (1993) and De Maria (1994) found that a majority of whistleblowers suffer stress-induced ill health. No studies have examined nurses who report misconduct, so it is not known the extent of their suffering. However, patient advocacy studies indicate that nurses who are unable to act as patient advocates suffer moral distress and psychological ill health (Wilkinson, 1987/88; Holly, 1993; Segesten, 1993). Nurses in Holly's study used words such as "grief" and "dread" to describe the times they felt powerlessness to help patients. Given the extent of nursing distress experienced when patient advocacy is denied,

there has been a grave omission in nursing research not to address the ramifications of that issue. This research will provide information on how nurses are affected when they work in an environment that jeopardises patient care.

A major source of stress and burnout in nursing occurs when nurses believe their integrity is compromised by not being able to act in the best interest of their patients (Kelly, 1996; Simoni & Paterson, 1997). Some nurses choose to leave nursing rather than cope with an environment where they lack autonomy or decision-making powers (Smith, Droppleman & Thomas, 1996). Yet nurses who are strong enough to speak up on behalf of their patients, and sensitive enough to consider moral judgements, are the very nurses who should be valued in the profession. This study offers new knowledge on how nurses were affected when they identified misconduct in nursing. It provides data on how nurses coped with whistleblowing situations, and identifies which coping behaviours were most effective. Uzych (1996) acknowledges the need for such research:

> It is one thing to say that, according to some professional code of conduct, a nurse must act to safeguard patients from incompetent, unethical or illegal practices of some healthcare provider. But it is another thing to lose your job, or be disadvantaged in various ways, because you chose to speak up, and no mechanisms were in place to protect you against reprisals of some sort. The matter of protecting a 'whistleblower' is an important one, and one which needs to be fleshed out. (p. 36).

Significance to the Profession

Factors that impede the delivery of effective nursing care require serious consideration. When a person is registered to practice nursing, a commitment is made to uphold the standards of practice. Inherent in those standards is a code of

ethics that requires the nurse to protect and safeguard the interests of the patient. If institutions place constraints on a nurse's ability to uphold the profession's ethical codes, then those codes become worthless. Dwyer (1994) believes that when one remains silent in the face of perceived wrongs, ethical values become permanently diluted. It is important for all nursing professionals to ensure that our standards and values are not 'diluted' or compromised

This study identified factors within the healthcare system that nurses perceived to be unethical or illegal. Nurses in the study expressed grave moral concern because those factors affected patient care and patient safety. In fact, the core values of the nursing profession are embodied in those concerns. If the profession is intent on preserving its values, then it must allow those moral concerns to be expressed and examined. This requires an atmosphere of open support for, and commitment to, the ethical codes of practice. In order to safeguard nursing values, it is imperative that nurses are able to identify and express moral concerns.

Many patient advocacy studies have identified oppressive and patriarchal elements within the environment of nursing (Chafey et al., 1998; Kelly, 1996; Mohr, 1995b; Smith et al., 1996). Other studies have identified factors that impinge on the ability of nurses to uphold their moral authority (Duncan, 1992; Holly, 1993; Segesten, 1993; Watt, 1997). This study went a step further by examining the nurse's *response* to negative factors in the work environment (unethical, illegal or incompetent behaviour) and reported how their responses (blowing the whistle or remaining silent) affected them physically, emotionally and professionally. That information will provide insight into what nurses may expect when they respond to moral concerns.

Significance for the Public Good

Finally, this study has provided significant insight into nursing care in Western Australia today. By studying nurses who have attempted to stop what they considered wrong, this study has offered a better understanding of the environment in which these nurses are working. In view of the series of Royal Commissions into alleged healthcare fraud and abuse (Fagan, 1996), it is apparent that misconduct has occurred in hospitals in Australia. As a profession we owe it to each other, and to the public, to address the issue of health care misconduct openly, and without fear of reprisals. Uzych (1996) stated that fraud-related problems would continue to plague the healthcare system unless mechanisms are put in place to safeguard whistleblowers.

Research Purpose

The purpose of this study was to examine the experience of nurses who, in the course of their career, encountered incompetent, illegal or unethical situations. It examined the effect of stress on nurses in a whistleblower situation and compared the physical, emotional and professional effects reported by whistleblowers and non-whistleblowers. The research also examined the coping behaviours reported by nurses in a whistleblowing situation, and identified which coping behaviours were considered most effective. Finally, the study assessed the validity of the theoretical framework that guided this research, namely Lazarus and Folkman's Model of Stress and Coping (Lazarus & Folkman, 1984).

Research Questions

1. What are the physical effects of identifying misconduct in the workplace for whistleblowers and non-whistleblowers?
2. What are the emotional effects of identifying misconduct in the workplace for whistleblowers and non-whistleblowers?
3. What are the professional effects of identifying misconduct in the workplace for whistleblowers and non-whistleblowers?
4. Which coping behaviours (defined by Lazarus and Folkman's Model of Stress and Coping) are used by nurses when they identify misconduct at work, and which ones are perceived by them to be most effective?

Definitions of Terms

Whistleblower: A nurse who identifies an incompetent, unethical or illegal situation in the workplace and reports it to someone who may have the power to stop the wrong.

Non-Whistleblower: A nurse who identifies an incompetent, unethical or illegal situation in the workplace, but does not openly report it. Non-whistleblowers may use other methods to handle the situation.

After reading the definition for whistleblower and non-whistleblower, respondents were asked to tick the box that best described the action they took when they encountered incompetent, unethical or illegal activity in their workplace, thus nominating themselves as whistleblower or non-whistleblower.

Advocate: A patient advocate is a nurse who seeks to protect a patient's rights from infringement by institutional policies (Nurses Legal Handbook, 1996). It involves providing patients with the information they need to make informed decisions, supporting their decisions and safeguarding their dignity, safety and interests (Adapted from Clark, 1982).

Coping: The self-reported cognitive and behavioural actions used by nurses to manage their stressful whistleblowing experience. The coping behaviours are assessed as effective or ineffective by the nurse's own appraisal.

Dilemma/Ethical Dilemma: A dilemma is having to choose between equally unsatisfactory alternatives, and an *ethical* dilemma is a situation involving choice between conflicting rights, responsibilities and values (Davis & Aroskar, 1991). In this study, the whistleblowing situation was an ethical dilemma and the choice was whether to report the situation (whistleblow) or *not* report the situation (non-whistleblow).

Emotional Effects of Whistleblowing: The stress-induced emotional feelings which nurses reported they experienced as a result of being involved in a whistleblowing situation. The number of emotional feelings reported measured the emotional effects of whistleblowing and non-whistleblowing.

Physical Effects of Whistleblowing: The stress-induced physical symptoms which nurses reported they experienced as a result of being involved in a whistleblowing situation. The number of physical problems reported measured the physical effects of whistleblowing and non-whistleblowing.

Professional Effects of Whistleblowing: The professional consequences nurses reported they experienced as a result of being involved in a whistleblowing situation.

The number of professional consequences reported measured the professional effects of whistleblowing and non-whistleblowing.

Stress: The relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being (Lazarus & Folkman, 1984). In this study, stress is measured by the number of stress-related physical and emotional problems reported by the nurse.

Whistleblowing Situation: Activity in the workplace of a nurse which is identified by the nurse as being incompetent, unethical or illegal.

Definition of Terms Related to Lazarus and Folkman's Model of Stress and Coping

Appraisal: The cognitive process one goes through to determine possible harm or threat in an event (Lazarus & Folkman, 1984).

Direct Action: A mode of coping in Lazarus and Folkman's model which involves "fight or flight" reactions to stress. Direct Action behaviours attempt to prevent, avoid or overcome the stressful event. In this research, Direct Action is "Blowing the Whistle" or "Remaining Silent".

Intrapsychic Process: A mode of Palliative Coping in Lazarus and Fokman's model that involves the use of defence mechanisms such as information seeking, problem solving and fantasy thinking to cope with a stressful event.

Lazarus and Folkman's Model of Stress and Coping: The conceptual model used to guide this research. It provides a framework to measure one's reaction to stress, identify coping behaviours and determine whether those coping behaviours are successful or unsuccessful (Lazarus & Folkman, 1984).

Palliative Action: A mode of coping in Lazarus and Folkman's model which involves reactions to stress that are used to make one feel better, or less stressed. The model identifies two different modes of Palliative Action, *Somatic Intervention* and *Intrapsychic Process* (Lazarus & Folkman, 1984).

Primary Appraisal: The first action used in Lazarus and Folkman's Model of Stress and Coping (1984). It operates when one evaluates the characteristics of a stressful situation by asking the basic question, "Am I danger – do I need to cope"? Responses to primary appraisal are; (1) *Irrelevant,* in which the person has no investment in the outcome of the encounter, and it doesn't impinge on any values or commitments. (2) *Benign-Positive*, in which the outcome of the encounter is viewed as positive and (3) *Stressful,* in which the outcome is viewed as potentially harmful, threatening or challenging.

Reappraisal: When one reconsiders a situation and appraises it in light of new or changing information (Lazarus & Folkman, 1984).

Secondary Appraisal: The second action used in Lazarus and Folkman's model wherein one considers possible options to a situation, and asks, "How effective will this response be?" and "What are the negative consequences?" (Lazarus & Folkman, 1984).

Somatic Intervention: A mode of Palliative Coping in Lazarus and Folkman's model that involves the use of biofeedback or relaxation tapes to cope with a stressful event.

Chapter Two

Literature Review

Introduction

Although the subject of whistleblowing is mentioned with increasing frequency in nursing literature, the content has been mostly theoretical and no empirical studies were found that examined nurse whistleblowers. Generally the literature discusses such subjects as the risks involved in whistleblowing (Anderson, 1990; Fahy, 1992; Kiely & Kiely; 1987), or the conflicting loyalties experienced by nurses (Hayne, Moore and Osborne, 1990; Kelly, 1996; Trandel-Korenchuk & Trandel-Korenchuk, 1982). Many papers offer legal advice for nurse whistleblowers (Fiesta, 1990; Fry, 1989; Johnstone, 1994; Lunn, 1995), and some have profiled nurse whistleblowers (Anonymous, 1989; Fry, 1989; Johnstone, 1994; Witt, 1983).

In nursing, a whistleblowing situation exists when misconduct or wrongdoing is identified in the workplace. To correct the wrong, the nurse must make ethical decisions based on personal values and the Nurses Code of Conduct. A major tenet of all nursing codes is patient advocacy. It states that a nurse's primary responsibility is to the patient, and it compels the nurses to safeguard the physical and emotional health of the patient. When the nurse identifies misconduct in the workplace, patient advocacy may require the nurse to report it. Reporting misconduct is known as whistleblowing, and whistleblowing is professionally risky. Risk causes stress and stress can cause stress-related conditions affecting physical and emotional health.

In this review of the literature, the subject of whistleblowing will be covered in the following order. The first section will show how the ethical codes of nursing

require patient advocacy. It will then describe the factors involved in patient advocacy. The second section will show how patient advocacy sometimes involves ethical dilemmas, and how those dilemmas could lead to whistleblowing. The third section will describe the professional risks involved in whistleblowing and the fourth section will show how those risks can cause stress-related conditions of ill health. The final section of the literature review will profile nurse whistleblowers.

The Professional Codes of Nursing and Patient Advocacy

Advocacy is defined from its root in the legal system, that is, 'one who pleads the cause of another' (Allmark & Klarzynski, 1992; Fahy, 1992; Kendrick, 1994; Mallik, 1997; Woodrow, 1997). In nursing, patient advocacy has come to mean that a nurse's primary responsibility is to those who require nursing care. The form that responsibility takes is defined in nursing codes around the world. The International Council of Nurses *Code for Nurses* states that "...The nurse takes appropriate action to safeguard the individual when his care is endangered by a co-worker or any other person" (Johnstone, 1994, p. 252).

Nursing codes drawn up by the United Kingdom Central Council (UKCC) are just as explicit, requiring every registered nurse, midwife and health visitor "to safeguard and promote the interests of patients and clients" (Health Visitor, 1993, p. 277). Clause 12 of the UKCC Code of Professional Conduct requires the registered nurse, midwife or health visitor to "...report to an appropriate person or authority any circumstances in which safe and appropriate care for patients and clients cannot be provided" (Health Visitor, 1993, p. 277).

The American Nurses Association (ANA) Code of Ethics states the nurse must "safeguard the client and the public when health care and safety are affected by the incompetent, unethical or illegal practice of any person" (ANA, 1985).

Similarly, the Canadian Nurses' Association Code of Ethics states that "the nurse takes steps to ensure that patients receive competent and ethical care" (Nurses Legal Handbook, 1996, p. 286). A comparable message is conveyed in the Nurses Code of Practice, issued by the Nurses Board of Western Australia (1995). It states that "a nurse who is caring for a client who is in a vulnerable physical or emotional state should ensure, to the extent practicable, that no unfair advantage is taken of the client".

The wording of these codes clearly state the ethical and moral responsibilities of the profession and as such, legally bind a nurse to the role of patient advocate. Johnstone (1994), a legal scholar in nursing, analyses these codes to mean that "...nurses are primarily responsible and professionally accountable to the patient, not to other health team workers (for example, doctors), administrators or even to their employers" (p. 253). This analysis is important to remember because one of the major issues discussed in patient advocacy literature is that nurses feel a conflicting loyalty between patient and employer.

Evidence from court cases in the USA and the UK show that courts are reluctant to recognise nurses as autonomous decision makers (Johnstone, 1994; Montgomery, 1992; Murphy, 1987). For example, Chafey et al. (1998) cite the Tuma case as one of the reasons the American Nursing Association made radical changes to its code of ethics (ANA, 1976:1985). Jolene Tuma lost her nursing license in Idaho for advocating for a cancer patient and was assisted by the ANA to successfully appeal the action. The ANA Code of Ethics was rewritten to "move the profession away from a model of obedience and organisational loyalty" to a model of patient advocacy (Chafey et al., 1998, p. 44). But the courts do not always support the ANA's code. When the code was invoked as a defence for a nurse in

New Jersey, the court rejected statements within the ANA's Code of Ethics, invalidating the code and the moral autonomy of the nurse. (Johnstone, 1994). Nurses in the studies reviewed for this research conclude that although nurses are expected to act as moral advocates, the authority to do so is weak (Chafey et al., 1998; Duncan, 1992; Holly, 1993; Mohr, 1996; Segesten, 1993; Soderberg & Norberg, 1993).

There is a vast amount of literature on the subject of patient advocacy. Most of the discussion focuses on arguments justifying or rejecting the belief that nurses should be patient advocates. The following themes are central to the debate:

- advocacy is the philosophical foundation of nursing
- patients require advocates because they are vulnerable
- nurses are in the best position to be patient advocates
- nurses are not prepared for the role of patient advocacy

Advocacy Is The Philosophical Foundation of Nursing.

Many nursing scholars believe that patient advocacy is the philosophical core of nursing (Anderson, 1990; Curtin, 1986; Bandman & Bandman, 1990, Davis & Aroskar, 1991; Kelly, 1996; Wilkinson, 1987/88), and that it has always guided the profession's duty to care (Bramlett, Gueldner & Sowell, 1990; Miller, Manson & Lee, 1983). However, the premise that nurses have always advocated for their patients is not supported in history or literature. Florence Nightingale taught nurses to simply obey doctors (Witts, 1992), and there is a strong body of literature that speaks about the subordination of nurses within the medical system (Johnstone, 1994; Mackay, 1993; Roberts, 1996; Stein, Watts & Howell, 1990; Witts, 1992).

Curtin (1979) and Gadow (1980) offered some of the earliest writings on the inherent nature of advocacy in nursing, and define it in terms of the philosophical

nature of the nurse/patient relationship. Curtin reasoned that since the end purpose of nursing is to promote the welfare of humans, human advocacy must be the foundation of nursing. Kohnke (1982) presented one of the first definitions of advocacy in her comprehensive guide for nurse advocates, but she does not believe that advocacy is a natural role for nurses.

In a qualitative study using grounded theory, Watt (1997) explored the concept of patient advocacy as perceived by eight nurses working in an acute care hospital. She found that the participants did not perceive advocacy to be the philosophical foundation of nursing because it forced them to "step outside the boundaries" of nursing (p. 122). Watt's participants, especially the inexperienced nurses, felt constrained from acting as patient advocates because of the feeling that it was not within their domain.

Patients Require Advocates Because They Are Vulnerable.

Patient vulnerability is the reason most nurses give for believing that patients require advocates. Many nursing theories are based on the premise that patients are made vulnerable by the pain of illness or injury, the fear of life-threatening consequences, and the lack of medical and/or technical knowledge (Curtin, 1979; Irurita, 1996; Orem, 1994). Mallik (1997) questions why this vulnerability is now viewed in terms of loss of patient rights. She points out that in the past, the sick role was expected to generate dependency needs, and that before the 1970's, patients obediently deferred to physician authority. Mallik suggests that "cultural conditions in the USA with the concurrent strong emphasis on individual rights and autonomy were important in shaping the rise of the advocacy movement in health care" (1997, p. 131).

Nurses in several recent studies accept the premise that vulnerable patients require advocacy. In a qualitative study by Chafey et al. (1998) nurses described the need for advocacy when "the client was vulnerable, being intimidated, taken advantage of, neglected, or complaining" (p. 47). Nurses in Segesten's (1993) study referred to a "powerless patient" when describing the need for advocacy, and Marshall (1994) discusses the need for advocacy when a patient's autonomy has been threatened or diminished.

Nurses Are in the Best Position to be Patient Advocates.

When authors state that nurses are in the best position to act as patient advocates, they refer not only to the nurse's position within the health care team, but also to the special relationship that exists between patient and nurse. Bishop and Scudder (1990) argue that nurses can act with legitimate authority from the middle ground they occupy in the health care team. A good example of this is a nurse in Watt's (1997) study who acted to preserve a patient's dignity and self-worth:

> *I remember one situation. The patient had been on the ward for a long time. One morning he arrested. The resuscitation was long and unsuccessful. One of the medical staff thought that it would be a good time for the students to practice intubation. I didn't say anything to them; I just removed all of the equipment from the bed and covered the man with a sheet. Nobody said anything; they all just left the room* (p. 121).

All of the nurses in Watt's (1997) study believed that the reason nurses were in the best position to advocate for patients was that they had developed special relationships with their patients due to the intimate care they gave them. This was consistent with the belief of nurses who stated that the interpersonal relationships they had with their patients formed the "cornerstone of their advocacy" (Chafey et al., 1998, p. 49). These views are important to the subject of whistleblowing because

the relationship that is formed between nurse and patient could explain one reason why a nurse would be willing to risk blowing the whistle to protect the interests of the patient.

Tanner, Benner, Chelsa and Gordon (1993) agree that knowing the patient presents the best opportunity for advocacy, but they believe that employment areas and economic considerations constrain nurses from knowing patients. Morse (1991b) believed that time constraints hindered nurses from developing relationships necessary for patient advocacy, and this view was supported by nurses in Segesten's (1993) study who found that advocacy was time consuming. These factors may account for some of the dynamics associated with non-whistleblowing.

Nurses Are Not Prepared for Patient Advocacy.

Another question that enters the debate of patient advocacy is whether or not nurses are adequately prepared for the role of advocacy. Melia (1989) advises against the role of patient advocate because she believes that it is beyond nurses' competence, and that it is not a realistic view of the nurse-patient relationship. Witts (1992) concluded that many nurses were not suitably educated for an advocacy role and Duncan (1992) found that knowledge development was required in patient advocacy situations. Those findings were supported by the research of Wlody (1993) who discovered that advocacy perception scores varied in direct relation to the level of education achieved, and that masters prepared nurses performed significantly higher.

In a critical analysis of the subject, McAlpine (1996) found that the literature reflected a "growing awareness that nurses might be lacking the appropriate educational base required to potentiate recognition of health care dilemmas, and reasoned ethical decision-making" (p. 122). Maas (1989) found that autonomy was

necessary for advocacy, and there was a strong correlation between education levels and the exercise of autonomy. Ballou (1998) supported those findings in her discussion on the complexities of autonomy. In whistleblowing literature, the need for education and the difficulty of autonomous decision-making in some institutions is reiterated (De Maria, 1994; Hunt, 1995).

Chafey et al. (1998) listed lack of knowledge, lack of experience and lack of self-confidence as deterrents to advocacy. Their sample also cited fear of job security, lack of support and intimidating behaviour by physicians as reasons *not* advocate. Fear of job loss and lack of support were the primary sources of stress reported by whistleblowers and patient advocates in other studies (De Maria, 1994; Lennane, 1993; Mohr, 1996). According to Chafey et al. (1998) the components necessary for advocacy were values, beliefs and convictions of the nurse. Those are precisely the qualities required of whistleblowers (De Maria, 1994; Lennane, 1993) and they are the characteristics required for taking 'direct action' as defined by the theoretical model that guided this research (Lazarus & Folkman, 1984).

Some authors argue that patient advocacy should not be the duty of the nurse for other reasons. Nelson (1988) argues that nurses are in a dependent position in relation to their employers and to physicians, and those superiors expect obedience and loyalty, making advocacy too difficult for nurses. Clearly, that is the root of the ethical dilemma involving whistleblower situations.

A qualitative study by Sellin (1995) explored the nature of patient advocacy as experienced by 40 nurses in North America. Data was collected in semi-structured interviews, and participants were asked to define patient advocacy, and discuss their experiences. Sellin concluded that the nurses believed their role as a patient advocate consisted of gathering information for patients, supporting a

patient's decision, and *protecting patients from harm by intervening or reporting problem situations.* Reporting problem situations could result in a whistleblowing action, which makes research such as this study relevant.

The Dilemma of Patient Advocacy and Whistleblowing

This section will briefly describe the ethical dilemmas encountered by nurses in recent patient advocacy research. This information will provide the basis for understanding how patient advocacy can generate ethical dilemmas that, in turn, could place the nurse in a whistleblowing situation. Anderson (1990) goes so far as to state, "Every act of patient advocacy is a potential whistleblowing incident..."(p. 10).

Holly (1993) explored the perceptions of 65 nurses regarding the ethical problems they encountered on a daily basis. The nurses were all employed in acute care nursing and data was collected over two years. Three categories emerged from the situations recounted by the nurses: exploitation (the nurses' concern with the inhumane treatment of seriously ill patients), exclusion (the lack of attention paid to patients' wishes) and anguish (the powerlessness and frustration felt by nurses involved in ethical situations). It was concluded that the nurses who attempted to become involved in situations of an ethical nature were relegated to a conventional role. The nurses used words such as "grief", "ineffective" and "dread" to describe their practice situations and they felt powerless to practice in a fully professional manner. Many members of the sample stated they were "ignored" when they tried to act in the best interests of their patients. Furthermore, they believed that taking an ethical stance in a non-supportive environment was emotionally draining.

Some of the ethical situations described by Holly's sample were events that required advocacy, and should have been reported. If they had been reported, the

ethical dilemma would have become a whistleblowing situation. This study will provide information on how reporting misconduct changes the situation and how it affects nurses.

Segesten (1993) published a descriptive study that mentions the components of whistleblowing. Her findings analysed 78 narratives, of which one third involved patient advocacy situations requiring action by the nurse. Segesten's participants realised the risk involved in being a patient advocate, and spoke about their fear of opposing hospital rules and routines, and being punished by the physician or other co-workers. In analysing the characteristics of an advocacy situation, Sergesten's study concluded that the necessary components were: (1) a powerless patient (2) a problem and (3) an adversary. Resolution of the conflict was seen to occur when the nurse: (1) took prompt action (2) acted out of conviction (3) accepted additional work and (4) took the risk of being punished. Interestingly, Sergesten's components of a patient advocacy situation parallel factors known to occur in whistleblower situations, namely that a problem exists, there is an adversary, the advocate (whistleblower) acts out of conviction and there is the risk of professional consequences .

The fear of negative professional consequences is repeated in other patient advocacy studies. Duncan (1992) examined the ethical dilemmas encountered by 30 community health nurses in British Columbia, Canada. The nurses described ethical conflicts that generated feelings of anger, frustration and fear. One nurse stated; "I think it takes a person who is willing and able to risk losing employment to do this" (p. 1037).

Soderberg and Norberg (1993) examined 20 enrolled nurses, 20 registered nurses, and 20 physicians to find out if the experience of being in ethically difficult

care situations varied depending on education, gender or professional role. The findings indicated that in some ethically difficult situations, the nurses felt ashamed of the care they provided because they lacked the courage or influence to confront the physician. This finding supports the qualitative study done by Uden et al. (1992) which found that RNs knew how to act ethically, but were prevented from doing so by physicians, and by Pike (1991) who examined ethical problems related to nurse-physician conflict. Martin (1989) found that although 80% of the neonatal nurses in her study believed they were patient advocates, only 20% said they would be willing to take their concern of inappropriate treatment by physicians "all the way to the top".

In summary, nurses in patient advocacy situations appear to have an understanding of what would be involved if they decided to take their concern to the next step, namely reporting the incident. Acknowledgement of risk and the fear of reprisal are themes that occur many times in patient advocacy studies, and are the cornerstone of whistleblowing literature (DeMaria; 1994; Hunt; 1995; Johnstone, 1998; Lennane; 1993; Mohr, 1996;Wilkinson, 1987/88).

The Professional Risks Involved in Whistleblowing

Reading accounts of whistleblowers (in nursing, and in other professions) is disturbing. The overall impression is that no matter how legitimate the concern is, and no matter how serious the offence is, the whistleblower will almost certainly be victimised for reporting the incident. Whistleblowers are repeatedly described as being demoted, dismissed, professionally ruined and made ill by their effort to correct wrongdoing (De Maria, 1994; Hunt, 1995; Lennane, 1993).

A large study in the United States examined 233 whistleblowers and reported the following statistics (Soeken and Soeken, 1987):

- 90% lost their jobs or were demoted
- 27% faced lawsuits
- 26% faced psychiatric or medical referral
- 17% lost their homes
- 15% were subsequently divorced
- 10% attempted suicide

As these statistics reveal, no matter how beneficial whistleblowing may be for the public good, it is devastating for the whistleblower. That is why this study is important, since until now, there has been no information on whether nurse whistleblowers are also negatively affected.

Hunt's (1995) whistleblower survey included 30 health care professionals who worked in the National Health Service (NHS) in England. Five of the respondents were physicians, 19 were nurses, three were midwives or health visitors, and three were other professionals. Among the problems reported were patient abuse, inadequate care, fraud/theft, staff shortage and poor practice. All of the respondents took their complaints up a managerial line, expecting the problem to be quickly resolved once superiors knew of it. However, instead of the problem being resolved, the whistleblower was victimised. Sixteen of the whistleblowers lost their jobs or resigned, and the concern they raised was never addressed.

The professional consequences were equally devastating for the whistleblowers in Lennane's (1993) research on the effects of whistleblowing. Her sample consisted of 35 people who were employed in various professions in Australia, including health care, teaching, banking, law enforcement, and local government. Each of the respondents uncovered corruption at work, or identified an illegal activity that they considered to be a danger to the public. The dangers they

reported included such things as unsafe aircraft, faulty railway signals, child sexual abuse, and the contamination of waterways. The cost of the corruption they uncovered cost the Australian taxpayer millions of dollars. Yet when they blew the whistle on what they observed, eight lost their jobs, 10 were demoted, and 10 were forced to resign or accept early retirement.

Clearly such data indicates that there are grave professional risks involved in whistleblowing. Thirty-four of the 35 subjects in Lennane's sample were victimised as a result of reporting misconduct. In 26 of the cases, victimisation began immediately after the first report. In addition, the families of the whistleblowers were adversely affected with divorce, separation, anxiety, insecurity, poverty and public attacks on their integrity. One family was unable to go out because the father was under police protection with a contract on his life; a 6-year-old girl received a death threat and a teenage boy's pets were killed. Such data makes it clear that whistleblowing is a dangerous undertaking, and some organisations will go to extreme lengths to silence whistleblowers.

The Queensland Whistleblower Study (QWS) is a larger Australian study (N=83) that was investigated by De Maria (1994) and De Maria and Jan (1994). Eleven of the respondents were nurses, but their responses were not separated from the overall study, so it is not possible to compare De Maria's nurse whistleblowers with nurse whistleblowers in this study. However, it is interesting to compare the professional reprisals suffered by De Maria's participants and those experienced by participants in two other whistleblower studies, the American study (Soeken & Soeken, 1987) and Lennane's (1993) whistleblower study. The studies differ in matters such as sample size, and definition of key concepts, but the results show enough of a common profile to demonstrate that whistleblowing involves risks that

transcend international borders. Figure 1 demonstrates some of the professional consequences experienced by whistleblowers in the three studies:

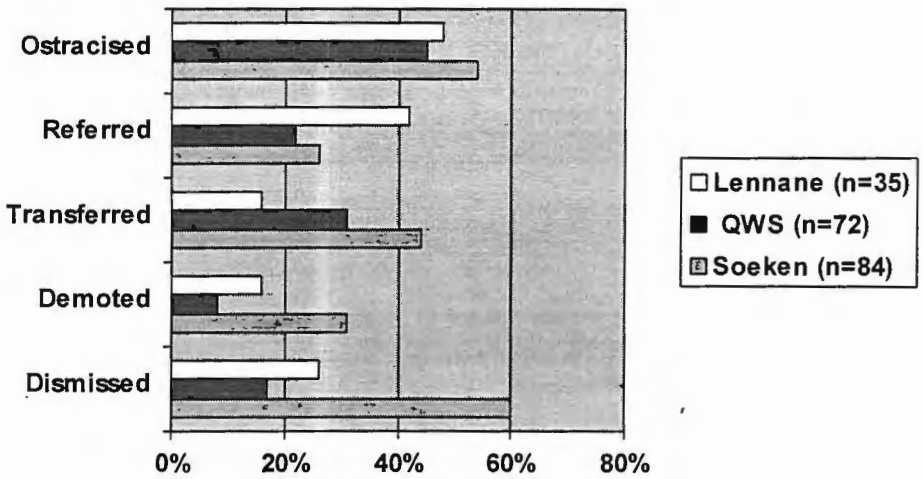

Figure 1. Comparison of the professional reprisals suffered by whistleblowers in three different studies. "Ostracised" means those who were shunned by managers, and co-workers; "Referred" means that the whistleblower was referred to a psychiatrist; and "Transferred" means a punitive transfer within the company.

In analysing results, De Maria and Jan (1994) separated the professional consequences of whistleblowing into "official" and "unofficial" reprisals. Official reprisals were defined as those which must follow legal procedure (dismissal, written reprimands, punitive transfers), while unofficial reprisals were those actions which are hard to investigate because they are subtle and deniable (threats, workplace ostracism, humiliation, being labelled a "troublemaker"). De Maria reasoned that public sector employees with permanent status are not easy to dismiss, but that *threats* of dismissal or demotion, even if unenforceable, serve as strong deterrents.

Seventy one per cent of De Maria and Jan's whistleblowers experienced official reprisals (dismissal, reprimand, punitive transfer and psychiatric assessment),

and 94% experienced unofficial reprisals (social ostracism at work, personal attacks and increased scrutiny). Over half of the sample reported that their income decreased as a result of their whistleblowing, and over 70% reported deterioration in their physical and emotional health.

Nursing scholars support De Maria's assessment of management tactics to intimidate workers. Threats, and the hostile environment created by denial, humiliation, altered work loads and ostracism, all serve to make the work situation so intolerable that most workers back off or "voluntarily resign" (Anderson, 1990, Curtin, 1993, Kiely & Kiely, 1987). Job security is so important to workers, that a threat to it causes severe stress. The patient advocacy studies reviewed here corroborate the importance of job security, and confirm that speaking out against the status quo is very stressful (Duncan, 1992; Holly, 1993; Pike, 1991; Segesten, 1993). That data relates to this study because it suggests the reason whistleblowers and non-whistleblowers feel stress.

Like the whistleblowers in Hunt's (1995) study, DeMaria's respondents believed that superiors would take corrective action as soon as they learned of the problem. His data suggests that whistleblowers report a problem because they think it is their duty and they believe management will correct it because it is" the right thing to do".

Anderson (1990) describes a more typical scenario of what occurs when nurses, acting as patient advocates, attempt to report patient abuse or neglect. She states that when a nurse encounters patient abuse or neglect, there are three possible courses of action: the nurses could leave the organisation, confront the problem by speaking out about it, or remain silent, thereby placing self-interest or loyalty to the organisation above patient concern. If a nurse chooses to voice concern in an

organisation that is nonresponsive or defensive, institutional constraints would almost certainly be applied to obstruct the nurse's ability to report misconduct. Overt threats to job security and the "silent treatment" are two common institutional actions used to obstruct a nurse whistleblower. As the nurse advances up the administrative ladder seeking a responsible administrative person, more people are implicated in the organisation's nonresponsiveness. This arouses anger and defensiveness from personnel in many echelons of the institution. At this point, the nurse is still hopeful that an administrator, at some level, will address the problem, but when that doesn't happen, the system becomes adversarial, and the nurse becomes known as a non-loyal troublemaker who is a danger to the system.

The nurse's performance is scrutinised for flaws, and there are attacks on the nurse's credibility, integrity and emotional stability. This causes the nurse to feel moral distress, and that distress escalates to outrage at the fact that such vilification is the result of a seemingly logical attempt to have a patient problem resolved. Whistleblowing is now considered a viable solution, not only because other options have failed to remedy the patient care problem, but also because it seems the only way to reaffirm the nurse's credibility. In Anderson's opinion, the hardship on the nurse after exposure of the patient problem is equally distressful, since common reprisals include lack of support, blacklisting and loss of employment.

Wilkinson (1987/88) examined the phenomenon of moral distress as experienced by staff nurses who felt constrained from making a moral patient-care decision. That study is included in the "whistleblower" section of this review because, although Wilkinson does not use the term "whistleblower", her sample met the criteria for the operational definition of this research.

Wilkinson's participants suffered moral distress when they were prevented from acting as patient advocates. They felt constrained from acting in the best interest of their patients by physician disapproval, the threat of lawsuits, fear of job loss and lack of courage. Several of the nurses in Wilkinson's (1987/88) study received reprisals for doing what they believed was right, and a majority believed they suffered distress severe enough to "damage their personal and professional wholeness" (p. 22).

Wilkinson discovered that when nurses are frequently exposed to situations of moral distress, one of their coping behaviours is to avoid patient care areas where moral decisions need to be made. That relates closely to this research which examines the coping behaviours of nurses in difficult ethical dilemmas.

Mohr (1996) conducted a qualitative study to describe the experience of psychiatric nurses who were employed in settings where widespread fraud, patient abuse and unethical conduct occurred. Some of her subjects chose to blow the whistle on what they witnessed, while others chose to leave the deviant setting. All of her participants experienced distress in the form of rage, despair, shame, self-accusation and fear. Mohr concluded that the nursing profession must begin to examine the issue of hostile work environments and the organisational constraints placed on nursing autonomy. That subject will be explored later in this review.

In summary, there are grave professional risks involved in reporting misconduct. The consensus from the literature is that whistleblowers and patient advocates will be victimised if they speak up, and the reprisals will involve personal and professional harm.

Stress-Related Conditions and Whistleblowing

This research asked nurses to identify the physical and emotional effects of being involved in a whistleblowing situation. Two assumptions were made in formulating those research questions: (1) being involved in a whistleblowing situation is stressful and (2) stress causes physiological and psychological conditions of ill health.

Earlier this review described how stressful it is to be involved in a whistleblowing situation. Stress, defined by Lazarus and Folkman (1984), is the "relationship between the person and the environment that is appraised by the person as taxing or exceeding one's resources to cope" (p. 19). Studies were cited which indicated that stress was experienced when nurses were constrained from acting as patient advocates. The cause of the stress was job insecurity, lack of support, frustration, guilt and feelings of moral outrage. Since the most frequently expressed emotion identified in whistleblower situations is anger, it is worthwhile to explore the relationship between stress and anger more closely.

Stress and Anger.

An appropriate definition of anger is one adapted from Smith et al. (1996): Anger is a normal and necessary human response to events, situations or behaviours that offend one's values, beliefs or human rights. Defined in that way, it is easy to see why it is the main emotion experienced by whistleblowers and patient advocates. As indicated earlier, nurses are obliged to uphold a code of ethics, and when that code has been offended, feelings of anger are experienced. Though anger is a universal reaction, the way it is expressed differs depending on one's cultural influences, family rules and/or gender/role socialisation (Smith et al., 1996). Results

of early and recent research suggest that when anger is suppressed, hypertension is influenced (Gentry, Chesney, Gary, Hall & Harburg, 1982; Spielberger et al., 1991).

Hypertension is generally considered to exist when blood pressure readings are chronically elevated (140/90, or higher). It is the most prevalent form of cardiovascular disorder and is an important risk factor in coronary heart disease. Thomas (1997) cites a 1994 study that measured 12 different mood states, including fear, and found that anger produced the largest blood pressure increase. Interpersonal conflict is the major cause of anger, and has been linked to high blood pressure readings. That is relevant to whistleblower research, since it has been shown that whistleblowing causes interpersonal conflict and anger.

Deffenbacher (1994) found that suppressed anger was significantly correlated with several negative consequences, including physical illness, depression and feeling dumb, embarrassed, and/or ashamed. Nurses in Wilkinson's (1987/88) study, described previously, felt 'moral distress' and 'moral outrage' in situations that involved suppressed anger. Studies of whistleblowers have shown that job related concerns are the major drawback in expressing anger. Research by Linden et al. (1997) support those findings in a study that indicates that employees withhold angry feelings when they fear retribution and that they experience a higher intensity of anger when the anger is directed at a person who maintains a higher status at work.

A phenomenological study of nurses found that one of the predominate causes of nurses' anger was the feeling of powerlessness (Smith et al., 1996). Nurses in Smith's study were angry that, although they possessed sufficient knowledge, they were not given the authority to act on it. They were also angry

when they felt a lack of control and when they were not involved in decision-making processes.

Several studies mentioned physician-nurse conflict as a source of stress and anger (Duncan, 1992; Holly, 1993; Pike, 1991; Segesten, 1993; Uden et al., 1992). They relate in substance to the nursing studies that describe lack of autonomy and powerlessness as the provocateurs of stress and anger (Ballou, 1998; Chafey et al., 1998; Smith et al., 1996).

In summary, anger is a normal human response to actions that offend one's values or beliefs. For that reason, anger is the predominate emotion experienced by people in whistleblowing situations (De Maria, 1994; Hunt, 1995; Lennane, 1993). Patient advocacy studies indicate that anger is experienced when nurses feel powerless (Smith et al., 1996) and that anger is suppressed in situations where employees fear retribution (Linden et al., 1997). The stress produced by expressing and/or suppressing anger has been linked to cardiovascular changes, including hypertension. Next this review will demonstrate how stress is connected to other physiological and psychological conditions of health.

Stress and Health.

Many scientists have described and analysed the effect of stress on the physical and emotional health of humans. Selye (1952,1976) is responsible for a substantial amount of stress research, and offers a clear description of how stress affects diseases of the heart, kidney, blood vessels, and brain. He discusses how stress can cause inflammatory diseases, nervous diseases, digestive diseases, metabolic diseases, cancer and infectious diseases. Many scientists have made direct connections to the neurochemical consequences of stress (Anisman, Kokkinidis & Sklar, 1985), the hormonal and immunity responses (Solomon, Amkraut & Rubin,

1985) and the cardiovascular response to stress (Corley, 1985; Dyck, Yuen, Schonwetter & Janisse, 1991; Whiteman, Dreary, Lee & Fowkes, 1997). Flanigan and Sandman (1985) discuss the neuroendocrine relationships with stress and Wilson (1985) discusses the pituitary-adrenocortical response to stress.

It is beyond the scope of this review to describe the voluminous data linking all the components of ill health to stress. For purposes of this study, the physiological "flight or fight" reactions to stress were examined, since the emotions that cause those responses (fear, anxiety and anger) are known to be involved in whistleblower situations. The physical consequence of "flight or fight" reactions are increased adrenaline, diaphoresis, vasodilation of voluntary muscles, dilation of coronary vessels, vasoconstriction in the intestinal tract, decreased peristalsis, and decreased renal output (Brunner & Suddarth, 1980). Illnesses that have been directly linked to stress include hypertension, coronary artery disease, migraine headaches, asthma, peptic ulcer and ulcerative colitis (Corley, 1985; Dyck et al., 1991; Haney & Blumenthal, 1985). Solomon et al., (1985) discuss how elements within the immune system are influenced by stress, causing conditions such as cancer, rheumatoid arthritis, depression, and many infectious diseases. Other researchers connected the following psychological conditions of stress to ill health; anger and hypertension (Harburg, Blakelock & Roeper, 1979; Thomas, 1997; Thomas & Williams, 1991); substance abuse and stress (Horowitz, 1982); anxiety and asthma (Kinsman, Dirks, Jones & Dahlem, 1980), and anxiety and hypertension (Spielberger et al., 1991).

Thus there is ample evidence to conclude that stressful situations, such as being involved in a whistleblowing event, can cause physical and emotional symptoms of ill health. The question arising from this is how is stress manifested in whistleblowers and non-whistleblowers?

Stress and Whistleblowing.

The effect of stress on the health of whistleblowers is evident in the research of Lennane (1993) and De Maria and Jan (1994). Their studies examined the physical and emotional deterioration of employees involved in whistleblowing situations and found that they suffered from a variety of stress-induced symptoms. Physical problems included insomnia, hypertension, headaches, palpitations, exhaustion and digestive disorders. Emotional problems consisted of depression, anxiety, anger, suicidal thoughts, and feelings of guilt and worthlessness.

The damaging effects of whistleblowing on health was also demonstrated in Hunt's (1995) study of whistleblowers and are discussed in Dempster (1997) and Glazer and Glazer (1989). Patient advocacy studies discuss the stress-induced physical and emotional symptoms experienced by nurses in ethical dilemmas. For example, Wilkinson (1987/88) reported that all 24 participants in her study (described earlier) suffered physical and emotional symptoms when they were constrained from acting morally, including nightmares, palpitations, diarrhoea, headaches and feelings of worthlessness, frustration and anger. In addition, stress-induced physical and emotional symptoms were reported by nurses in other studies involving conflicts in patient advocacy situations (Chafey et al., 1998; Duncan, 1992; Erlen & Frost, 1991; Holly, 1993; Kushnir, Rabin & Azulai, 1997; Soderberg & Norberg, 1993).

Stress and the Hostile Work Environment of Nursing.

One of the disturbing themes that pervades the literature on patient advocacy is the hostile environment nurses are working in. Unfortunately, the doctor-nurse relationship described as patriarchal/hierarchical by Stein (1967) over thirty years ago is still being described in studies today. For example, Smith's et al. (1996) study

described an adversarial work climate that was rife with attacks on nurses by physicians, managers, peers and patients. The nine subjects all worked in different institutions, yet the hostile climate they described was common to all. They expressed anger at work-related incidents of gender discrimination, sexual harassment, authoritarian fault-finding and uncaring behaviour.

Manderino and Berkey (1997) examined the prevalence and consequence of verbal abuse of staff nurses (n=130) and found that 90% were verbally abused by physicians during the past year. The most frequent and stressful types of abuse were in the form of abusive anger, ignoring and condescension. The nurses in that study were able to interpret the abuse in adaptive ways, but other studies show that a negative climate and angry physicians affect patient care. For example, nurses in Chafey's et al. (1998) study were less likely to advocate for patients when a physician demonstrated behaviours such as yelling or throwing charts. Diaz and McMillin's (1991) nurses responded to physician anger by avoiding the physician's patient, by hesitating to phone an abusing physician (even if warranted), and by hesitating to make suggestions that could improve patient care. Those actions of avoidance were also evident in Wilkinson's (1987/88) study of nurse advocates.

In a large survey that examined the work environment of medical residents, Daugherty, Baldwin and Rowley (1998) found that 93% of the resident (n=1185) experienced at least one incident of mistreatment in the form of belittlement, humiliation, threats, discrimination, harassment or physical abuse. In that study, misconduct also involved patient care: 75% of the sample reported that they observed the mistreatment of patients, and 70% observed a colleague working in an impaired condition. Those findings are disturbing because the sample came from many different medical residency programs across the United States, indicating that

the hostile environment within teaching hospitals is pervasive and constant. It is also disturbing because the misconduct that was observed was not reported, suggesting that the observers of the misconduct were not prepared to speak up, or blow the whistle in the interest of patient care.

Work settings that are characterised by conflict are stressful and dysfunctional. Mohr (1995a, 1995b, 1996) is one of the few authors to address the issue of deviant work environments in nursing. In her study of nurses who worked in a system where patient abuse and exploitation occurred, the nurses felt fear and powerlessness in the face of corporate control. Mohr calls on the profession to confront the 'darker' aspects of the nursing environment by recognising the presence of oppression within it and reaffirming nursings' value of care.

In summary, studies indicate that nurses today are working in an environment that is stressful and sometimes hostile. Such work conditions have a negative impact on patient care, because studies indicate that nurses avoid patients when there is conflict regarding patient care (Chafey et al., 1998; Diaz & McMillin, 1991; Mohr, 1996; Wilkinson, 1987/88). The Nurses Code of Ethics requires nurses to advocate for patients, and there are times when patient advocacy means the nurse must report misconduct. Whistleblowing literature has shown that institutions are intolerant of employees who report misconduct. If the work environment of a nurse is already stressful, then it stands to reason that reporting misconduct would be especially difficult for the nurse. The following section will profile nurses who reported misconduct and became known as nurse whistleblowers.

Nurse Whistleblowers

The subject of whistleblowing in nursing would not be complete without mention of the nurses who have been labelled "whistleblower" in the literature and

in court cases. This section will briefly discuss the cases most often referred to in the press, but acknowledges that there are many, many more anonymous nurses who have had the courage to speak up for the welfare of their patients.

Historically, nurses had a legal obligation to obey physicians. In return for obedience, nurses were seldom held responsible for their actions, even if those actions were negligent. For example, in England in 1904, *(Hall v Lees)*, the Court of Appeals found that the nurse was not liable for her negligent actions because she was "subject to the control of the medical man attending the patient" (Johnstone, 1994, p. 154). As times changed, this strict duty to obey weakened. It was challenged in 1929 by an important case that was tried in the Philippines under American jurisdiction (Johnstone, 1994). In that case, a young graduate nurse, Lorenza Somera, was found guilty of manslaughter and sentenced to prison in connection with the death of a 13 year old girl who died during a tonsillectomy. Somera was found guilty because she failed to question the doctor when <u>he</u> administered the wrong drug to the patient. The physician who performed the operation, and the assisting doctor who handled the deadly syringe, were both acquitted.

The Somera case dramatically changed the liability of nurses and was interpreted to mean that nurses should <u>not</u> obediently follow a doctor's order if that order endangered a patient. But questioning a physician, then and now, entails risk. A more recent example of this is the 1975 case of *Daly v St. Agnes Hospital, Inc.* (Johnstone, 1994). Thomas Daly was the Director of Nursing at a small Pennsylvania hospital when he was dismissed for supporting his staff nurses who refused to give a prescribed drug because of its potential harm to the patient. His dismissal was at the recommendation of the medical staff and despite appeals, Daly was not reinstated.

A well-publicised example of a patient advocate who challenged a doctor's authority is that of *Tuma v Board of Nursing of the State of Idaho*, 1979. Tuma was a clinical nurse instructor who provided information on laetrile (an alternative cancer treatment), to a dying patient who *requested* the information. Despite the fact that the patient continued with the physician's prescribed treatment of chemotherapy, (and died two weeks later), Tuma was reported to her State Board of Nursing by the physician. The Board suspended Tuma's licence for six months on grounds that she "interfered with the physician-patient relationship" and thus was guilty of 'professional misconduct'. Tuma appealed the suspension in the Supreme Court, and was successful, but not because she was able to show that her actions were valid under the 'nurse-patient relationship' of 'providing information'. Instead, the Supreme Court found that the nursing board's definition of 'unprofessional conduct' was not clear (Johnstone, 1994).

Legal experts have taken careful note of the verdict in a case that relates to the question of how far a nurse can go in questioning a physician. Sandra Bardenilla was awarded $US114, 000 in civil damages when she questioned a physician in 1981. Ms. Bardenilla was accused of "overstepping her role as a nurse" when she voiced concern to the physician about the care he ordered for comatose patients who required nutritional support. Bardenilla met with the director of nursing and was told to be quiet and to apologise to the doctor. Instead, she reported the misconduct to the Department of Health Services, and murder charges were filed against the doctor. The case ended in acquittal for the physician, but Bardenilla was criticised for her actions, was not supported by professional bodies, and found re-employment difficult (Fry, 1989).

One of the largest lawsuits involving a nurse was filed by Barbara Kraus, a nurse executive who blew the whistle on a physician for documenting bronchostomies that had never been performed. Despite the fact that no other physician or nurse had seen or cared for the "bronchostomy' patients, the allegation against the doctor was dismissed and the Medical Board stated that Kraus had started a "witchhunt". Kraus then filed a lawsuit for libel and conspiracy, claiming she was subjected to verbal, emotional and psychological abuse (Fiesta, 1990). The physician countersued, claiming defamation, and Kraus was terminated by the hospital.

As the studies reviewed indicate, physicians sometimes limit a nurse's ability to act as patient advocate. However, other forces also constrain nursing action. Hospital administrators, nursing administrators and institutional policies all vie for nurse loyalty. In the Lampe case, the assistant head nurse in an intensive care unit was dismissed for refusing to reduce staff overtime hours (Kiely & Kiely, 1987). Ms. Lampe claimed that the hospital violated tenets in the Colorado Nurse Practice Act which required nurses to protect patients from harm. In her suit she was able to show that reduced staff would have endangered patient care, but she failed to get her job back or to recover damages from the dismissal.

Graham Pink is so renowned as a nurse whistleblower that the phrase, "Do you want to be Pinked", is now used as a warning to other nurses who may feel inclined to speak up (Lunn, 1992). Pink complained about the dangerously low staffing levels on his ward of highly dependent geriatric patients and was warned to keep quiet. When he continued to seek better care for his elderly clients, he was dismissed. His case dragged through the courts for two years, and cost him over 50,000 pounds in lost earnings and pension rights.

As these cases of nurse whistleblowers show, it can be professionally damaging for nurses to uphold ethical codes of conduct. The courts appear to be reluctant to recognise the moral authority of the nurse to make independent ethical decisions affecting patient care. In addition to the emotional and psychological trauma involved, institutions can still deliver the ultimate reprisal, loss of employment. If patient advocacy demands such heroic action, most nurses will not be able to deliver. As an official appointed to investigate whistleblowers' complaints in Britain warned, "...unless you are in a position to retire or are independently wealthy, don't do it. Don't put your head up because it will be blown off." (Fisher, 1991, cited in Hunt, 1995, p. 127).

The dilemma for nurses is that patient care situations require moral decisions and those decisions should be based on ethical codes of conduct, not on fear of job loss or fear of reprisals. The literature has clearly shown that when nurses are faced with an ethical decision, their choice of action is often between two unacceptable alternatives. On the one hand, they could choose to blow the whistle on the unethical situation, thus risking potential physical, emotional and professional consequences. On the other hand, they could choose to remain silent, though evidence from patient advocacy literature suggests that nurses who make that choice suffer moral distress (Wilkinson, 1987/88).

To date, no studies have examined the effect of those choices on nurses. This study was designed to address that void in the literature by examining the effect of whistleblowing and non-whistleblowing on nurses. It is anticipated that information from this study will be useful for nurses who must make difficult ethical decisions when they identify misconduct in their workplace.

Chapter Three

Conceptual Framework

This study adapted Lazarus and Folkman's Model of Stress and Coping (1984) as a conceptual framework to investigate the effects of whistleblowing and non-whistleblowing on nurses in Western Australia. As discussed in the previous chapter, stress is defined by Lazarus as being a "relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (p19). Stress in nursing has been associated with anxiety, fatigue, anger, psychosomatic illnesses, absenteeism and job turnover (Borda & Norman, 1997; Fimian, Fatenau & Thomas, 1988; Norbeck, 1985; Simoni & Paterson, 1997). Nurse researchers have examined stress in nursing (Grout, 1980; Hipwell Tyler & Wilson, 1989; Manderino & Berkey, 1997; Norbeck, 1985; Wilkinson, 1987/88) and found the major cause of stress to be *interpersonal conflict*. Whistleblowing could be considered to be a severe form of interpersonal conflict, since people who identify misconduct and attempt to have it stopped are often in direct conflict with colleagues and employing institutions. According to Lazarus and Folkman's model, stress would occur if the nurses believed the interpersonal conflict was harmful or threatening in ways that taxed their resources to cope with the conflict. Studies of whistleblowers show that stress levels are high at all levels of the process, from identifying the problem to deciding to report it (De Maria, 1994; Hunt, 1995; Lennane, 1993).

The previous chapter demonstrated how stress is linked to the physiological and psychological conditions of health. Lazarus and Folkman (1984) provide a history of the medical connotations of the term as it was used in the 14th century to

present day, and describe the research done to analyse the concept. As reported earlier, Selye (1952) and others demonstrated that stress could cause fatigue, exhaustion and ultimately death if not counter-balanced by homeostatic adaptations. Stress reactions are known to be driven by hormonal stimulation and the sympathetic nervous system causing "flight or fight" reactions (Mason et al., 1976; Sigg, 1975).

The previous chapter described some of the data linking physical health to stress-related conditions. A small example of early research made the following connections: anger and hypertension (Harburg et al., 1979), substance abuse and stress (Horowitz, 1982), anxiety and asthma (Kinsman et al., 1980), and stress and hormonal changes (Mason et al., 1976). Many later studies confirmed that the physiologic response to stress is increased heart rate, elevated blood pressure, increased adrenaline, diaphoresis, decreased peristalsis and decreased renal output. Illnesses that have been directly linked to stress include hypertension, coronary artery disease, migraine headaches, asthma, peptic ulcer, and ulcerative colitis (Brunner & Suddarth, 1980).

Because stress has been so closely linked with physical and emotional ill health, it is appropriate to conceptualise the health effects of whistleblowing within the framework of a stress model. Lazarus and Folkman's model of stress and coping is a well-respected psychological model that accommodates the steps of whistleblowing from identification of the problem (appraisal) to the effectiveness of the coping strategies.

The Personal Factors Involved in Responding to Stress

In Lazarus and Folkman's model (1984), the process of responding to stress is determined by ***dispositional variables*** and ***situational variables.*** Dispositional variables are concerned with the commitments and beliefs of a person. According to

Lazarus and Folkman, commitments express what is important to a person and determine what is at stake in a specific stressful encounter. If the stressful encounter interferes with a strongly held commitment, it is evaluated in terms of how far one would be willing to go to maintain that commitment. This has direct application to nurses, since they commit to a Code of Practice when they register to become nurses. The fact that it is a public commitment (in the sense that other nurses know and share the responsibilities of the Code), makes it a stronger commitment because the more 'public' a commitment is, the more threatening it is to have it challenged (Janis & Man, 1977). Therefore, not to uphold the commitment involves matters of self-esteem, as well as a threat to one's value system. Furthermore, the depth with which a commitment is held determines the risk and the effort a person is willing to take to uphold the commitment.

Lazarus and Folkman also include personal beliefs as a dispositional variable. They propose that many personal beliefs are used when appraising a stressful situation, the most relevant one being the belief in one's ability to control the situation. If a person feels able to control an event, that event is not seen as stressful or threatening. In this study, stress related to the ability (or inability) to control the whistleblowing situation is a core feature of the research. In addition, nursing studies support the conceptual model by demonstrating the relationship between nursing stress and control issues such as lack of autonomy, power hierarchies, verbal abuse, and powerlessness (Ballou, 1998; Chafey et al., 1998; Manderino & Berkey, 1997; Smith et al., 1996).

When discussing control beliefs, Lazarus indicates that there is an internal locus of control (the belief that events are contingent one's own behaviour) and an external locus of control (the belief that events are *not* contingent on one's actions,

but on luck, chance, fate or more powerful others). Those factors of internal or external locus of control guided the development of two sections of the questionnaire; one was the section which identified the actions taken by respondents and the other was the section which identified the coping behaviours of respondents. Control issues are often discussed in whistleblower and patient advocacy studies, particularly in relation to the loss of personal control due to the fear of professional reprisal (De Maria, 1994; Holly, 1993; Lennane, 1993; Watt, 1997).

Lazarus and Folkman also discuss **situational variables** that affect how one will appraise a situation. Those variables are the environmental aspects of the event such as timing, duration uncertainty and ambiguity, which create the potential for threat, harm or challenge. Studies by Lazarus and Folkman (1984) found that the perception of threat was greatest when the person was uncertain how to react, especially when the situation conflicted with a personal commitment. Situations are also appraised as threatening when the person does not feel there is enough time to make an informed decision, a factor defined as "imminent time" by Lazarus and Folkman (1984, p.92). In such situations, the person "manifests a very high level of psychological stress...becomes preoccupied with the threatened losses in store for him..." and is immobilised by fear and uncertainty (p. 115).

The application of that concept to nursing advocacy situations is described clearly in Segesten's (1993) research which indicated that advocacy decisions were required "on the spot", and that nurses did *not* have time to weigh the efficacy of alternative actions. Therefore, the situational variable of "imminent time" was considered to be an important variable to include in this study. The questionnaire also included the factors of fear and uncertainty suggested by the conceptual model because they are inherent to whistleblowing situations.

Lazarus and Folkman advise that dispositional and situational variables are always interdependent. By that they mean that the personal beliefs of the person and the factors within the situation combine to determine the relationship between the two. They are both equally important in determining how one will appraise a stressful situation. The next step in the model relates to how the appraisal process is effected.

The Appraisal Process

Lazarus and Folkman use the term 'appraisal' when they describe the cognitive process one goes through to determine possible harm or threat in an event. In ***primary appraisal,*** one evaluates the characteristics of the situation by asking the basic question, "Am I in danger – do I need to cope?" If the answer is yes, one moves to ***secondary appraisal,*** where one considers possible options, and asks, "How effective will this response be?" and "What are the negative consequences?" Lazarus and Folkman believe that these steps are not necessarily sequential and may overlap or occur simultaneously. ***Reappraisal*** and reflection also occur throughout the cognitive process and they are based on negative or positive stimuli within the event.

Lazarus and Folkman name three ways to appraise a potentially threatening encounter during the "primary appraisal" phase. They are (1) irrelevant, (2) benign-positive, and (3) stressful. When the person has no investment in the outcome of the encounter, and it doesn't impinge on any values or commitments, the encounter is appraised as irrelevant. Benign-positive encounters occur if the outcome of an encounter is viewed as positive and pleasurable emotions such as joy, love, or happiness are anticipated to follow. In this study, neither of the first two types of appraisals are expected to occur since stress has already occurred by the time the

whistleblowing decision needs to be made, and furthermore, it is the nature of whistleblowing events to threaten values and commitments.

An encounter that is appraised as stressful includes the components of *harm/loss, threat*, or *challenge*. In "harm/loss", the person has already sustained damage in the form of illness, injury or loss. In whistleblowing situations, that could be the physical and/or emotional effects of the stress, or the loss of self-esteem, integrity, or social contacts. According to Lazarus and Folkman, the most damaging life events are those in which commitments have been lost. "Threat" concerns harms or losses that are anticipated, but have not yet occurred. They are characterised by negative emotions such as fear, anxiety and anger. In whistleblowing situations, the threat to one's professional career causes severe anxiety and fear. Nurses in Wilkinson's (1987/88) study expressed fear of job security when discussing their dilemma in acting as patient advocates. Nurses in the following studies also expressed fear of job loss in relation to patient advocacy: Chafey et al. (1998), Duncan (1992), Holly (1993), Segesten (1993) and Watt (1997).

The third kind of stress appraisal is "challenge", and it is characterised by pleasurable emotions such as eagerness and excitement. Those who view a stressful situation as "challenging" focus on the potential for gain or growth from the encounter. Such people tend to possess a high degree of confidence, and are capable of drawing on available resources to cope with the encounter. Challenge appraisals are more likely to occur when the person feels a sense of control over the event, or feels able to control one's self in the face of adversity. Whistleblowers who persevered to maintain their moral values, despite risks to their personal and professional self, have appraised their situations from the perspective of a "challenge" (Hunt, 1995; Mohr, 1996).

Lazarus and Folkman (1984) indicate that during the secondary phase of appraisal, when one is evaluating which coping options are available, stress levels can be very high. That is particularly true if the person has a high stake in the outcome, and the threat is to a strongly held commitment. Lazarus and Folkman define coping as "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). It is emphasised that coping is a shifting process that involves changes in thoughts and actions as the stressful encounter unfolds. At times a person will rely more heavily on one form of coping, for example defensive strategies, and at other times, on problem-solving strategies. The dynamics that characterise coping as a process involve continuous appraisals and reappraisals, and it may include using several different types of coping strategies at one time.

The Coping Process

The decision process involves choosing between two types of coping strategies, ***Direct Action*** or ***Palliative Action.*** Direct Action concerns "fight or flight" behaviours that attempt to prevent, avoid or overcome the problem. In a whistleblowing situation, Direct Action would be to 'Blow the Whistle' or to 'Remain Silent'. Both are active choices that attempt to alleviate the problem that is considered to be the threat.

The other coping strategy Lazarus and Folkman name is ***Palliation***, and by that they mean the actions used to reduce the physiologic and psychologic disturbances caused by the stress of the event. Palliative behaviours are separated into two categories, ***Somatic Interventions*** and ***Intrapsychic Processes.***

Somatic interventions are techniques used to reduce stress, such as biofeedback and relaxation tapes. Intrapsychic processes are the defence mechanisms used to cope with a stressful event. Lazarus and Folkman name several different defence mechanisms and they are considered to be either "problem-focused" defences, or "emotion-focused" defences. The defences are listed in descriptive form on a 68-item Ways of Coping checklist which Lazarus used to gather data on coping mechanisms (please see Appendix A). Examples of problem-focused strategies included "got the person responsible to change his mind", "made a plan of action and followed it", and "stood my ground and fought for what I wanted". Emotion-focused strategies included such items as "looked for the silver lining", "tried to look on the bright side", and "tried to forget the whole thing". The items are categorised under the following broad headings: defensive coping, information seeking, problem solving, palliation, inhibition of action, direct action and magical thinking.

Summary

This study adapted Lazarus and Folkman's (1984) Model of Stress and Coping to describe the effects of whistleblowing and non-whistleblowing on nurses in Western Australia. The model is an appropriate one to use because research has shown that there are personal and professional risks involved in whistleblower situations, and those risks cause stress. The model takes into consideration the personal ('dispositional") and situational variables which are unique to each event. Personal variables include the persons' beliefs, the strength of their commitment, and the locus of control they feel they have. Situational variables include such things as the timing of the event, and it's duration, uncertainty and ambiguity.

The next step of the model is the appraisal process. The nurse whistleblower must ask the question, 'How much danger am I in?' ('Primary Appraisal') and 'How effective will this response be?' (Secondary Appraisal). If the nurse views the situation as potentially threatening, physiologic and psychologic responses are involved, and the nurse must choose a coping response. Lazarus and Folkman list two main modes of coping, 'direct action' and 'palliative'. A nurse takes direct action by choosing to blow the whistle (whistleblower), or choosing to remain silent (non-whistleblower). Research indicates that both courses of action are potentially stressful. Palliative actions could also be used, and these include such defence mechanisms as avoidance, denial, and fantasy thinking. Some of those mechanisms are viewed as problem-focused, and some are viewed as emotion focused. Lazarus and Folkman believe that these coping behaviours change as the intensity of the perceived threat changes and that several different strategies may be employed at one time during the stressful encounter. The effectiveness of the coping responses is evaluated as successful if the physiologic and psychologic states are reduced or eliminated. They are evaluated as unsuccessful if the physiologic and psychologic states remain unchanged or are worse.

This is a dynamic model that accommodates the many facets of a whistleblower encounter. It was used to identify the variables involved, to formulate the questionnaire, to structure the data collection procedure and to analyse the effectiveness of the coping responses. A conceptual map of the model appears in Figure 2, and was used as the framework to guide this research from conception to completion.

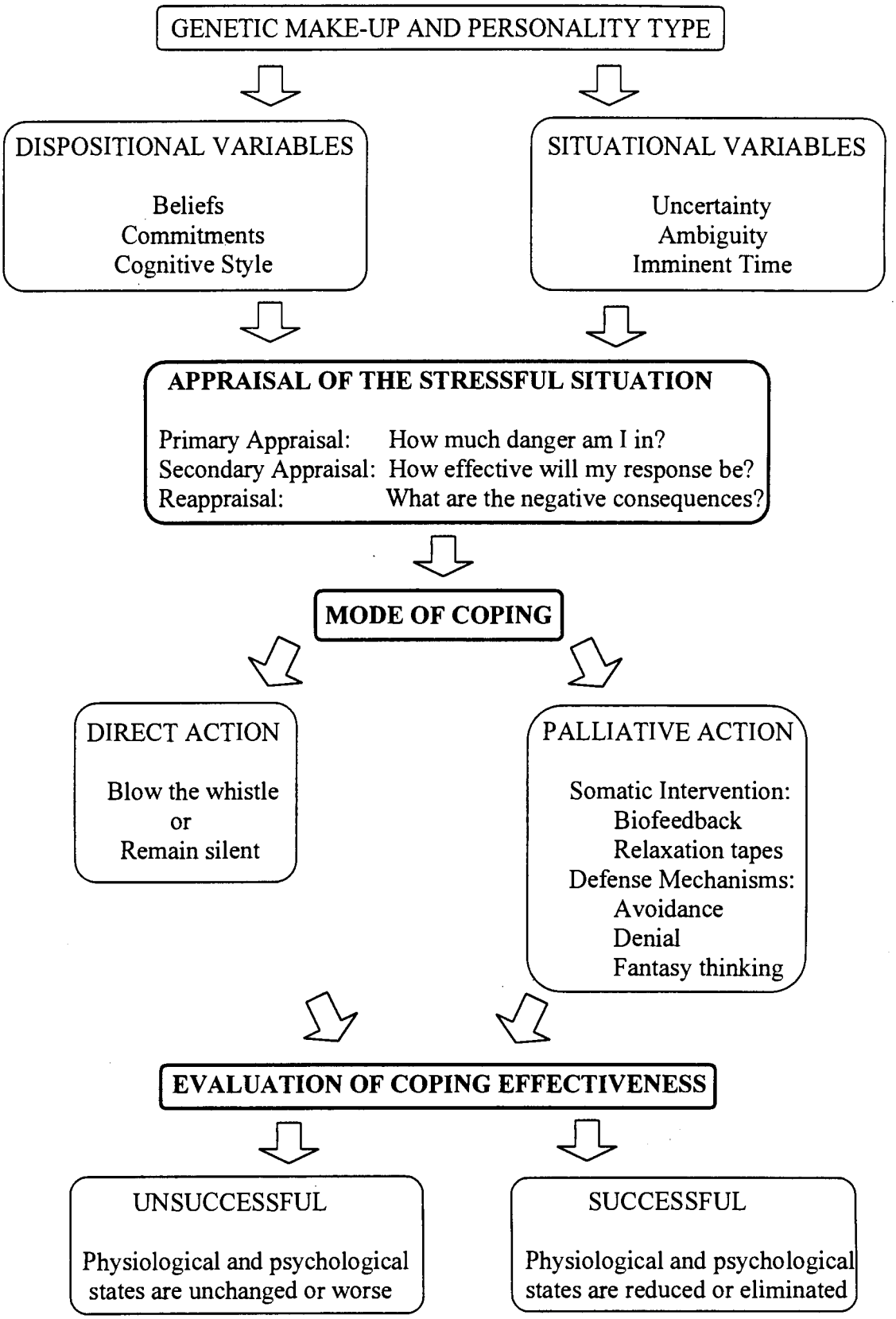

Figure 2. Conceptual map of Lazarus and Folkman's (1984) Model of Stress and Coping.

Chapter Four

Method

Research Design

A descriptive survey design was used to develop a profile of the effects of whistleblowing and non-whistleblowing on nurses in Western Australia. The research examined whether whistleblowing affected the physical, emotional and professional well-being of registered nurses as reported by them. It also examined whether non-whistleblowing nurses reported any physical, emotional and/or professional effects. Finally, it described the coping behaviours reported by nurses who identified misconduct in their workplace, and defined which coping behaviours were perceived to be successful and which coping behaviours were perceived to be unsuccessful.

Sample

Participants in this study were randomly selected from Division 1 of the Nurses' Board of Western Australia register. Division 1 consists of nurses in Western Australia who hold a practising certificate in the area of general nursing, midwifery and/or mental health. The Board's computer randomly selected the names of 500 nurses and they were posted an invitation to participate in the study; 250 were listed as general nurses and 250 were listed as mental health nurses. The decision to split the register's list evenly between general and mental health nurses was made to ensure that both general and mental health nurses in WA were reported. The aim was to receive a composite view of all areas of nursing in WA. This was especially relevant in view of the fact that misconduct in mental health areas has been reported in the literature with increasing frequency (Fagan, 1996; Gibson, 1997; Hunt, 1995; McDonald, 1994; Mohr, 1995b).

Instrument

The instrument used for this study (Appendix B) was modelled after existing instruments, but developed by the researcher to include relevant nursing items. Two instruments served as a model; one was De Maria's (1994) tool, and the other was Lennane's (1993) tool. The questionnaire developed for De Maria's research (1994) consisted of 99 items that included a mixture of closed (70%) and open-ended (30%) questions (personal communication, March 19, 1997). Lennane's (1993) questionnaire (Appendix C) was developed in consultation with the organisation, Whistleblowers Australia, and it covered common whistleblower problems, including health problems related to whistleblowing. Both questionnaires had items pertinent to this research, though neither tool addressed items pertaining to nursing or patient advocacy.

The questionnaire used for this study was guided by the focus of De Maria's research (1994), and adapted some items from Lennane's research tool. It was designed by the researcher to incorporate relevant nursing dilemmas, whistleblower and non-whistleblower actions, stress-induced health problems and professional responses. Lazarus and Folkman's Model of Stress and Coping (1984) guided the section of the questionnaire related to coping responses.

The cover page of the questionnaire explained the purpose of the study and defined the terms "whistleblower" and "non-whistleblower" in relation to nurses who identified wrongdoing in their workplace. The definitions were adapted from whistleblower literature (De Maria, 1994; Lennane, 1993), and nursing literature (Johnstone, 1994; Nurse's Legal Handbook, 1996). After reading the definition for whistleblower and non-whistleblower, respondents were asked to tick the box that best described the action they took when they encountered unethical, incompetent or

illegal activity in their workplace, thus nominating themselves as whistleblowers or non-whistleblowers.

Section One of the questionnaire collected information about the respondents at the time of the whistleblowing event. Although the general trend in nursing research is to place demographic data at the end of a questionnaire (Burns & Grove, 1993), it was placed at the beginning of this study. The reason for this was that subsequent sections of the questionnaire pertained to sensitive issues and most authors recommend that questionnaires begin with a non-threatening section and progress to more sensitive issues (Brink & Wood, 1989; Burns & Grove, 1993). The respondents were asked to tick a box describing their age, gender, number of years in nursing, education level, employment location, employment level, type of registration (general, mental health or midwifery), and the nursing area they worked in at the time of the event.

Section Two of the questionnaire concerned the whistleblowing event. A list of possible whistleblowing events was provided. The list was compiled from data in whistleblowing literature and in patient advocacy studies. Each item, and the corresponding literature used to formulate its relevancy is shown in Appendix D. Furthermore, an item labelled "Other" gave the respondents a place to write in an event if it was not provided. Participants were asked to tick the boxes which best described the wrongdoing they observed. The intent of the research was to discover what happened when nurses observed wrongdoing, *not* what the wrongdoing was. Therefore, definition of the events was purposely broad to discourage specific descriptions of wrongdoing. Furthermore, validity of the allegations was irrelevant because proving fault was not the intent of the study. What was important was that the list in Section Two contained an event (of misconduct, incompetence or illegal

activity) which was observed by the respondent. That observation then became the basis for the study, namely *how* the nurses responded to the event, and how that response *affected* them physically, emotionally and professionally.

Section Three of the questionnaire concerned the action the nurse took when confronted with a whistleblowing event. The choices given were actions that a whistleblower would take, and actions that a non-whistleblower would take. The actions listed were taken from studies on whistleblowers and patient advocates, as well as from ethical dilemma studies. Each action and the corresponding literature used to demonstrate its relevancy is shown in Appendix E. Participants were asked to tick the boxes that best described the actions they took, or to fill in the blank on the final item labelled "Other" describing their action.

Section Four relates directly to the first two research questions, namely the physical and emotional effects of whistleblowing or not whistleblowing. Stress is known to cause physical and emotional conditions of ill health. The list of conditions in Section Four were taken directly from medical texts and studies on stress-related conditions (Brunner & Suddarth, 1980; Corley, 1985; Deffenbacher, 1994; Dyck et al., 1991; Flanigan & Sandman, 1985; Haney & Blumenthal, 1985; Horowitz, 1982; Seyle, 1952, 1976; Solomon et al., 1985; Wilson, 1985). The physical conditions were listed on one page, in alphabetical order, and the emotional conditions were listed on the next page, also in alphabetical order. The reason for placing the conditions in alphabetical order was to present them in an unbiased and non-leading format. Respondents were asked to tick the conditions they believed they suffered as a result of being involved in a whistleblowing situation.

Section Five of the questionnaire was designed to answer the third research question regarding the professional consequences of whistleblowing and non-

whistleblowing. A list of professional consequences was compiled from data in whistleblowing literature and in patient advocacy studies (De Maria, 1994; Hunt, 1995; Lennane, 1993; Wilkinson, 1987/88). Respondents were asked to tick the boxes which best described the professional consequences they believed they suffered as a result of blowing the whistle, or not blowing the whistle.

Section Six of the questionnaire was designed to answer the research question regarding effective and ineffective coping behaviours used by nurses who identified misconduct at work. During a review of the literature, 14 common coping strategies were extracted from whistleblower and patient advocacy studies, and matched with items from Lazarus and Folkman's (1984) Ways of Coping Checklist (Appendix A). Table 1 presents the coping responses, the literature which backs each response, the corresponding item in the Ways of Coping Checklist and Lazarus and Folkman's description of each coping behaviour.

According to Lazarus and Folkman, coping responses are evaluated as successful if the physiological and psychological stress is reduced or eliminated. They are evaluated as unsuccessful if the physiological and psychological states remain unchanged. Those concepts were incorporated in Section Six of the questionnaire by listing the coping behaviour and then providing three possible responses that described whether the coping behaviour was effective or not. For example, one item listed the behaviour as; "I expressed my concern to the person who caused the problem." The three possible responses were (1) It's something I tried, and it helped me feel better (2) It's something I tried, but it did **not** make me feel better and (3) It's **not** something I tried. If choice (1) was ticked, the coping behaviour was perceived to be successful, and if choice (2) was ticked, the coping behaviour was perceived to be unsuccessful.

Table 1

Coping Responses: Their Base in the Literature and How They Correspond to Lazarus and Folkman's Conceptual Model

Coping Response on Questionnaire	Literature Source	Lazarus & Folkman (1984) Ways of Coping	Type of Response
1.) I expressed my concern to the person who caused the problem.	Chafey et al., 1998; De Maria, 1994; Manderino & Berkey, 1997; Segesten, 1993	#17 I expressed anger to the person(s) who caused the problem.	Direct Action
2.) I tried to get the person responsible to change his or her mind.	Chafey et al., 1998; Erlen & Frost, 1991; Segesten, 1993; Soderberg & Norberg, 1993; Watt, 1997	#7 I tried to get the person responsible to change his or her mind.	Direct Action
3.) I tried to keep my feelings to myself, and not let other know how I felt.	Manderino & Berkey, 1997; Smith & Thomas, 1996; Wilkinson, 1987; Watt, 1997	#14 I tried to keep my feelings to myself.	Inhibition of Action
4.) I tried to forget the whole thing by just concentrating on my work.	Erlen & Frost, 1991; Holly, 1993; Segesten, 1993; Wilkinson, 1987	#3 Turned to work…to take my mind off things.	Inhibition of Action
5.) I talked to someone …who could do something ….	De Maria, 1994; Hunt, 1994, Lennane, 1993; Watt, 1997	#31 Talked to someone who could do something….	Direct Action
6.) I stood my ground and fought for what I believed was right.	Chafey et al.,1998; De Maria, 1994, Segesten, 1993, Soderberg & Norberg, 1993	#46 Stood my ground and fought for what I wanted.	Direct Action
7.) I found myself avoiding the patient & others.	Holly, 1993; Smith & Thomas, 1996; Wilkinson, 1987	#40 Avoided being with people in general.	Inhibition of Action

Continued/…

.../Continued Table 1

Coping Responses: Their Base in the Literature and How They Correspond to Lazarus and Folkman's Conceptual Model

Coping Response on Questionnaire	**Literature Source**	**Lazarus & Folkman (1984) Ways of Coping**	**Type of Response**
8.) I had fantasies/wishes about how things might turn out.	Holly, 1993; Simoni & Paterson, 1997; Smith & Thomas, 1996	#59 Had fantasies/wishes about how things might turn out.	Magical Thinking
9.) I tried not to burn my bridges and went on as if nothing had happened.	Erlen & Frost, 1991; Manderino & Berkey, 1997; Soderberg & Norberg, 1993; Wilkinson, 1987	#10 Tried not to burn my bridges, but leave things open somewhat.	Defensive Coping
10.) I asked a friend or relative I respected for advice/support.	Manderino & Berkey, 1997; Simoni & Paterson, 1997; Uden et al., 1992	#42 I asked a friend or relative I respected for advice.	Information Seeking
11.) I prayed that it would end up all right.	Chafey et al., 1998; Manderino & Berkey, 1997	#60 I prayed.	Magical Thinking
12.) I got away from it for a while; took time off, or went on holiday.	Chafey et al., 1998; Holly, 1993; Manderino & Berkey, 1997	#32 Got away from it for a while; tried to rest or take a holiday.	Palliation
13.) I tried to make myself feel better by eating, drinking, smoking, using drugs.	De Maria, 1994; Lennane, 1993; Manderino & Berkey, 1997	#33 Tried to make myself feel better by eating, drinking, smoking using drugs.	Palliation
14.) I drew on past experiences to come with a way to handle problem.	Chafey et al., 1998; Duncan, 1992; Manderino & Berkey, 1997; Segesten, 1993; Uden et al., 1992	#48 Drew on past experiences; I was in similar situation before.	Information Seeking

Instrument Format.

A variety of question styles was used in the development of the questionnaire, including open-ended, closed and ranking questions. In the closed questions, participants were requested to tick a box that matched their response. In the open-ended questions, respondents were given the opportunity to qualify and explain their response in more detail. In the ranking questions, respondents were asked to rank their response from "strongly agree" to strongly disagree". Use of a combined format such as this is recommended when the questionnaire is lengthy because variation alleviates repetitious material (de Vaus, 1985). Furthermore, it is important to provide an opportunity to qualify responses in an open-ended section when the questionnaire concerns personal or controversial subjects such as this one (de Vaus, 1985).

Validity

Construct.

Construct validity examines the fit between the conceptual and operational definitions of variables (Burns & Grove, 1993). It is important because it determines whether the instrument actually measures the theoretical construct it purports to measure (Polit & Hungler, 1995). The development of the questionnaire was based on published literature (Appendix B, C, D and E) and the conceptual model that guided this research. The tool included physiological and psychological items which have emerged as sequalea in whistleblowing research, as well as items related to the professional consequences of whistleblowing (De Maria, 1994; Hunt, 1995; Lennane, 1993; Wilkinson, 1987/88). In addition, the instrument was designed to identify elements from the stress-coping model, including cognitive appraisal,

behavioural reactions and coping effectiveness in the context of whistleblowing situations (Table 1) using Lazarus' and Folkman's model as a framework for inclusion of the items.

Content.

Content validity is concerned with the relevance of the content area being measured (Polit & Hungler, 1995). In order to ensure content validity, Wood and Haber (1998) suggest that the instrument be submitted to a panel of judges considered experts in the field of study. The questionnaire for this study was submitted to a panel of three experts with knowledge of Lazarus & Folkman's (1984) theory of stress-coping, as well as the domain of whistleblowing. They were asked to assess the tool for content validity using the 4-point ordinal rating scale described by Lynn (1986). Lynn states that a minimum of three experts is sufficient to use when knowledge of the domain area is restricted. Experts on the effects of whistleblowing in nursing is limited, so three nurses who had experienced an ethical dilemma in their practice and/or a whistleblowing situation were approached to form a panel of experts. Two of the experts are Masters-prepared nurses who have worked for over fifteen years as nurse managers in a clinical setting. One of them is responsible for Risk Management at her hospital, and the other sits on her Hospital Board's Ethics Committee. Both of them have published in the area, and have experienced a whistleblower situation. The other nurse expert has a doctorate in nursing, and over thirty years experience as a nursing leader. She is a university professor who has conducted research on ethical dilemmas and nursing stress.

The panel of three experts was given instructions on the use of Lynn's (1986) procedure for evaluating the content validity of a tool (Appendix F). They rated each item in the tool, as well as the tool as whole, using Lynn's four-point rating scale.

Lynn's four-point rating scale is scored as follows:

A score of 1 = item not relevant

A score of 2 = item unable to be assessed without major revision

A score of 3 = item needs minor alteration

A score of 4 = item relevant and succinct.

According to Lynn, when the panel consists of five or fewer experts, all of them must agree on content validity (by giving a score of 3 or 4), and agree that no relevant items have been omitted from the tool. The experts who rated the content validity of this tool assessed all but three items to be relevant and succinct (a rating score of 4). Three of the items were rated a score of 3 (minor alteration required), and those items were reworded and submitted for a second assessment. Those items then received a rating of 4. (Please refer to the table in Appendix G to view how each question was rated.) The panel did not identify any omissions from the questionnaire. Therefore, the instrument was assessed to be a valid tool to measure the physical, emotional and professional effects of whistleblowing and non-whistleblowing.

Lynn's (1986) Content Validity Index (CVI) was also used as a rating to measure the validity of Section Six of the questionnaire, which measured coping responses. The panel of experts was given Lazarus' Ways of Coping Checklist (Appendix A), in addition to the questionnaire (Appendix B). Using the same 4-point CVI rating scale, they assessed the content validity of the instrument (Appendix H). All fourteen items in Section Six were assessed as relevant (rating score of 4) in identifying successful and unsuccessful coping behaviours.

Reliability

In order to ensure that each section of the instrument was measuring the same construct, Cronbach's alpha coefficient was used to measure internal consistency. Cronbach's alpha is appropriate to use for dichotomously scored items (Carmine & Zeller, 1979) and is considered a useful way to establish reliability in a structured quantitative data collection instrument (Brink & Wood, 1988; Burns & Grove, 1987). A reliability of .80 is a satisfactory level of reliability for an established instrument (Carmines & Zeller, 1979), however, a reliability of .70 is considered acceptable for a newly developed instrument (Burns & Grove, 1993).

The purpose of the tool was to measure the physical, emotional and professional effects of reporting misconduct, and those items are measured in Section Four and Section Five of the questionnaire. The physical symptoms received an alpha rating of .64, the emotional symptoms had an alpha rating of .88, and the professional consequences achieved an alpha rating of .79. Therefore, the questionnaire could be said to be a reliable tool for measuring the emotional and professional effects of whistleblowing.

Pilot Study

A pilot study of the tool was performed to test the clarity of the instructions, the completeness of the items and the time required to complete the questionnaire. The questionnaire was presented to a class of 25 nurses who were studying for a bachelor's degree at Edith Cowan University. The students were informed of the intent of the pilot study, and were asked to identify any problems they had understanding or completing the questionnaire. Consent to participate was voluntary, and was indicated by completion of the questionnaire. Confidentiality was maintained by the provision of a private box for completed questionnaires. Five

nurses completed the questionnaire, and although this is a small number, it was enough to provide information on specific problems of the questionnaire:

- The first difficulty concerned the term, "non-whistleblower". Two of the respondents described themselves as non-whistleblowers, but the actions they took were clearly those of a whistleblower. This was interpreted as meaning that (1) the term "non-whistleblower" was not clearly defined, or (2) respondents did not like the choice of labelling themselves "whistleblower". Definition of the terms "whistleblower" and "non-whistleblower" were examined for negative connotation, and whistleblower and non-whistleblower actions were rewritten in a clearer format.
- A second problem uncovered by the pilot study involved Section Two of the questionnaire. Respondents were asked to tick the boxes which best described their whistleblowing event. From the responses received, it was apparent that some participants did not understand that the question referred to just one event. This was corrected by re-writing the instructions to Section Two and highlighting the direction to choose one event only.
- A final problem with the questionnaire uncovered by the first pilot study was the format of Section Six, which involved ways of coping and coping effectiveness. The directions and layout of this section were confusing, and clarity was achieved by reformatting the layout into a more succinct style.

A second pilot study was performed by three nurses, one nurse researcher and two nursing academics to test the revised version of the questionnaire. They found the content and clarity of the questionnaire to be acceptable and offered no further suggestions for refinement. The final version of the questionnaire used in this study is provided in Appendix B.

Data Collection Procedure

Approval from the Nurses Board of Western Australia was granted to access a random sample of nurses from the Nurse's Board register. The researcher supplied the Board with 500 blank envelopes, each one containing a questionnaire (Appendix B), a cover letter (Appendix I), and a pre-paid return envelope which was addressed to Edith Cowan University and stamped "Confidential". Staff at the Nurses Board addressed and mailed the envelopes to a computer-generated random sample of 250 nurses registered in Division 1 as General nurses, and 250 nurses registered in Division 1 as Mental Health nurses.

Those nurses who chose to participate in the study mailed their completed questionnaires to Edith Cowan University. The responses were identified by the "Confidential" stamp and were collected by the researcher. None of the returned questionnaires had identifying names or addresses on them, so the researcher had no way of knowing who had returned the questionnaires. This procedure effectively prevented anyone from knowing who the respondents were. Of the 500 envelopes posted by the Western Australian Nurses Board, 100 were returned to the researcher, giving a return rate of 20%. From that number, five were returned too late to be included in the study, which reduced the sample number to 95. The poor response rate, as well as possible explanations, is discussed in Chapter Seven.

Ethical Considerations

This research concerned the study of nurses who had to make difficult ethical decisions. Therefore, it was important to ensure that the principles that guided this research were ethically sound and rigorously applied. Of primary importance was the principle of justice, which includes the right to privacy, anonymity and confidentiality. Whistleblower studies reveal that when the identity of a

whistleblower is known, reprisals occur (Anderson, 1990; De Maria, 1994; Hunt, 1995; Lennane, 1993). For that reason, the data collection procedure was carefully planned to ensure that respondents remained completely anonymous. In addition, the relatively small number of nursing places in Western Australia was taken into consideration when naming the areas of nursing where events occurred. When the event occurred in a speciality where there were less than three events, the name of the speciality was defined in broad terms to preserve the anonymity of respondents. For example, the broad area of 'General Clinical' included the following specialities: neonatal, intensive care operating suite, emergency, orthopaedics and outpatient clinics.

Neither the Western Australian Nurses Board, nor the researcher has knowledge of who received the questionnaires, or of who returned the questionnaires. The questionnaires are secured in a locked filing cabinet and will be shredded by the researcher after five years. Ethical considerations were reviewed and approved by the University Ethics Committee prior to implementation of the study.

Informed Consent.

Information regarding the study was detailed in a cover letter (Appendix I) which accompanied each questionnaire. Potential respondents were assured that neither their identity nor their place of employment would be asked at any stage of the research. Furthermore, the cover letter explained how use of the Nurse's Board Register to obtain a random selection of WA nurses ensured confidentiality. Potential respondents were informed that return of the questionnaire implied consent to participate in the research.

Chapter Five

Results

Introduction

This chapter will present the findings of the study in six sections. The first section will report the demographic data of the respondents, and identify the type of misconduct reported and the actions taken by the respondents. It will also discuss what happened *after* the whistleblowing event, and what happened to the wrongdoers. The next three sections will present findings related to the research questions, namely the physical, emotional and professional effects of whistleblowing and non-whistleblowing. The final section of the results will present the findings of the coping behaviours used by respondents and describe which ones they considered to be effective and non-effective.

Of the 500 questionnaires posted, one hundred responses were returned, which is a response rate of 20%. From that number, 95 responses were returned in time for inclusion in the study; 74% were from nurses who identified themselves as whistleblowers (n=70), and 26% were from nurses who identified themselves as non-whistleblowers (n=25).

Data were analysed using the Statistical Package for the Social Sciences (SPSS for Windows, Release 7.5 and 8.0). All findings have been rounded to one decimal point.

Demographic Information

As Figure 3 illustrates, the responses were evenly divided between General and Mental Health nurses.

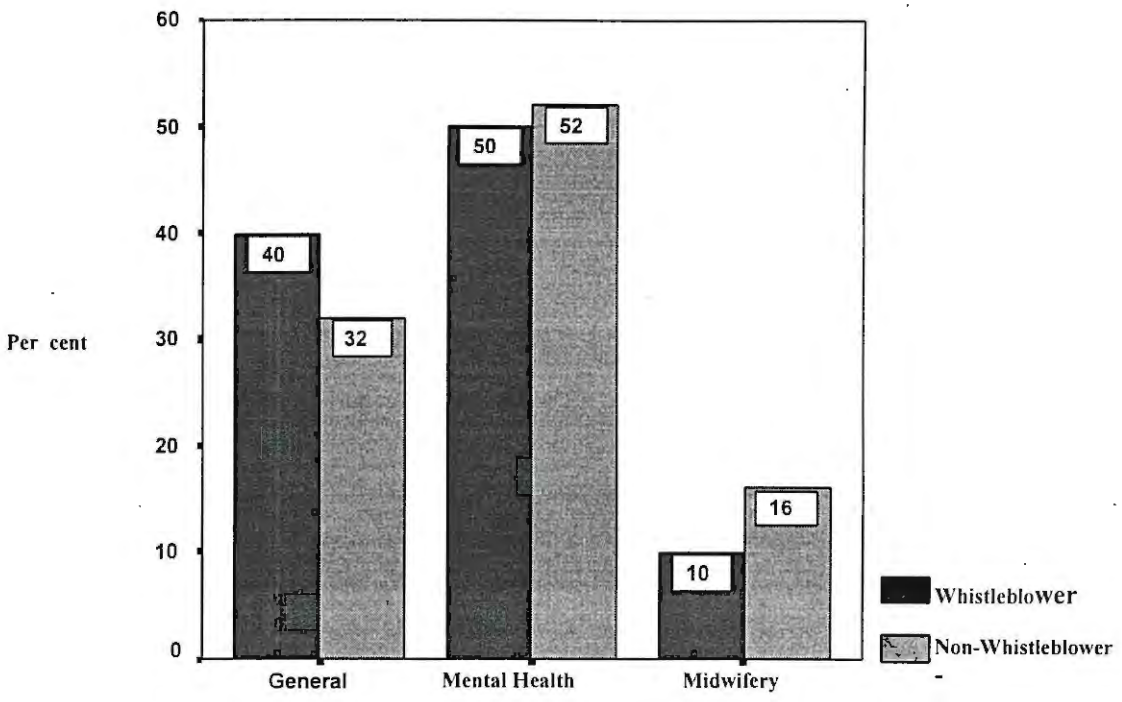

Figure 3. Professional registration of whistleblowers (n=70) and non-whistleblowers (n=25).

The majority of whistleblowers (71%) and non-whistleblowers (96%) worked in public hospitals, and most whistleblowers (70%) and non-whistleblowers (84%) were employed as Level 1 or Level 2 nurses. Information regarding gender, age, and years in nursing is listed in Table 2.

Table 2

Demographic Information of Sample

Demographics	Whistleblower		Non-whistleblower	
Gender	**n**	**%**	**n**	**%**
Male	17	24	2	8
Female	49	70	20	80
Missing data	4	6	3	12
Age				
18-35	22	31	9	36
36-50	40	58	13	52
51-66	7	10	2	8
Missing data	1	1	1	4
Years in Nursing				
0-5	10	14	5	20
6-10	10	14	6	24
11-15	14	20	2	8
16+	35	50	9	36
Missing data	1	1	3	12

Most nurses in the sample were hospital trained. Of those who identified themselves as whistleblowers, 41 were trained in a hospital, seven had a tertiary diploma, 13 had a bachelors degree and nine held post-graduate degrees. Sixty-four per cent of non-whistleblowers (n=16) were hospital trained, five had a bachelors degree in nursing, and four held post-graduate degrees.

The speciality area where whistleblowing events occurred is presented in Table 3. In order to preserve the anonymity of respondents, categories with less than three respondents were combined with others and labelled in broader terms. For example, the category of General Clinical included the areas of neonatal, intensive care, operating suite, emergency, orthopaedic/rehabilitation, and outpatient clinics. The category of Other included the areas of research, community, flight nursing,

infection control, administration, education and small country hospitals. Three respondents who listed Other did not specify their speciality area.

Table 3

Specialty Area Where Event Occurred and the Number of Events Reported by Whistleblowers and Non-Whistleblowers

Nursing Area	Number of Events Reported by Whistleblowers	Number of Events Reported by Non-Whistleblower
Mental Health*	35	11
General Clinical	13	4
Medical/Surgical	6	4
Geriatrics	5	3
Other	11	3
Total	**70**	**25**

*Includes: Adult Psych, Geri-Psych, and Child/Adolescent Psych

Whistleblower Event.

This section of the questionnaire examined the whistleblowing event that nurses identified as being illegal or unethical. Respondents were asked to think of one event and then tick the responses that best described that event. Multiple responses were allowed so that the nurses could define the event in broad terms. For example, one nurse ticked "non-compliance with nursing standards", and also ticked "impaired condition at work". Another nurse ticked "assault", and then ticked "abusive person allowed to work with patient". Since multiple responses were encouraged, the number of events recorded is higher than the sample number. That is not considered a problem because the focus of the study was on the consequences resulting from the nurses' response to the event, *not* the event itself. The illegal or unethical event served only to provide the stimulus for the study. Table 4 presents an overview of the unethical or illegal events reported by respondents.

Table 4

Event as Reported by Whistleblowers and Non-Whistleblowers

Event	Whistleblower		Non-Whistleblower	
	n	%	n	%
Non-compliance with hospital policy	12	17	7	28
Non-compliance with nursing standards	16	23	5	20
Sex discrimination	4	6	1	4
Race discrimination	4	6	1	4
Theft	1	1	1	4
Assault of patient	9	13	5	20
Sexual misconduct	3	4	2	8
Impaired condition at work (alcohol and/or drug use)	11	16	2	8
Physical/sexual harassment	3	4	3	12
Concealment of wrongdoing	9	13	4	16
Improper training	5	7	3	12
Incompetent person allowed to work with patients	15	21	5	20
Abusive person allowed to work with patient	9	13	4	16
Inadequate/unsafe staffing	5	7	3	12
Incompetent or hostile management	11	16	2	8
Favouritism/nepotism	7	10	1	4
Violation of patient rights	10	14	3	12
Poor quality of patient care	18	24	7	28
Unnecessary treatments and/or tests	3	4	2	8
Misuse of public money	4	6	3	12

However, despite the fact that the event was not the focus of the study, the serious nature of the misconduct warrants mention. The following criminal offences were reported: 14 cases of patient assault, two cases of theft, six cases of physical or sexual harassment and ten cases of racial or sexual discrimination. Thirteen patients had their rights violated and there were five incidents of sexual misconduct. In addition, three nurses described an event that caused the death of a patient.

Whistleblowing and Non-Whistleblowing Actions.

Respondents were asked to tick the box(s) which described the action or actions they took when faced with an unethical or illegal situation at work. In order for the action to be classified as a whistleblower action, the respondent must have reported the incident to someone who had the power to stop the wrongdoing. Many whistleblowers (51%) and non-whistleblowers (48%) spoke directly to the offending person, and, although that is an assertive action, it was not considered a whistleblowing action because it did not expose the event to someone who could stop the wrongdoing.

All 36 whistleblowers who spoke directly to the offending person went on to report the incident to a higher authority when the action did not stop. Most participants (60%) who reported an incident reported it first to their immediate supervisor. Many went on to report it to higher administrators inside and outside the organisation. From the multiple responses ticked, it appears that whistleblowers reported their concern up a managerial chain of command. For example, those who numbered their responses reported that they spoke first to the person involved, then to their supervisor, then to the nursing administrator and finally to the hospital administrator. Although, no whistleblowers reported their concern to the media, 23 made a written complaint in the form of an incident report, and seven whistleblowers

took their concern outside the organisation. Details of the actions taken by whistleblowers and non-whistleblowers are listed in Table 5.

Table 5

Whistleblower and Non-Whistleblower Actions

Actions taken	Whistleblower		Non-Whistleblower	
	n	%	n	%
Refused to carry out an order or follow instructions	7	10	2	8
Spoke directly to wrongdoer	36	51	12	48
Told my supervisor	42	60	0	-
Told the admin. of nursing	28	40	0	-
Told admin. of organisation	8	11	0	-
Told a physician or other professional	13	19	0	-
Complained to an authority within the organisation	14	20	0	-
Complained to an authority outside the organisation	7	10	0	-
Wrote an incident report	23	33	0	-
Went to the media	0	-	0	-
Told the next shift	7	10	5	20
Told "higher-up" in confidence	6	9	8	32
Quietly did the right thing	0	-	4	16
Used humour to change mind	0	-	2	8
Used manipulation to change situation	0	-	4	16
Did nothing	0	-	5	22

By definition, non-whistleblowers (n=25) did not openly report their concerns, but attempted to use other methods to handle the situation. For example, many spoke directly to the person involved, refused to carry out an order, or told the next shift. One of the non-whistleblowers who refused to carry out an order reported that she was professionally damaged by the experience, and that it resulted in "unfair rostering, sarcasm, and being put down for doing the right thing". She further stated that not participating in misconduct at work is very difficult because of her feeling of powerlessness, her fear of rejection, and the possibility of being labelled a "dobber".

Some non-whistleblowers reported that they attempted to use humour or manipulation to alter the outcome of a whistleblowing situation. For example, a non-whistleblower reported that when the physician failed to inform a patient of alternative treatment options, the nurse "casually" broached the subject during the physician/patient visit. This manipulated the physician into having to inform the patient, thus preventing the rights of the patient from being violated.

What Happened After the Event and What Happened to the Wrongdoers?

Whistleblowers and non-whistleblowers were asked if their actions were effective in altering the situation, and if they knew what happened to the wrongdoers. An equal percentage of whistleblowers and non-whistleblowers reported that the situation "stopped immediately", but 34% of whistleblowers and 40% of non-whistleblowers reported that the situation continued unchanged. A large percentage of whistleblowers and non-whistleblowers reported that nothing happened to the wrongdoers. Disciplinary action occurred in 19 of the 95 cases, and wrongdoers were promoted in four cases. Figure 4 illustrates the outcome of the whistleblowing event, and Figure 5 shows what happened to the wrongdoers.

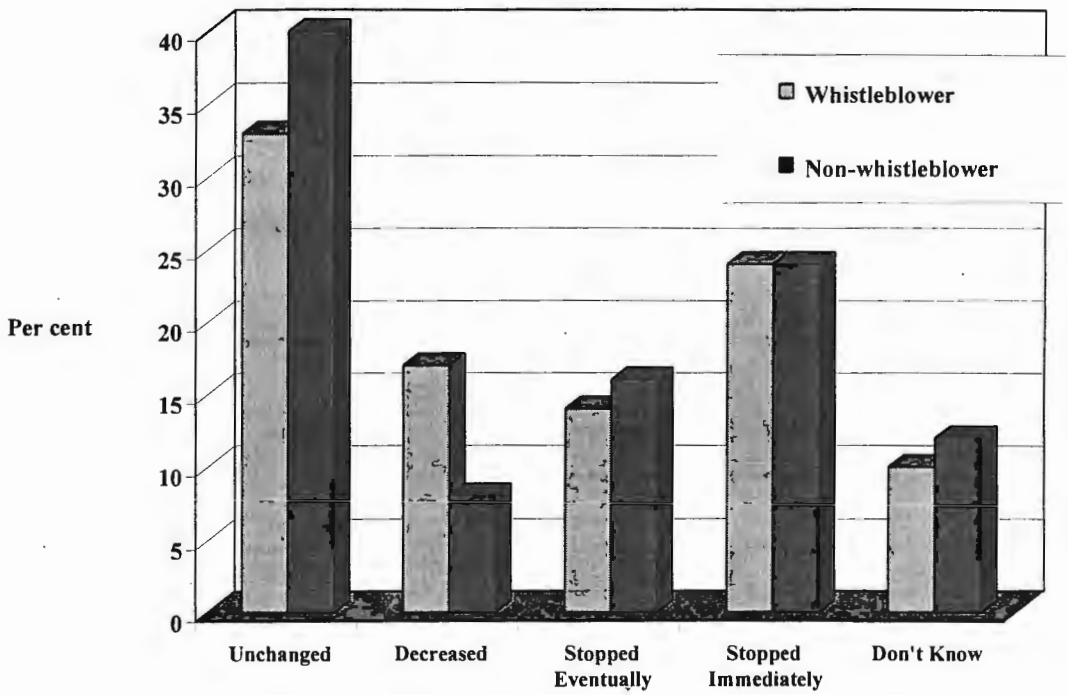

Figure 4. What happened after the whistleblowing event, as reported by whistleblowers and non-whistleblowers in the sample.

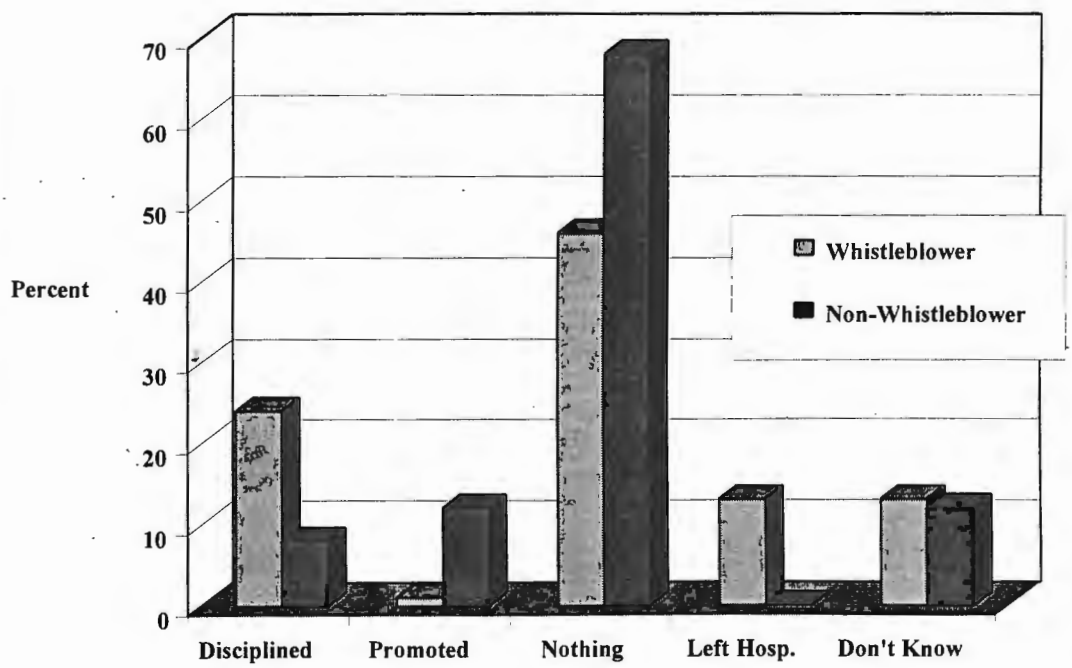

Figure 5. What happened to the wrongdoers, as reported by whistleblowers and non-whistleblowers in the sample.

Summary.

Ninety-five nurses working in the state of Western Australian participated in this study. Of those, 70 nurses were identified as whistleblowers and 25 nurses were identified as non-whistleblowers. The sample was equally divided between those registered as Mental Health nurses and those registered as General nurses and/or Midwives. A majority (78%) worked in public hospitals as Level 1 or Level 2 nurses.

Twenty per cent or more of the sample identified misconduct in the form of non-compliance with hospital policy, non-compliance with nursing standards, incompetent person allowed to work with patients and poor quality of patient care. Fourteen per cent or more of the nurses identified the following misconduct: assault, impaired condition at work, concealment of wrongdoing, patient abuse, hostile management, and violation of a patient's rights.

A majority of whistleblowers reported the misconduct they identified to their immediate supervisor and one-third wrote an incident report. Most non-whistleblowers spoke directly to the wrongdoer and told a higher up in confidence. The whistleblowing event continued unchanged in 35% of the cases. In a majority of the cases, nothing happened to the wrongdoers.

The next three sections will present the results of the research questions, namely how nurses were affected physically, emotionally and professionally from their involvement in a whistleblowing situation. The final section will present the effective and ineffective coping behaviours reported by the sample.

The Physical Effects of Identifying Misconduct at Work

The first research question asked, "What are the physical effects of identifying misconduct at work for whistleblowers and non-whistleblowers? This section will present the physical problems reported by nurses who were identified as whistleblowers or non-whistleblowers.

Seventy per cent of whistleblowers and 64% of non-whistleblowers suffered physical symptoms as a result of identifying misconduct in their workplace. Thirty nurses (31% of sample) did not indicate any physical problems related to their experience of being in a whistleblower situation.

From a list of 50 physical problems, whistleblowers reported that they experienced 43 of the problems, while non-whistleblowers reported that they experienced 27 of the problems. There were six problems on the list of 50 that were not experienced by either whistleblowers or non-whistleblowers. They were: addictions, alcoholism, allergies, asthma, conjunctivitis and stuttering.

The large number of physical problems suffered by nurses is striking. Sixty-five nurses reported a total of 313 physical complaints. Thirty-one nurses reported that they suffered five or more physical problems. Four nurses suffered 18 or more physical symptoms and one nurse suffered 24 physical complaints. Although the questionnaire listed the physical complaints in alphabetical order, they are presented here in categories of related symptoms to give a clear view of the overall effect of being involved in a whistleblowing situation.

Lack of Energy and Sleep Disturbances.

Physical complaints affecting energy levels or sleep were the most frequently reported. Sixty-six per cent of the sample suffered some form of sleep disturbance, with whistleblowers reporting more problems than non-whistleblowers. Figure 6

shows the percentage of whistleblowers and non-whistleblowers who reported problems related to sleep or energy levels.

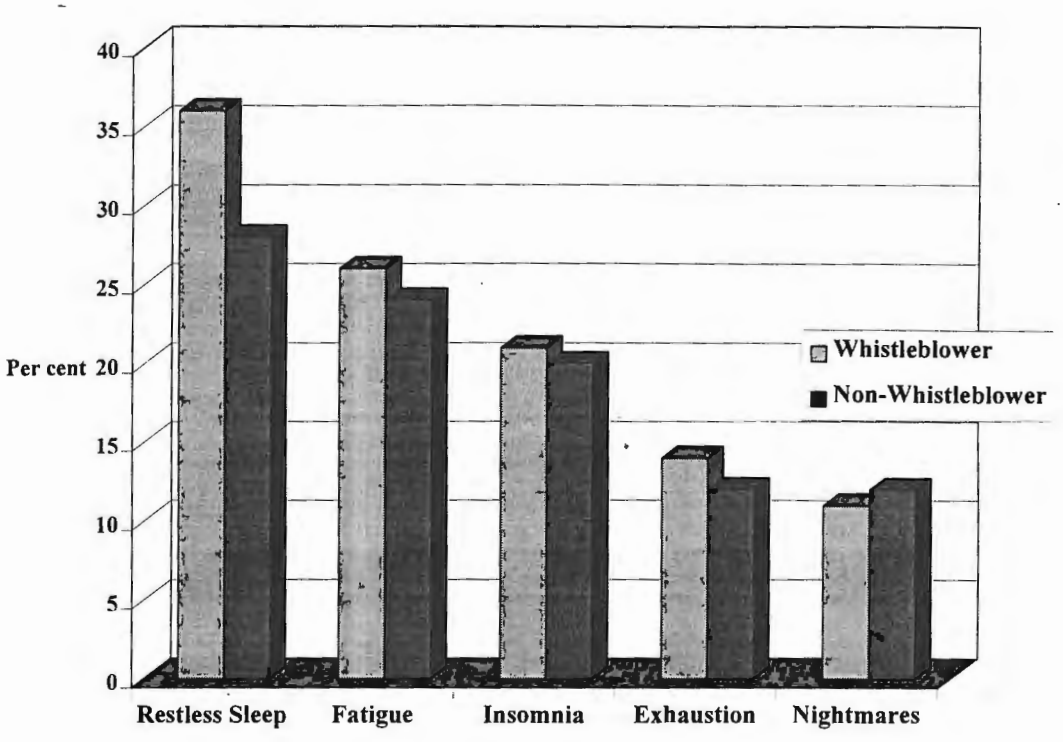

Figure 6. The percentage of nurses who experienced physical problems related to energy or sleep disturbances.

Nervous System, Immune System and Body Disturbances.

Whistleblowers and non-whistleblowers reported physical problems that affected their immune or nervous system and/or caused body disturbances. Approximately seven per cent of whistleblowers and four per cent of non-whistleblowers reported that the experience of identifying misconduct at work caused an increased number of colds or flu, migraines, cold sores and a decline in sex drive. Three per cent or less of whistleblowers, but no non-whistleblowers, reported having sexual problems, rashes or skin problems, acne, and tics or twitches. Two whistleblowers reported that they developed an eating disorder. One whistleblower and one non-whistleblower admitted to using an excessive amount of

drugs and/or alcohol. Other physical effects reported by whistleblowers and non-whistleblowers were headaches, backaches, weight gain, weight loss and increased smoking. The percentage of whistleblowers and non-whistleblowers who reported those complaints are shown in Figure 7.

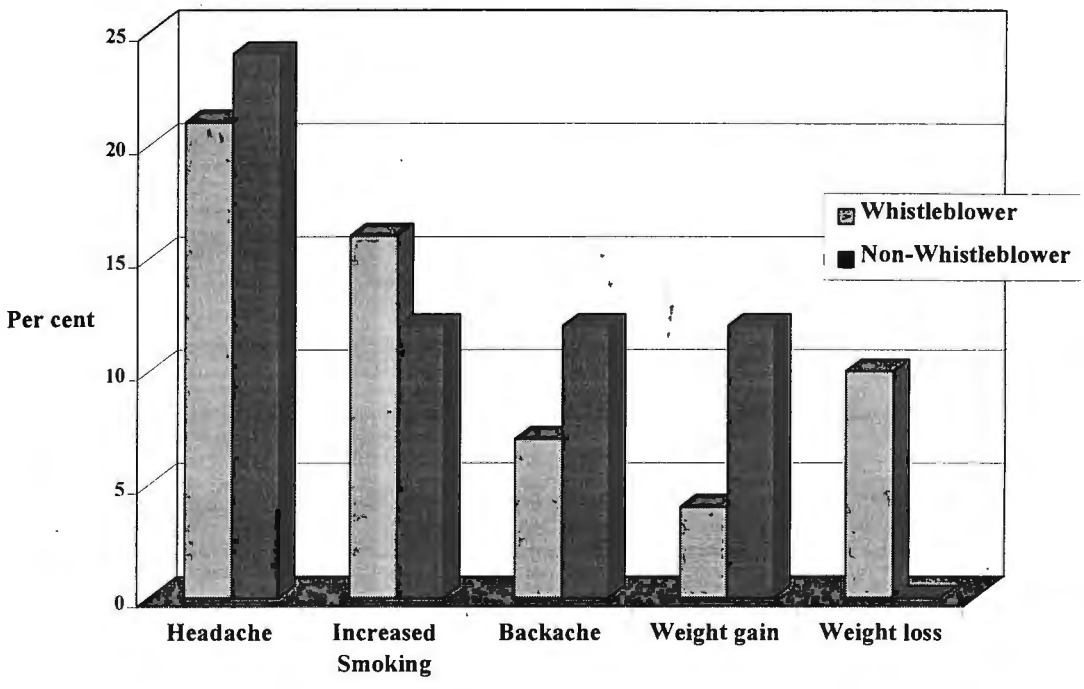

Figure 7. The percentage of nurses who experienced headache, increased smoking, backache, and weight gain or loss.

Digestive System Problems.

Some participants in this study experienced digestive system problems. Four per cent of whistleblowers and non-whistleblowers reported nausea and bowel problems. Seven per cent of whistleblowers reported indigestion and three to four per cent of whistleblowers suffered constipation and/or diarrhoea, though those conditions were not reported by non-whistleblowers. One whistleblower and one non-whistleblower reported having bladder problems. Other digestive system problems experienced by whistleblowers and non-whistleblowers are listed in Figure 8.

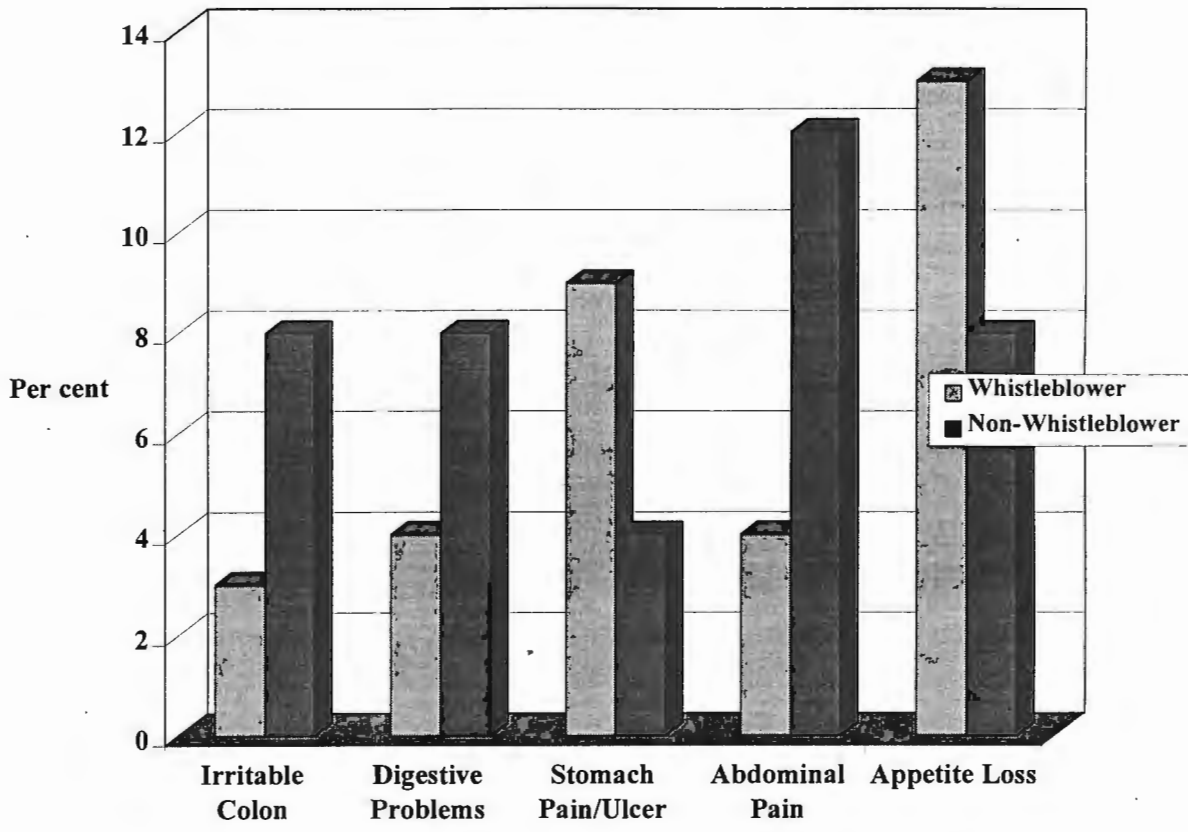

Figure 8. The percentage of nurses who experienced digestive system problems.

Respiratory/Cardiac System Problems.

The most serious stress-related problems were those affecting the respiratory and cardiac system. One whistleblower reported having a heart attack that he believes was caused by the stress of reporting misconduct. Four per cent of whistleblowers and non-whistleblowers reported suffering sinus problems. Three per cent of whistleblowers reported heartburn and dizziness, and one per cent reported respiratory problems and shortness of breath, though those conditions were not reported by non-whistleblowers. Table 6 shows the percentage of whistleblowers

and non-whistleblowers who reported other problems related to the respiratory or cardiac system.

Table 6

Cardiac Problems Reported by Whistleblowers and Non-Whistleblowers

Cardiac Problem	W/B (n=70)	Non-W/B (n=25)
Increased Blood Pressure	7 %	8 %
Palpitations	9 %	8 %
Chest pains	6 %	0 %

Summary.

Nurses who identified misconduct in the workplace suffered a variety of physical conditions that they attributed to the stress of being in a whistleblowing situation. The most frequently reported conditions were restless sleep, fatigue, exhaustion, headache, and insomnia. Problems within the digestive system were experienced by 58% of the sample, and cardiac and/or respiratory problems were experienced by 32% of the sample.

Twenty-two physical problems were reported in higher frequencies by whistleblowers than non-whistleblowers. For example, weight loss was a physical problem reported by 10% of whistleblowers, but not reported by any non-whistleblowers. Other physical problems unique to whistleblowers were indigestion, chest pains, constipation, acne, eating disorder, rashes, sexual problems, tics/twitches, diarrhoea, dizziness, heart attack, heartburn hypertension respiratory problems and shortness of breath. There were no physical complaints that were experienced solely by non-whistleblowers.

The Emotional Effects of Identifying Misconduct at Work

The second research question asked, "What are the emotional effects of identifying misconduct in the workplace for whistleblowers and non-whistleblowers?" This section will present the emotional problems reported by nurses who were identified as whistleblowers or non-whistleblowers. Ninety-four per cent of whistleblowers and 92% of non-whistleblowers reported that they suffered stress-related emotional problems when they identified misconduct at work. Four whistleblowers and two non-whistleblowers denied having any emotional problems from their experience of being in a whistleblowing situation. A total of 743 emotional symptoms were reported. The emotions most frequently experienced by the sample were anger (67%), anxiety (42%) and disillusionment (38%). Although the emotional symptoms were listed in alphabetical order on the questionnaire (Appendix B), they will be reported here in groups of related feelings. Each group has an identifying title and the items placed in each group share similar characteristics.

Feelings of Anger.

The experience of identifying misconduct at work was the reported cause of increased conflict with others for more whistleblowers (13%) than non-whistleblowers (8%). Whistleblowers (6%) and non-whistleblowers (4%) also reported that the experience caused them to have family problems consisting of fighting, separation and/or divorce. However, 12% of non-whistleblowers were short-tempered and had thoughts of retaliation, compared to 6% of whistleblowers.

As stated, a majority of nurses in this study felt anger. Related feelings are irritability, bitterness, cynicism and suspiciousness. Figure 9 shows the percentage of whistleblowers and non-whistleblowers who reported those emotions.

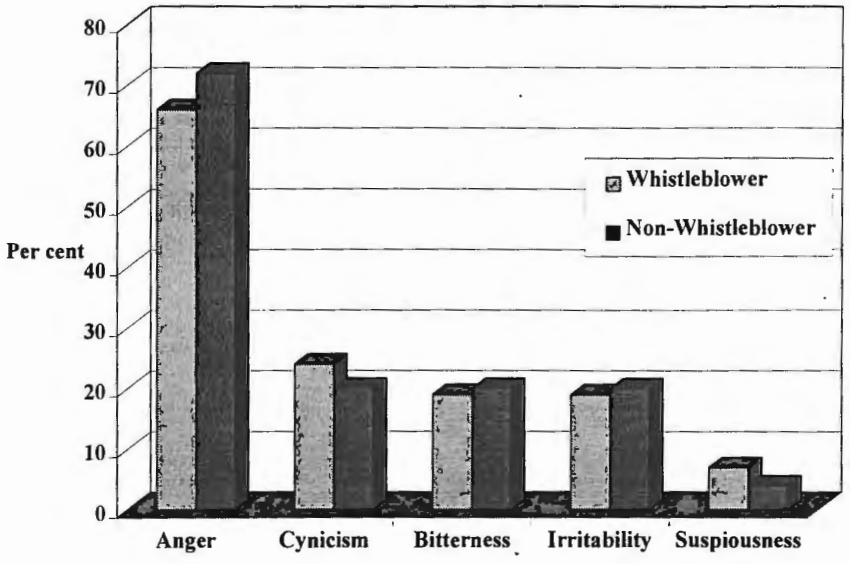

Figure 9. The percentage of nurses who experienced feelings related to anger.

Feelings of Sadness.

Twelve per cent of non-whistleblowers and 9% of whistleblowers reported that they cried easily when they thought about their experience. In addition, more non-whistleblowers (16%) than whistleblowers (6%) felt the need to physically withdraw from colleagues. Listlessness was reported by 8% of non-whistleblowers and 6% of whistleblowers. A large percentage of non-whistleblowers (12%) reported that they felt a deterioration of personal values, compared to a small percentage of whistleblowers (1%).

A similar percentage of whistleblowers (9%) and non-whistleblowers (8%) felt the need to emotionally withdraw from others, and also felt a loss of satisfaction in life. Eight per cent of whistleblowers and 4% of non-whistleblowers reported that they suffered coping difficulties as a result of their experience. Grief was an emotional problem suffered by 3% of whistleblowers, but not reported by any non-whistleblowers. Figure 10 illustrates additional feelings of sadness experienced by whistleblowers and non-whistleblowers.

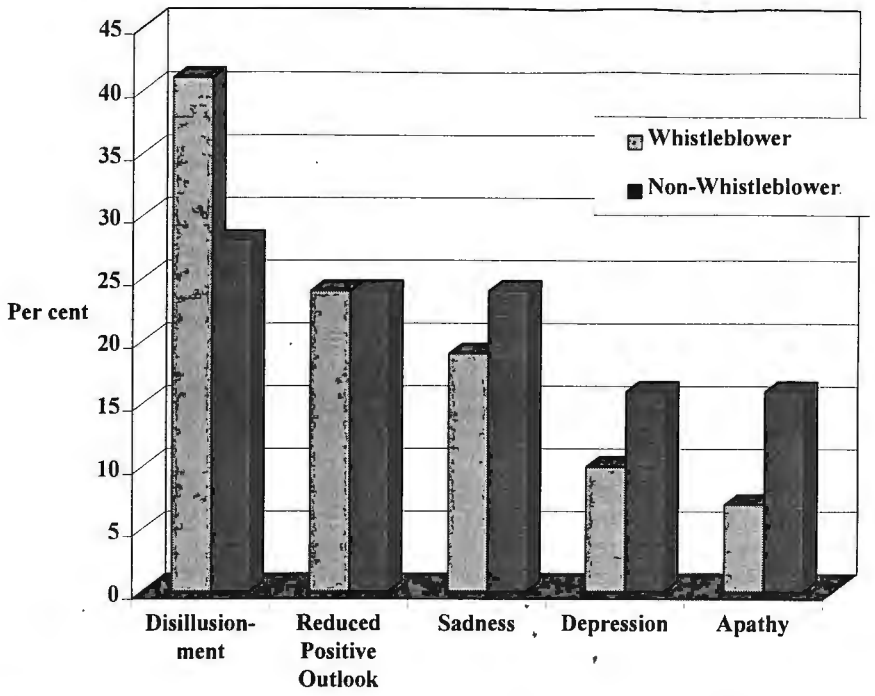

Figure 10. The percentage of nurses who experienced feelings related to sadness.

Feelings of Fear.

Four per cent of whistleblowers and non-whistleblowers suffered panic attacks and were frightened by their whistleblowing experience. Ten per cent of

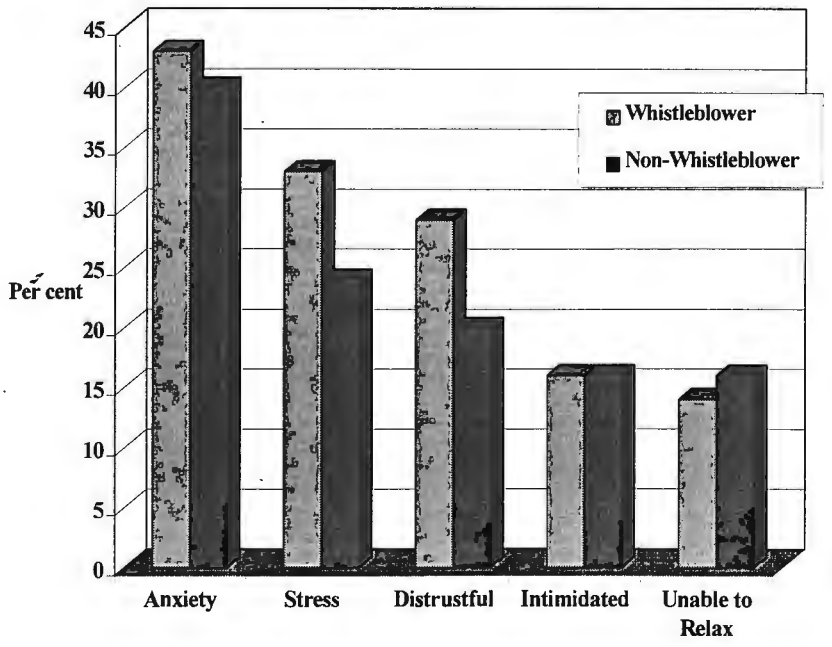

Figure 11. The percentage of nurses who experienced feelings related to fear.

whistleblowers and 4% of non-whistleblowers had thoughts of leaving their position. Also 12% of non-whistleblowers and 6% of whistleblowers reported that they constantly relived the experience. Figure 11 shows the percentage of whistleblowers and non-whistleblowers who had other feelings related to fear when they identified misconduct at work.

Feelings of Unworthiness.

Only one item in this category, namely a loss of emotional control, was experienced by more whistleblowers (7%) than non-whistleblowers (4%). An equal percentage of whistleblowers and non-whistleblowers (16%) felt powerless. All of the other emotions in the category of unworthiness (shown in Table 7) were experienced by a higher percentage of non-whistleblowers.

Table 7

Feelings of Unworthiness Experienced by Whistleblowers (n=70) and Non-Whistleblowers (n=25)

Feelings of Unworthiness	Whistleblower %	Non-Whistleblower %
Guilt	17	28
Shame	03	12
Unworthiness	04	08
Self-Doubt	09	12
Helplessness	17	20
Loss of Confidence	16	20
Loss of Self –Esteem	09	16
Suicidal Thoughts	03	04

Feelings Related to the Workplace.

Many nurses reported that after they identified misconduct in the workplace, they no longer felt job satisfaction, and they had lost respect for their place of employment. Figure 12 shows the percentage of whistleblowers and non-whistleblowers who experienced other negative feelings related to their workplace.

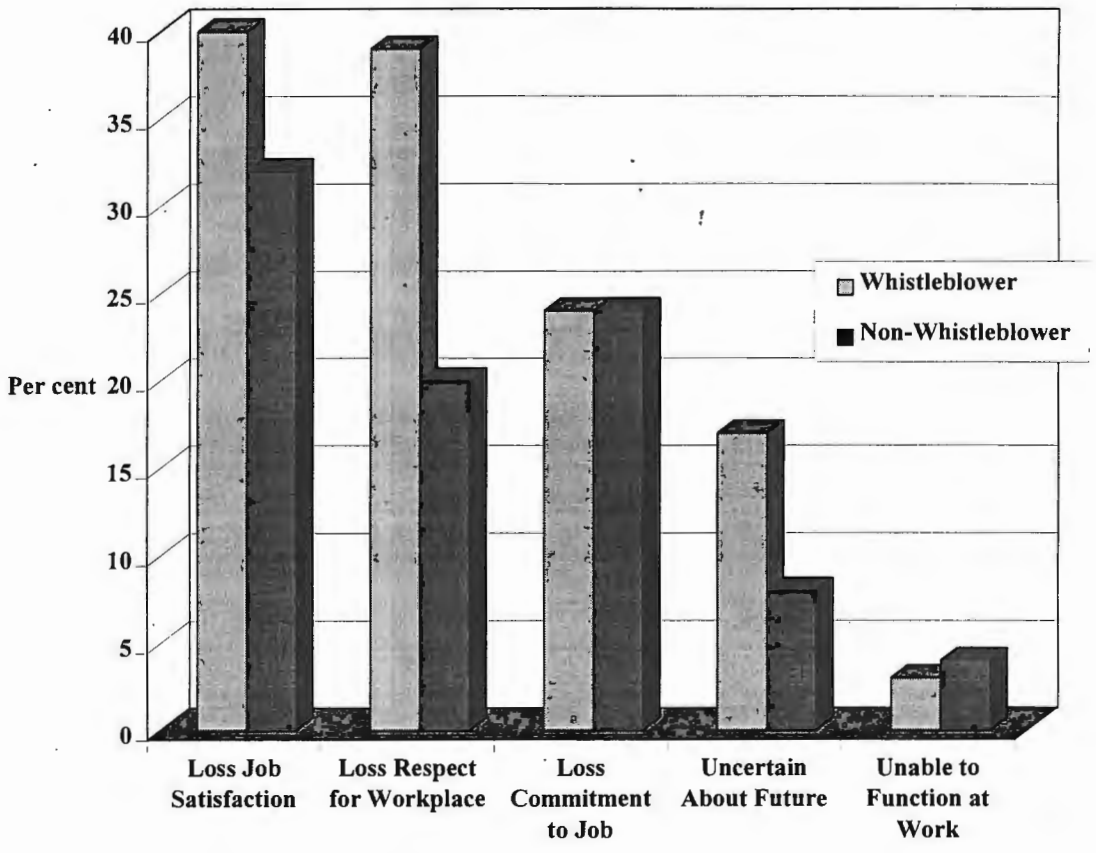

Figure 12. The percentage of nurses who experienced feelings related to the workplace.

Summary.

The questionnaire listed 56 emotional problems. Whistleblowers and non-whistleblowers experienced 54 of the conditions. The two items not reported by either whistleblower or non-whistleblower were bulimia and attempted suicide. Twelve of the problems were reported by a higher percentage of whistleblowers (n=70) and 24 of the problems were reported by a higher percentage of non-

whistleblowers (n=25). The other 18 problems were experienced by a similar percentage of whistleblowers and non-whistleblowers.

Ninety-four per cent of nurses in this study experienced emotional effects from being in a whistleblower situation. Anger (67%) and anxiety (42%) were the emotions most frequently reported.

Ten to 20% of the sample felt bitter, irritable, short-tempered, intimidated, unable to relax, tearful, depressed, powerless and helpless. They also felt a loss of confidence, loss of self-esteem, increased conflict with others and uncertain about their future.

Twenty per cent or more of the sample experienced the following emotions: cynicism, distrust, stress, disillusionment, reduced positive outlook, guilt, loss of respect for their job and workplace and reduced commitment to work.

The Professional Effect of Identifying Misconduct at Work

The third research question asked nurses to name the professional consequences of being involved in a whistleblowing event. This section will present the professional consequences reported by participants who were identified as whistleblowers and non-whistleblowers. For clarity, the consequences were grouped together in categories of related actions. Data is presented in the form of frequencies and percentages.

Thirteen members of the sample (N=95) left the professional consequences page blank, and seven wrote "none" in the space provided by the label "Other". That was interpreted as meaning that those 20 respondents were not professionally affected by their whistleblowing experience. The remainder of the sample (n=75) consisted of 63 whistleblowers and 12 non-whistleblowers. They experienced a total

of 179 professional consequences; 25 were positive consequences, and 161 were negative consequences. No respondents in this study received a pay rise for reporting misconduct, or were promoted.

Positive Consequences.

Thirty-four nurses (30 whistleblowers and 4 non-whistleblowers) reported that they were privately or publicly praised for their part in identifying misconduct. The best example of a nurse who was privately praised for her action was a whistleblower who reported a physician for performing a life-threatening procedure without proper training. The whistleblower received a letter of thanks for proper action from the senior nurse of the unit and from the medical superintendent.

However, nine of those who were praised privately and/or publicly stated that only select colleagues congratulated them, while many others threatened and/or ostracised them.

Another item that initially appeared to be positive was later considered negative when analysed in context. Two whistleblowers reported that they received an official commendation for reporting misconduct, but the accolade was accompanied by many negative reprisals. For example, case number 25 stated, "I was forced to resign, threatened with legal action, treated as a traitor, told that my career was over and physically isolated from my colleagues. When the matter was taken to Disciplinary Court, I received an official commendation." Case number 40 received an official commendation for reporting a staff member who physically abused an elderly patient; "For this I was 'sent to Coventry', ignored and verbally attacked by peers and some junior staff, as the person I reported was socially very popular." The remaining professional consequences reported by respondents in this study were negative, and primarily experienced by whistleblowers.

Official Reprisals.

Seven per cent of whistleblowers received a verbal reprimand for reporting misconduct, and four percent received a written reprimand. Whistleblowers were also demoted (four per cent), suspended (one per cent), and referred to a counsellor or a psychiatrist (nine per cent). No non-whistleblowers were reprimanded, demoted, suspended or referred for counselling. One non-whistleblower reported being punitively transferred for voicing concern to a supervisor in confidence, while two whistleblowers were punitively transferred.

Unofficial Reprisals.

Nine per cent of whistleblowers, and no non-whistleblowers, reported being given impossible or menial tasks. Seven per cent of whistleblowers had their work written up as inferior and ten per cent reported that their career advancement was halted, compared to four per of non-whistleblowers.

Threatened.

Six per cent of whistleblowers were threatened with a transfer, and threatened with legal action. Whistleblowers (4%) were also threatened with dismissal. No non-whistleblowers were threatened with transfer, dismissal or legal action. Whistleblowers (nine per cent) and non-whistleblowers (four per cent) were pressured to "voluntarily" resign.

Ostracised.

Nine per cent of whistleblowers, and no non-whistleblowers, were physically isolated from peers. However, eight per cent of non-whistleblowers believed they were socially isolated and rejected by their peer group, as did 14% of whistleblowers. Fourteen per cent of whistleblowers also reported that they were treated as a traitor, which was not experienced by non-whistleblowers.

Discounted.

Whistleblowers (21%) and non-whistleblowers (12%) were ignored when they expressed concern, and 17% of whistleblowers and 20% of non-whistleblowers were told to "forget it". Six per cent of whistleblowers and no non-whistleblowers were told they were "imagining things".

Other.

Seventeen respondents listed a professional consequence that was not on the questionnaire, or added a written addendum to define the consequences they received. One was a non-whistleblower who reported that she witnessed a "horrible" assault on a patient, and chose to immediately resign (case number 83). The other 16 respondents who ticked "Other" were whistleblowers and the professional consequences they defined are:

- Asked to change report. Told report was wrong. (2)
- Quietly supported by colleagues. (2)
- Verbally abused. (2)
- On-going, persistent lack of support. (2)
- Given poor roster. (2)
- Placated with promise that something would be done, but nothing was. (2)
- Incident report was used to confront issue with individual, thereby causing conflict in team. (1)
- Was forced to resign to take the case to disciplinary court. (1)
- Threatened by perpetrator, but supported by Health Department of Western Australia legal division. (1)
- Required psychiatric counselling to cope with trauma of event and eventually resigned. (1)

Table 8 gives an overview of the professional consequences that were experienced by a majority and/or a similar percentage of whistleblowers and non-whistleblowers.

Table 8

The Professional Effect of Whistleblowing and Non-Whistleblowing

Professional Effect	Reported by a Higher % of Whistleblowers	Reported by a Higher % of Non-Whistleblowers	Reported by a Similar % of W/B and Non W/B
Positive Consequence			
	Privately praised		
	Publicly praised		
	Commendation		
Official Reprisal			
	Verbal reprimand		
	Written reprimand		
	Demoted		
	Suspended		
	Referred to psych.		Punitive transfer
UnofficialReprisal			
	Given imposs.tasks		
	Work scrutinised		
	No career advance.		
Threatened			
	Threat transfer		
	Threat dismissal		
	Threat legal action		
	Pressured to resign		
Ostracised			
	Physically isolated		
	Socially isolated		
	Treated as a traitor		
Discounted			
	Ignored		Told to 'forget' it
	Told 'imagining' it		

Summary.

There were few professional rewards for nurses who identified and reported incompetent, illegal or unethical events at work. No whistleblowers (n=70) were promoted or given a pay rise, and only three whistleblowers were publicly praised. Two whistleblowers received an official commendation, but those commendations were preceded by many negative reprisals from colleagues. Twenty-seven whistleblowers said select colleagues privately praised them, but again those praises were accompanied by negative reprisals from others.

Most of the professional effects of whistleblowing were negative and included reprimand, demotion, transfer, threats, referral to a psychiatrist, and pressure to resign. Furthermore, many whistleblowers were given impossible tasks or had their work unfairly scrutinised. Thirty-three whistleblowers were ostracised by colleagues, treated as a traitor and/or believed their career was halted. Thirty-one nurses who blew the whistle on misconduct were ignored, told to forget it or told they were imagining things.

Non-whistleblowers (n=25) did not suffer as many negative consequences as whistleblowers. However, many were ignored or told to forget their concern, and four reported that they were ostracised or received unofficial reprisals.

The next section will present the coping behaviours used by nurses in a whistleblowing situation and identify the coping behaviours they believed were effective and not effective.

Ways of Coping and Coping Effectiveness

The final research question asked which coping behaviours were used by whistleblowers and non-whistleblowers when they identified misconduct at work, and which ones did they believe were effective or ineffective. This section will discuss the ways nurses coped when confronted with a whistleblowing situation in their workplace.

The questionnaire listed fourteen coping behaviours related to identifying misconduct in the workplace. After each coping behaviour on the list, respondents were asked to tick one of three choices: (1) It's something I tried, and it helped me feel better (2) It's something I tried, but it did **not** help me feel better or (3) It's **not** something I tried.

The Coping Behaviours of Whistleblowers.

There were four coping behaviours that were considered effective by a majority of whistleblowers. They were:

- I talked to someone whom I thought could do something about the problem.
- I stood my ground and fought for what I believed was the right thing to do.
- I asked a friend or relative I respected for advice and support.
- I drew on my past experiences to come up with a way to handle the problem.

Many whistleblowers reported that it did *not* help to express their concern to the person or people who caused the problem, and furthermore, it was ineffective to try to change the mind of the person responsible. Table 9 (shown at the end of this chapter) lists the effective and ineffective coping behaviours used by whistleblowers.

The Coping Behaviours of Non-Whistleblowers.

There were no coping behaviours that were considered effective by a majority of non-whistleblowers. A large number (40%) reported that it was helpful to ask a friend or relative for advice or support.

Most of the coping behaviours used by non-whistleblowers were reported as being ineffective. A majority of non-whistleblowers were not able to "forget the whole thing by concentrating on work", and many reported that it was not helpful to act as if nothing had happened, or to keep others from knowing how they felt. Furthermore, many non-whistleblowers reported that it did not make them feel better when they avoided the patient or the people involved in the misconduct. Table 9 (shown at the end of this chapter) lists the effective and ineffective coping behaviours used by non-whistleblowers.

Summary.

When the sample is taken as a whole, there are three coping behaviours that were reported to be effective by a majority of participants who used them. Those coping behaviours were: (1) Stood one's ground and did the right thing (2) Asked a friend or relative for advice/support and (3) Drew on past experiences to solve the problem. There were eight coping behaviours that were considered ineffective by a majority of participants who tried them. Those behaviours were: (1) Expressed concern to the person who caused the problem (2) Tried to change the mind of the person responsible (3) Kept feelings to self (4) Forgot about it by concentrating on work (5) Avoided the patient and/or people involved (6) Fantasized about how things might turn out (7) Tried not to burn bridges by pretending nothing happened and (8) Tried to feel better by eating, drinking, smoking or using drugs.

Table 9

The Effective and Ineffective Coping Behaviours Used by Whistleblowers (n=70) and Non-Whistleblowers (n=25)

Coping Behaviour	Effectiveness	% of W/B	% of Non-W/B
1. Expressed concern to person who caused problem.	Tried and helped	33	24
	Tried and no help	50	40
	Did not try	17	24
2. Tried to get person to change his/her mind.	Tried and helped	36	16
	Tried and no help	39	32
	Did not try	26	36
3. Kept feelings to self and didn't let others know.	Tried and helped	7	4
	Tried and no help	29	48
	Did not try	64	36
4. Tried to forget whole thing by concentrating on work.	Tried and helped	14	16
	Tried and no help	29	52
	Did not try	54	20
5. Talked to someone who could do something about it.	Tried and helped	51	36
	Tried and no help	37	24
	Did not try	11	24
6. Stood my ground and fought for the right thing.	Tried and helped	60	24
	Tried and no help	27	24
	Did not try	13	36
7. Avoided the patient and/or people involved.	Tried and helped	14	4
	Tried and no help	33	36
	Did not try	53	44
8. Had fantasies about how things might turn out.	Tried and helped	23	4
	Tried and no help	23	36
	Did not try	53	44

Table 9 Continued..../

.../Continued Table 9

Coping Behaviour	Effectiveness	% of W/B	% of Non-W/B
9. Tried not to burn bridges; acted like nothing happened.	Tried and helped	9	24
	Tried and no help	24	36
	Did not try	67	28
10. Asked a friend/relative for advice and support.	Tried and helped	57	40
	Tried and no help	16	0
	Did not try	27	60
11. Prayed that it would end up all right.	Tried and helped	20	20
	Tried and no help	16	8
	Did not try	64	56
12.Got away from it; Took time off, went on holiday.	Tried and helped	21	8
	Tried and no help	7	4
	Did not try	70	72
13. Tried to feel better by eating, drinking, smoking,etc.	Tried and helped	3	0
	Tried and no help	14	24
	Did not try	83	60
14. Drew on past experiences to solve problem.	Tried and helped	69	36
	Tried and no help	13	24
	Did not try	17	28

Chapter Six

Discussion

Introduction

The purpose of this study was to examine the effect of whistleblowing and non-whistleblowing on nurses in Western Australia. Possible response bias makes interpretation of results difficult since many of the characteristics of participants appear to be inter-related. There were proportionally more responses from mature women, people with higher qualifications, male nurses and psychiatric nurses than from the general nursing population.

It is not possible to separate the effects of individual characteristics when they probably acted as co-variants in this research. For example, it is likely that people with higher qualifications are older than people with minimum qualifications, since it takes several years to obtain a higher degree. Therefore, it would seem that age and education levels are related. Also, the over-representation of males in this study could be related to the high response of psychiatric nurses, since in Western Australia, there are more males in psychiatric nursing than in general nursing.

Despite this limitation, results presented in the previous chapter will be discussed with reference to the framework and the literature. Where a finding cannot be clearly identified as the effect of one variable, discussion will focus on the effects of the possible combination of factors. The final section of this chapter will include limitations of the study, strengths of the study and recommendations for future research.

Demographic Information

Gender.

The profession of nursing has a predominately female workforce. According to Besomo (1996), figures from a 1995 labour force survey of nurses registered in Western Australia (WA) show that males account for only about 7% of the registered nurses in WA. Therefore, the high number of male participants in this study was surprising, since 20% of those who responded were male and 73% were female (seven respondents did not specify gender).

It is possible that more males responded to the questionnaire because a higher percentage of males work in mental health nursing in WA, and this questionnaire was distributed to mental health nurses as well as general nurses (Besomo, 1996). That is supported by the data, which reveals that seventy four per cent of the males who participated in this study worked in psychiatric nursing.

Another possible explanation for the high response rate of males to this study is that the subject of whistleblowing *attracted* male respondents. Other whistleblower studies reveal that the majority of whistleblowers are male (De Maria, 1994; Lennane, 1993). In De Maria's research of Queensland whistleblowers (n=83), males accounted for 63% of the sample and Lennane's sample (n=31) consisted of 71% male. De Maria (1994) poses some interesting questions regarding this gender bias. For example, he wonders whether females are less assertive in the workplace or if they are denied access to certain types of information because of their generally lower job status. He also asks whether females weigh the consequences of speaking up more than males do, or if they are pressured by spouses to 'keep quiet'.

This study does not have the data to answer those questions. However, many patient advocacy studies discuss the powerlessness, subservience and fear of speaking up reported by nurses who were presumably female (Chafey et al., 1998; Duncan, 1992; Erlen & Frost, 1991; Segesten, 1993; Soderberg & Norberg, 1993; Mohr, 1996; Pike, 1991; Watt, 1997; Wilkinson, 1987/88). According to Lazarus and Folkman (1984), people are shaped by *cultural* forces within their social system. Therefore, if the culture values subservience in woman, then women in that culture will respond subserviently. Price, Price, Williams and Hoffenberg (1998) suggest that the socialisation of females in early childhood is an important factor in the development of their ethical framework, while other authors have suggested that females are socialised to be less assertive than males (Simoni & Paterson, 1997; Thomas & Droppleman, 1997).

If there is a male bias in the phenomenon of whistleblowing, it has implications for the predominantly female profession of nursing. The concern is that nurses, *regardless of gender*, are compelled by their code of practice to act as patient advocates. Patient advocacy may mean reporting misconduct (whistleblowing), and that requires strong assertiveness skills.

Age.

Most of the nurses in this study (56%) were between the ages of 36 and 50. That was consistent with De Maria's whistleblower study, which found that the majority of his participants (73%) were between the ages of 30 and 50. The relevance of age to whistleblowing may simply be that people in that age group are not as intimidated by authority as younger age workers might be. However, Erlen and Frost (1991) found that older age nurses were just as likely to report feeling powerless as younger age nurses.

In addition, employees between the ages of 30-50 have often gained some status in their career and would seem to have more to risk by speaking up. That was true in many patient advocacy studies which found that nurses *knew* how to respond in an ethical dilemma, but felt constrained by hierarchic forces (Erlen & Frost, 1991; Holly, 1993; Mohr, 1996; Wilkinson, 1987/88; Uden et al., 1992).

It was stated earlier that variables such as age and experience are inter-related. That is evident in the suggestion that perhaps more middle aged nurses were involved in a whistleblowing situation because nurses in that age group have enough experience to know when standards of care have been compromised. That is supported in patient advocacy studies which found that experienced nurses have no difficulty determining the 'right' and ethical position to take (Soderberg & Norberg, 1993; Uden et al., 1992). Furthermore, whistleblower studies found that whistleblowers are typically experienced and about 40 years of age (Hunt, 1995; Lennane, 1993).

The low representation of nurses in the 51-65 age group in this research could suggest several things: that nurses in that age group have not been socialised to question authority; that they accept the status quo or that they are not prepared to 'make waves' at the end of their careers. De Maria (1994) found that women over 50 were well below the ratio of men who report misconduct, but that younger females (20-29) blew the whistle twice as often as males. That suggests that younger women have felt some empowerment in the workforce which has not transcended to older women (De Maria, 1994). References to age or gender are scarce in nursing literature, so it is difficult to determine how those variables affect a nurses' commitment to ethical standards and hence, how that relates to whistleblowing.

Years in Nursing and Nursing Education.

Over 50% of the nurses in this study had been nursing for over 16 years, and another 34% had been a nurse for ten years or more. This makes them a highly experienced sample of nurses. Chafey et al., (1998) found that knowledge and experience were qualities required for nurses to act as a patient advocates.

In addition, the whistleblowers and non-whistleblowers who responded to this study were better educated than most WA nurses. Forty percent of the respondents had university qualifications in the form of a bachelors degree, an honours degree, a post-graduate diploma or a masters degree, compared to the norm in Western Australia, where only five to six per cent of nurses have university qualifications (Besomo, 1996). De Maria's (1994) participants were similarly well educated and he questions whether whistleblowers' higher degree of education *enhances* their ability to discern whether an act requires disclosure.

Some nursing scholars would support that supposition. McAlpine (1996) found that nurses required a higher educational base to recognise health care dilemmas. Wlody (1993) found that masters-prepared nurses scored significantly higher on tests to determine the need for patient advocacy. Kiely and Kiely (1987) found that whistleblowers were better educated than other members of an organisation. Therefore it is reasonable to suggest that nurses who chose to participate in this study did so because they had enough experience and education to *recognise* the ethical ramifications of their whistleblowing situation.

Whistleblower Event.

As was described in Chapter Four under the heading 'Instrument", participants in this study were asked to indicate the event that best described the wrongdoing they observed. The description of the event was purposely broad since

the intent of this research was to learn about the nurse's *reaction* to the misconduct, **not** learn about the misconduct. However, the fact that the misconduct was not the relevant feature of the study does not mean that it should be minimised. Serious allegations were made including assault, patient rights violations, sexual misconduct, theft, harassment and discrimination.

Some of the events that seemed less serious in their broad definition had the most serious consequences. For example, case #76 ticked 'poor quality of patient care' as the whistleblowing event, then went on to describe how a geriatric patient had died as a result of the poor care. In another example, case #8 ticked 'favouritism and/or nepotism' as the event, then described how a nurses' career was ruined after being wrongly blamed for the death of a baby.

A recent survey of working conditions in US hospitals found that serious and widespread misconduct occurred in the health care system (Daugherty, Baldwin & Rowley, 1998). In that survey, 70% of medical interns (n=1274) observed others mistreating patients and working in impaired conditions. Data from that study and from this research indicates that serious misconduct occurs in hospitals. Since nurses are the one constant in a setting where many caregivers come and go, they are in a prime position to identify misconduct. The number of events reported by respondents in this study demonstrates that nurses not only identify misconduct, but also, report it.

Whistleblowing and Non-Whistleblowing Actions.

In this study, the action of reporting misconduct was usually in the form of telling a supervisor or writing an incident report. All of the nurses who reported misconduct (whistleblowers) experienced serious professional consequences. Some of them were demoted, others were transferred and many were harassed, ostracised

or treated as a traitor. Other whistleblower studies confirm that blowing the whistle causes severe professional reprisals, and whistleblowers are profoundly victimised (De Maria, 1995; Dempster, 1997; Glazer & Glazer, 1989; Hunt, 1995; Kiely & Kiely, 1987; Lennane, 1993). Therefore, the most pertinent question to discuss in this section is what motivates a person to blow the whistle?

The decision to blow the whistle can best be understood in context with the theoretical framework which guided this study. According to Lazarus and Folkman (1984), a person with a strongly held commitment will go to extreme lengths to ward off any threat to that commitment. We have seen that nurses are compelled to uphold a commitment to patient advocacy, so it may be that nurses in this study were motivated to blow the whistle in order to uphold their commitment to patient advocacy. That would also explain why the non-whistleblowers in this study, and patient advocates in other studies, experienced stress and emotional problems, since, as nurses, they also felt their commitment to patient advocacy threatened.

Whistleblowing literature describes the personal characteristics of whistleblowers. Hunt (1995) found that whistleblowers were risk-takers with a clear sense of morality, and a strong ability to determine right from wrong. He found them to be "more self-reliant and less dependent on their immediate peer group for their sense of personal identity" (p. 205). Kiely and Kiely (1987) found that whistleblowers were different from other employees "because they are not motivated by blind organisational loyalty, and do not aspire to move vertically within the organisational structure" (p. 41). De Maria (1994) found that 60% of his sample blew the whistle during their first five years of employment, and that whistleblowing was rarely done by people who had been with an organisation for 10-20 years.

Martin (1985) supports that observation, noting that whistleblowers are usually people who are not 'invested' in the system.

That would imply that *new* nurses would be more likely to whistleblow than say, nurse managers who are promoted from within the system. The findings from this research could not verify whether the whistleblowers were 'new' nurses to the organisation, but the majority of them were Level 1 or 2 nurses, which suggests that they were not promoted to managerial positions. Therefore, it seems that the very people who would be expected to uphold the profession's commitment to a standard of care (i.e., managers) can not be counted on to remedy misconduct. Unfortunately, such was the case in this study, where it was usually nursing managers who were perceived as having retaliated against the whistleblowers.

Edwards (1996) questions whether nurses are obliged to act in ways which benefit patients if it leads to substantial harm to themselves and their dependents. He concludes that nurses who refrain from whistleblowing due to fear of adverse consequences are acting in accordance with ordinary moral standards, whereas those who whistleblow are acting out of 'supererogatory' moral standards. Nurse ethicists disagree, arguing that if nurses believe the rights of a patient are being abused, they have the moral responsibility to make a complaint (Fry, 1989; Johnstone, 1994).

The whistleblowers in this study provided strong reasons for whistleblowing, but those results do not pertain to the research questions, and have not been presented at this time. It is enough to say that the nurses felt a **need** to help their patients, and that need was stronger than their fear of professional reprisals. Therefore their actions are in line with what the theoretical framework would

predict, namely that when values are threatened, actions are determined by how strongly one is committed to personal values (Lazarus & Folkman, 1984).

What Happened After the Event and What Happened to the Wrongdoers?

This is perhaps the saddest section of the research, for it clearly shows that the illegal or unethical situation was likely to remain unchanged whether the nurse blew the whistle or not. If the results had indicated that reporting misconduct *stopped* the misconduct, then it would have been possible to suggest that, despite personal anguish, the whistleblower's actions were vindicated. However, blowing the whistle on misconduct did not usually change the situation, and in fact seemed to *lessen* the chance of changing the misconduct. More sadly, this research found that blowing the whistle does not result in discipline for the wrongdoer, and may even reward the wrongdoer with promotion. That suggests that retribution to wrongdoers is better achieved by remaining silent!

The patient advocacy literature speaks to this issue, for most of the studies reported high frustration levels among nurses whose concerns were not heard and not acted upon (Erlen & Frost, 1991; Holly, 1993; Mohr, 1996; Wilkinson, 1987/88; Uden et al., 1992). Unfortunately, the whistleblowers and non-whistleblowers in this study were not heard and the misconduct they identified continued unchanged, though they were physically and emotionally damaged by the experience. In addition, many of the whistleblowers lost professional status and experienced devastating long-term consequences, while most of the wrongdoers they reported went undisciplined.

Summary.

Some of the variables in this study relating to age, gender, experience and education level seem to be inter-related. For example, most respondents were between the ages of 30-50, and had acquired a higher level of education and experience than is the norm for Western Australian (WA) nurses. In addition, more males responded to this study than is representative of the number of males nursing in WA, but 74% of them were in the area of psychiatric nursing, where there are more males than in other specialty areas. Therefore, the following co-variants seem to have affected response bias: age-experience, age-education level, male gender-psychiatric nursing.

Another explanation given for the high response rate of males to this study was that males were *attracted* to the study, since research indicates that more males whistleblow than females (De Maria, 1994; Lennane, 1993). Patient advocacy studies indicate that women are socialised to be more subservient, and less assertive than males, which could account for the male bias in whistleblowing (Simoni & Paterson, 1997; Thomas & Droppleman, 1997). That has implications for the predominantly female profession of nursing, since patient advocacy research indicates that nurses must be assertive to be patient advocates (Chafey et al., 1998; Duncan, 1992; Pike, 1991; Segesten, 1993).

Most of the whistleblowers and non-whistleblowers in this study were mature, experienced and had a higher degree of education than is the norm for nurses in WA. Whistleblower research indicated that whistleblowers were similarly well-educated (De Maria, 1994), and nursing scholars proposed that higher education was the key to understanding and responding to ethical dilemmas (McAlpine, 1996; Wlody, 1993).

The whistleblowing events reported by participants concerned serious acts of misconduct, and the action of reporting those events was usually in the form of telling a supervisor or writing an incident report. The decision to blow the whistle was explained in context with the theoretical framework which demonstrated that when values are threatened, actions are determined by how strongly one is committed to personal values (Lazarus & Folkman, 1984). Whistleblowers and non-whistleblowers responded differently to their whistleblowing situation, and it is possible that their responses were pre-determined by certain characteristics that separate whistleblowers from non-whistleblowers. For example, research has shown that whistleblowers are self-reliant risk-takers and are not invested in organisational loyalty (Hunt, 1995; Kiely & Kiely, 1987; Martin, 1985).

Blowing the whistle on misconduct did nothing to change the misconduct and may have even increased the likelihood of it continuing. Furthermore, blowing the whistle on misconduct did not usually result in discipline for the wrongdoer.

The following three sections will interpret the findings of the research questions, namely the physical, emotional and professional effects of whistleblowing and non-whistleblowing. The final section of this discussion will interpret the results of the effective and ineffective coping behaviours used by whistleblowers and non-whistleblowers.

The Physical Effects of Identifying Misconduct at Work

Seventy nurses in this study were identified as whistleblowers, and 70% of them reported physical ill health related to the stress of reporting misconduct at work. Those numbers are remarkably similar to De Maria's (1994) research of whistleblowers (n=72) which found that 71% reported a deterioration of physical health. Since the number of physical problems experienced by participants in each study is so similar, it is worth displaying some of them together (Table 10):

Table 10

Some Physical Problems Experienced by Participants in this Study and Participants in De Maria's (1994) Study

Physical Problem	This Study (n=70) % of Whistleblowers who had the problem	De Maria Study (n=72) % of Whistleblowers who had the problem
Insomnia/Restless Sleep	57	50
Lethargy/Exhaustion	23	22
Headaches	21	17
Increased Smoking	13	16
Migraines	7	7
Increased Blood Pressure	7	6
Palpitations	9	6
Heart Attack	1	1

The high number of whistleblowers who reported health deterioration in these two studies is not appreciably different from an American study of whistleblowers (n=84) which found that 80% reported physical ill health (Soeken, 1987). In addition, 83% of Lennane's (1993) participants (n=35) reported having physical symptoms that are remarkably similar in number to this study. All of the

participants in the mentioned studies believed their physical problems were caused by the stress of identifying and reporting misconduct at work. In addition, they all self-reported their physical complaints, which is a methodological approach that is supported in the literature since it is the *perception* of stress that causes physical and emotional reactions (Lazarus & Folkman, 1984). Clearly, the majority of nurses in this study perceived that the stress of whistleblowing caused them to experience physical ill health.

The most serious physical conditions reported by nurses in this study were cardiac problems (palpitations, chest pains, increased blood pressure) which were evident in other studies (De Maria, 1994; Lennane, 1993). Those conditions may have been experienced when the whistleblower decided to report the wrongdoing observed. Research confirms that job security is vitally important to workers (Curtin, 1993; Kiely & Kiely, 1987; Williamson, 1994) and that speaking out against the status quo is known to threaten job security (Duncan, 1992; Holly, 1993; Pike, 1991; Segesten, 1993). Therefore, it would be reasonable to expect that nurses who risked their career to report misconduct would suffer serious stress-related problems.

What is surprising is that nurses who did **not** blow the whistle nevertheless suffered physical problems. Sixty-four per cent of non-whistleblowers suffered physical symptoms as a result of identifying misconduct in their workplace. Such a result can best be understood in reference to Lazarus and Folkmans' (1984) model that describes how "inaction" can be as stressful as "action" when personal values are compromised. That is confirmed in Wilkinson's (1987/88) study which found that respondents experienced stress-related problems (nightmares, palpitations, diarrhoea, and headaches) when they wanted to advocate for a patient, but were prevented from doing so. Findings from this study indicate that non-whistleblowers

suffered stress induced physical problems, even though they did not actively report the misconduct they identified.

In order to present other aspects of the data in a clear format, the data have been divided into the following subgroups:

Nurses Who Experienced Physical Problems, But Did Not Have Any Professional Consequences.

From the sample of 95 nurses, 28 reported that they did **not** suffer any physical problems (twenty were whistleblowers and eight were non-whistleblowers). In order to understand why those 28 nurses were not physically affected, the professional effects of their actions were examined. Since it has been established that job insecurity was an important component in producing stress-related symptoms, it seemed reasonable to determine whether those 28 nurses experienced professional consequences. It turned out that 23 of them were professionally *un*affected by their actions. In other words, they did not experience any negative professional reprisals from reporting or not reporting misconduct. They were not demoted, threatened, suspended or treated as a traitor and in fact, six were praised. Thus, not having negative professional consequences appears to safeguard against having physical problems.

Nurses Who Did Not Experience Physical Problems, but Had Professional Consequences.

Interestingly, there were five nurses (all whistleblowers) who were professionally harmed by their experience, but who reported **no** physical problems. This would seem to be an anomaly, since professional censure is extremely stressful. However, those whistleblowers shared two common attributes that may have prevented them from suffering physical problems despite being professionally

compromised. They had a strong conviction that their action was the right thing to do, and they had a strong support system.

For example, case number 52 was threatened with legal action, but when asked if she would do the same thing, she responded, "yes, I have never had any doubts about my actions". In addition, when asked what advice she would give to someone in a similar situation, she indicated that it was important to "act promptly and decisively". In De Maria's research, 80% of his sample responded "yes" to the question, "Knowing now what happened when you blew the whistle, would you make a public interest disclosure again?" This suggests that De Maria's whistleblowers, like respondents in this research, had a genuine belief in the rightness of their actions.

Another nurse in this study (#76) was professionally discredited and socially isolated by peers, but stood by her decision to report an incident that led to the death of a patient. When asked what advice she would give to someone in a similar situation, she stated, "have the courage of your conviction". Other comments by the five whistleblowers regarding the strength of their convictions include, "I had to take a stand against the assault of a patient", "I would have no hesitation next time", and "Have faith that right and goodness will prevail". The personal strengths evident in these first-hand accounts suggest that the nurses were assertive, ethical and persistent. Those are the same nursing traits that Chafey et al. (1998) and Duncan (1992) found to be necessary for carrying out client advocacy actions.

The other characteristic shared by the five whistleblowers who received professional reprisals, but did not suffer physical problems, was the fact that they all received strong support from family and friends. Wilkinson's (1987/88) study concurs with the importance of peer support to decrease stress at work. It seems

reasonable to accept that the combination of a good support system and a strong moral conviction could offer protection from stress-induced illness.

Nurses Who Experienced Physical Problems But Had No Professional Consequences.

Finally, this research found that 18 members of the sample suffered physical ill health, but suffered no professional consequences. This is adequately explained in literature that demonstrates how stress-induced conditions can be apparent even when there are no overt reprisals (Holly, 1993; Wilkinson, 1987/88).

Whistleblowing vs Non-Whistleblowing.

The results suggest that being in a whistleblowing situation causes stress-induced physical problems *whether one blows the whistle or not*. It would seem reasonable to expect that non-whistleblowers would suffer fewer symptoms than whistleblowers, since they were not "rocking the boat". However, this research did not find that to be the case. At times, a higher percentage of whistleblowers experienced the symptom, but even then, it was not a huge difference. For example, the symptoms that were experienced by the most whistleblowers (restless sleep, fatigue, headache, insomnia, and exhaustion) were also experienced by a similarly high percentage of non-whistleblowers.

There were three physical effects that were very different for whistleblowers and non-whistleblowers which cannot be explained by the data or literature. There was a wide disparity in the abdominal pain experienced by non-whistleblowers (12%) and whistleblowers (4%), and there was a difference in the weight gain and loss of participants. Many whistleblowers (10%) suffered weight loss, while no non-whistleblowers reported weight loss. On the other hand, more non-whistleblowers (12%) suffered weight gain, compared to only four per cent of whistleblowers. That

was not the case in De Maria's research which found that 13% of whistleblowers experienced weight gain, and only four per cent experienced weight loss.

It is possible that the response bias towards whistleblowers (n=70) and non-whistleblowers (n=25) led to the findings in this study. It could also be reflective of individual differences regarding behaviour and coping mechanisms. However, there is the explanation that people who gain weight from conditions such as bulimia resort to overeating because of powerlessness and control issues (ARAFMI, n.d.). That corresponds to this research which suggests that non-whistleblowers felt powerless, and although non-whistleblowers denied bulimia, it could account for the higher number who experienced weight gain. However, it is beyond the scope of this study to do more than pose the question.

Summary.

Seventy per cent of whistleblowers reported physical ill health which they believed was caused by the stress of reporting misconduct at work. Speaking up against the status quo is known to threaten job security, so the physical conditions whistleblowers reported may have been experienced when they risked their career to report the wrongdoing.

A surprising result is that nurses who did not blow the whistle also suffered physical problems. That is best understood in context with Lazarus and Folkman's (1984) model that describes how 'inaction' can be as stressful as 'action' if personal values have been compromised.

Twenty-eight nurses reported that they did not experience any physical problems, and the discussion then examined whether those whistleblowers had experienced professional problems, since job insecurity is known to cause stress-induced physical problems. It found that 23 of the 28 whistleblowers who reported

no physical problems, reported no professional problems either. The five nurses who reported no physical problems, but **had** professional problems, were shown to share two common characteristics; they had a strong conviction in the rightness of their action, and they had a strong support system.

Being in a whistleblowing situation causes stress-induced physical problems whether one blows the whistle or not. At times a higher percentage of whistleblowers experienced the physical symptom, but there was not a large difference, and the symptoms that were experienced by the most whistleblowers (restless sleep, fatigue, headache, insomnia and exhaustion) were experienced by a similarly high percentage of non-whistleblowers.

The Emotional Effects of Identifying Misconduct at Work

The emotional effect of being involved in a whistleblower situation was devastating for the participants of this study, whether they blew the whistle on misconduct or remained silent. Ninety four per cent of whistleblowers (n=70) and 92% of non-whistleblowers (n=25) reported stress-related emotional problems from their whistleblowing experience. Those high numbers are consistent with the percentage of whistleblowers in other studies who suffered emotional deterioration from blowing the whistle: De Maria, (n=81), 80%; Soeken, (n=84), 86%; Lennane, (n=35), 83%.

It would seem logical that non-whistleblowers would suffer fewer emotional symptoms, since they did not step outside the 'expectations of the group', and they were not harmed professionally. But that was not the case. Non-whistleblowers received just as many emotional symptoms as whistleblowers. In fact, in some areas, non-whistleblowers experienced *more* emotional symptoms than whistleblowers.

Therefore, remaining silent in the face of misconduct, does **not** seem to protect one from emotional pain. In order to present the discussion in a clear format, the subject headings from the results chapter has been retained.

Feelings of Anger.

Anger was the predominate emotion reported by nurses in this study when they identified misconduct at work. Sixty-six per cent of whistleblowers (n=70) and 72% of non-whistleblowers (n=25) experienced anger. That is comparable to Soeken's whistleblower study (n=84) which found that 80% of the sample experienced anger. In addition, many patient advocacy studies agree that anger is the predominate emotion experienced by nurses when they are prevented from acting as patient advocates (Chafey et al., 1998; Duncan, 1992; Erlen & Frost, 1991; Holly, 1993; Kusnir et al., 1997; Pike, 1991; Wilkinson, 1987/88).

This study listed anger as an emotion, but also included different facets of anger such as bitterness, cynicism and retaliatory thoughts. It is compelling that whistleblowers felt one type of anger, while non-whistleblowers felt another type. For example, more whistleblowers reported feeling bitter and cynical, while more non-whistleblowers felt anger and had thoughts of retaliation. Possible explanations for those findings are offered, based on the literature and the conceptual model that guided this research, namely Lazarus and Folkman's (1984) Model of Stress and Coping.

It makes sense that more whistleblowers reported feeling bitter, since bitterness is an emotion that is experienced when an event has caused negative consequences (Lazarus and Folkman, 1984). That certainly defines this sample, since *all* of the whistleblowers who reported feeling bitter (13%) experienced professional reprisals. It is helpful to remember that most whistleblowers expect

management to be grateful for being informed of wrong doing (De Maria, 1994; Dempster, 1997; Glazer & Glazer, 1989). In fact, "the last thing whistleblowers expect after 'doing the right thing' is to be castigated by superiors" (De Maria, 1994, p.15). Therefore, it makes sense that some whistleblowers in this study felt bitter when they were *rebuked* for informing their managers of misconduct. To make matters worse, the punishment meted out to this particular group of whistleblowers was extraordinarily severe. They all received some form of official reprisal (demotion, transfer, reprimand, referral to a psychiatrist), as well as many unofficial reprisals (isolation, threats, ostracism, pressure to resign).

Cynicism is related to bitterness in that it is an emotion experienced *after* an event is over, and is usually experienced because one has learned not to expect a positive outcome (Lazarus & Folkman, 1984). That would explain why over 20% of whistleblowers and non-whistleblowers in this study reported feeling cynical since, in most circumstances, the misconduct continued unchanged and nothing happened to the wrongdoers. De Maria (1994) offered an explanation as to why whistleblowers felt cynical when justice was not done. He compared the work values of whistleblowers with those of other employees and found that whistleblowers possessed an altruistic attitude that was absent in employees who worked for money or status. For one thing, whistleblowers were committed to the belief that their work was ***contributing to the welfare of their society*** (p. 63). This research suggests that nurses are similarly motivated, in that they are committed to a code of ethics which requires altruism in the form of patient advocacy. Therefore, it is possible that when the nurses in this study had their commitment threatened, they developed feelings of bitterness and cynicism in response to their thwarted ability to act as patient advocates. Lazarus and Folkman (1984) confirm that bitterness and

cynicism are two emotions which are experienced when commitments are threatened. A good example of that in this study is a whistleblower (case #43) who felt bitter and cynical when no action was taken after her report of illegal medication activity. She said, "Nothing changed. It has made me cynical about nursing in general. I now sell myself to the highest bidder through an agency."

It is interesting that a higher percentage of non-whistleblowers felt angry than whistleblowers. The explanation for such a finding can best be discussed in reference to stress/anger studies (Linden et al., 1997; Smith et al., 1996; Thomas & Williams, 1991) and patient advocacy studies (Duncan, 1992; Erlen & Frost, 1991; Holly, 1993; Wilkinson, 1987/88). Lack of support and a feeling of powerlessness were given as primary reasons for nurses to feel anger (Smith et al., 1996) and suppressed anger was found to provoke the highest rate of emotional ill health (Thomas & Williams, 1991). Since non-whistleblowers did not *directly* express the anger they felt when they identified misconduct, it is likely that they experienced a higher rate of *suppressed* anger. That analysis is supported by the theoretical model which guided this research. According to Lazarus and Folkman (1984) suppressed anger ("anger-in") is felt when a person ignores or denies emotionally significant events. The model demonstrates how a person can initially succeed in lowering emotional distress by denying or avoiding an unpleasant encounter, but that such denial (a form of "emotion-focused coping") prevents the person from responding with suitable action. The result is emotional and physical ill health, including self-blame, and anger at self and others. A good example of that in this study is a non-whistleblower (case # 29) who believed her non-action was the cause of migraine headaches and nineteen emotional symptoms, including many related to suppressed anger.

Nurses who wanted to act as patient advocates, but were prevented from doing so by internal or external constraints, described feeling 'angry' and 'powerless' (Duncan, 1992; Erlen & Frost, 1991; Holly, 1993; Mohr, 1996; Soderberg and Norberg, 1993; Uden et al., 1992; Wilkinson, 1987/88). In fact, anger caused by feelings of powerlessness is a pervasive and distressing theme in patient advocacy literature. In this study, powerlessness was experienced by an equal percentage of whistleblowers and non-whistleblowers (16%). Both whistleblower and patient advocacy studies cite powerlessness as an emotion experienced by participants. Eleven per cent of De Maria's (1994) whistleblowers felt powerless, and both Lennane (1993) and Hunt (1995) indicate that their participants felt powerless. According to nursing research, patient advocates who agonised over whether to report misconduct felt powerless in the face of a vastly more powerful system (Holly, 1993; Mohr, 1996; Pike, 1991; Soderberg & Norberg 1993; Uden et al., 1992; Wilkinson, 1987/88).

Some authors suggest that nurses feel powerless because of their organisation's unequal power structure (Mohr, 1996; Thomas and Droppleman, 1997) and others expand on that by describing a lack of support within nursing management (Erlen and Frost, 1991; Holly, 1993; Smith et al., 1996). When some nurses in this study exercised power by reporting wrongdoing, they were met with strong resistance from their organisation, and **no** support from nursing management or colleagues. On top of that, they received professional reprisals for their actions, and were threatened with job loss, demotion and ostracism. In the face of such opposition, it would appear that their feelings of powerlessness were justified!

However, if nurses in this study *had* felt supported, would their perception of powerlessness been different? It seems possible, since 58 nurses (n=80) believed

they **had** support from colleagues and/or supervisors and they did **not** report feeling powerless, whereas all 15 nurses who reported feeling powerless, also reported that they had **no** support from colleagues and/or supervisors. That is consistent with the theoretical model that guided this research which confirms that people have better adaptational outcomes if they receive or believe that they will receive support when it is needed (Lazarus and Folkman, 1984).

Another explanation as to why nurses feel powerless is that they have feelings of inadequacy and subservience (Pike, 1991; Thomas & Droppleman, 1997). Bush (1988) and Erlen and Frost (1991) found that inadequacy (and hence, perception of powerlessness) was felt more often by older age nurses (over 55) and nurses with less education (under a baccalaureate degree). That was not the case in this study, where powerlessness was perceived regardless of age or educational preparation.

However, it is worthwhile to explore the issue of subservience as it relates to powerlessness. Many of the nurses in this study referred to 'more powerful others' when discussing their vulnerability in the whistleblowing situation. Nurses in other studies reported feeling subservient to others, especially physicians and administrative hierachies (Chafey et al., 1998; Duncan, 1992; Erlen and Frost, 1991; Holly, 1993; Kushnir et al., 1997; Pike, 1991; Segesten, 1993). According to Lazarus and Folkman (1984) a factor that predicts how people will respond to a stressful event is their feeling of 'vulnerability', which affects their readiness to react to stressful situations. It is possible that the nurses in this study who felt subservient to 'more powerful others' were responding to feelings of vulnerability. This is consistent with the findings of patient advocacy studies which describe the subservience and powerlessness felt by nurses in ethical dilemmas (Chafey et al.,

1998; Duncan, 1992; Erlen and Frost, 1991; Holly, 1993; Kushnir et al., 1997; Pike, 1991; Segesten, 1993).

Smith et al. (1996) suggested that nurses must overcome inhibiting factors such as perceived inadequacy and powerlessness before they can manage their anger effectively. Thomas and Droppleman (1997) found that females are not socialised to express anger assertively and therefore respond to stressful events with avoidance or denial. However, that was not the case with the participants in this study. The majority of nurses who reported feeling powerless, *nevertheless* responded to the whistleblowing event with assertive action. Such courage should be considered exemplary in view of their reported feelings of overwhelming powerlessness.

Feelings of Sadness.

Most of the feelings in this category were experienced by a higher percentage of non-whistleblowers, and those few that were felt by more whistleblowers could be related to the professional consequences of the experience. For example, coping difficulties, and disillusionment were felt by more whistleblowers, but all of those whistleblowers had a high number of professional reprisals. Therefore, it is understandable that whistleblowers who had had their career threatened and were ostracised by colleagues, would find it difficult to cope and would feel disillusioned. Many patient advocacy studies reported that nurses felt disillusioned when they were restrained from acting as patient advocates (Chafey et al., 1998; Duncan, 1992; Erlen and Frost, 1991; Holly, 1993; Kushnir et al., 1997; Mohr, 1996; Pike, 1991; Segesten, 1993).

Of concern are the nurses in this study who reported a deterioration of personal values. Although small in number, the emotional toll of such a consequence is great. According to the theoretical model that guided this research, a

threat to one's values and beliefs causes severe stress leading to physical and emotional problems (Lazarus and Folkman, 1984). Mohr (1996) found that the intense suffering of her participants was caused by pressure from administration to ignore the voice of their own value system. Wilkinson (1987/88) used the term 'moral anguish' to describe the suffering of nurses who went against their code of ethics.

The participants in this study who reported "a deterioration of personal values" did not respond to the whistleblowing event according to their ethical standards. For example, case #11 did not report a serious incident because she "did not want to cop the flack from those who perpetrated the deed", and case #24 covered up an event that required legal action. Both nurses now report that they feel "damaged" by the experience, and both would recommend others to "speak up early, speak up honestly and follow one's own judgement."

The case studies above offer a good example of how well the conceptual model was able to predict the stress reaction of respondents who did not uphold their personal values. The theory that guided this research suggested that if a stressful encounter interfered with a strongly held commitment, it was evaluated in terms of how far one would be willing to go to uphold the commitment. Not to uphold the commitment would result in a loss of self-esteem and a threat to one's value system. This research confirmed that nurses valued their commitment to the Code of Practice and those who reported a deterioration of personal values did so because they felt they had not upheld their commitment.

Feelings of Fear.

One would expect whistleblowers to feel fear and intimidation since they are the ones who risk their career to report misconduct. However, the same percentage

of non-whistleblowers in this study reported fear and intimidation, which leads one to the conclusion that a whistleblowing situation causes fear whether one chooses to blow the whistle or not. Duncan (1992) and Segesten (1993) support this analysis, finding that nurses are fearful in their role as patient advocates because they *know* that it could involve a risk to their employment or a risk of being punished. The findings of Mohr (1996), Watt (1997) and Chafey et al. (1998) concur and indicate that fear of job loss is the primary reason patient advocacy does **not** always occur. A good example of that in this study is a non-whistleblower (case # 37) who chose to remain silent because she feared "job loss, being labelled a dobber, and maybe being rejected". Another nurse, this time a whistleblower (case #14), felt fear, intimidation and stress when she reported the dangerous misconduct of a physician. She acknowledged that her fear was tied to the possibility of negative consequences: "I feared nothing would happen to the wrongdoer, but I would be penalised."

Such fear is understandable in view of the alarming list of professional reprisals meted out to nurse whistleblowers in this study. As the literature review pointed out, fear of retribution is what causes stress in whistleblowing situations (De Maria, 1994; Lennane, 1993; Linden et al., 1997; Simoni and Paterson, 1997). In this study, the anxiety caused by such a serious fear was high. Forty-three per cent of whistleblowers and 40% of non-whistleblowers reported anxiety. According to De Maria (1994), 56% of his whistleblowers felt anxiety, and patient advocacy studies report that anxiety is the predominate emotion experienced by nurses in ethical dilemmas (Chafey et al., 1998; Duncan, 1992; Holly, 1993; Mohr, 1996; Pike, 1991; Segesten, 1993; Soderberg & Norberg, 1993; Watt, 1997; Wilkinson, 1987/88).

An interesting finding related to fear and anxiety is that a greater percentage of non-whistleblowers reported that they "constantly relived the whistleblowing

experience". It is a common human response to mull over an event when the outcome has been unsatisfactory, so it is possible that non-whistleblowers were re-evaluating their role in the experience. A non-whistleblower in this study (case #82) reported that although the misconduct she identified occurred in 1987, she "constantly relives the experience", and regrets the fact that she did not "rectify the situation at the time".

Feelings of Unworthiness.

Emotional problems associated with a feeling of unworthiness include guilt, shame, unworthiness, self-doubt, helplessness, loss of confidence, loss of self-esteem and suicidal thoughts. Interestingly, all of those emotions were experienced by more non-whistleblowers than whistleblowers. Therefore, it would seem that when faced with an ethical dilemma, *taking action,* rather than *remaining silent*, provides better protection from feelings of unworthiness. For example, 40% of nurses who remained silent suffered guilt and shame, compared to only 19% of nurses who took action by blowing the whistle. Clearly, it appears that *attempting* to stop a wrong made the whistleblowers feel less guilty than the non-whistleblowers who took no action.

It takes courage to respond to a situation that involves personal and professional risks. Besides for the trauma of ostracism and rejection, institutions can subject an employee to the ultimate reprisal, loss of employment. Edwards (1996) suggests that nurses should *not* be expected to blow the whistle on misconduct if that action places their own well being in jeopardy. However, this study has shown that a high percentage of nurses who did *not* blow the whistle *nevertheless* suffered adverse consequences, especially strong feelings of guilt and shame.

This finding is similar to Soderberg & Norberg (1993) and Mohr (1996) who found that nurses were ashamed of the care they provided when they did not have the

courage or influence to change things. Wilkinson (1987/88) found that nurses who lacked the courage to follow their moral decisions felt guilt and self-doubt. Other authors used the terms 'loss of self-esteem' and 'loss of confidence' to describe the feelings of nurses who were prevented from acting as patient advocates (Chafey et al., 1998; Holly 1993; Uden, et al., 1992; Watt, 1997). Those are all terms used by nurses in this study to describe their feelings of unworthiness. A good example of the devastating effects of guilt and shame is demonstrated by Case # 4, a nurse who was forced to change her chart notes concerning a baby who was "killed". The incident occurred 18 years ago, yet the nurse continues to feel guilty about the incident and thinks about it "at least every three weeks". She reported that she still has "sleepless nights" caused by her regret at not having the courage to report the incident to the highest possible powers.

Feelings Related to the Workplace.

According to Hunt (1995) and De Maria (1994) whistleblowers *begin* the process of reporting misconduct with the belief that managers will hasten to correct the wrong once they know about it. As this study, and other whistleblower studies have shown, misconduct in the workplace is not always corrected, and wrong doers are not always stopped. Instead, a "shoot the messenger" response is likely to occur and the whistleblower is the one subjected to reprisals.

Therefore, it should come as no surprise that whistleblowers experienced many negative feelings related to their job. Approximately 40% of whistleblowers reported that they had lost satisfaction in their job, and had lost respect for their workplace. In view of the many professional reprisals whistleblowers received, it seems reasonable that they would feel let down by their employer.

However, this research suggests that receiving professional reprisals was not the only reason that nurse whistleblowers felt a lack of respect and satisfaction at work. Several researchers have shown that nurses are committed to a code of ethics, and when they are constrained from upholding those ethics, they lose respect and satisfaction for their work (Duncan, 1992; Holly, 1993; Mohr, 1996; Wilkinson, 1987/88). That is perhaps why so many whistleblowers (24%) and non-whistleblowers (24%) in this study reported a reduced commitment to their work.

The conceptual model which guided this research offers an explanation for that result. According to Lazarus and Folkman (1984), the most damaging life events are those in which commitments are threatened or lost. When whistleblowers and non-whistleblowers were unable to stop the misconduct they identified, their commitment to their code of practice was threatened, and in some cases, lost. The conceptual model suggests that would cause a reduced commitment to work, since a nurse's commitment to work is *based* on her code of practice. A sad example of this is case #56, a whistleblower who reported that she no longer "gets as involved in patient care" because she was so "personally and professionally damaged" from her whistleblowing experience.

More whistleblowers felt uncertain about their future than non-whistleblowers. This is logical, since whistleblowers were the ones who received the majority of professional reprisals. In fact, 14 whistleblowers reported feeling uncertain about their future, and they received a total of 58 negative professional reprisals. Some of those reprisals were punishments that were directly related to their future employment, such as dismissal, demotion, reprimand and punitive transfer. Many were physically isolated from peers, socially ostracised, treated as a traitor and had their career prospects dashed. With such a grim list of professional

punishment for blowing the whistle, it is not surprising that the whistleblowers were uncertain about their future.

On the other hand, two whistleblowers (case #24 and case #37) were praised for their whistleblowing action, yet they both reported that they were uncertain about their future. A closer look at their responses indicates that they were both deeply traumatised by the misconduct they witnessed, and are considering leaving the profession of nursing. Therefore, it was *not* punishment, or lack of support which made them uncertain about their future in nursing, but rather because their personal values were offended. That is consistent with the stress model of Lazarus and Folkman (1984), which indicates that actions which offend personal values create "fight or flight" reactions.

Summary.

The emotional effect of being involved in a whistleblower situation was devastating for the participants in this study whether they blew the whistle on misconduct or remained silent. Non-whistleblowers received just as many emotional symptoms as whistleblowers, and in some areas, non-whistleblowers experienced *more* emotional symptoms than whistleblowers. For example, a higher percentage of non-whistleblowers reported experiencing feelings of shame, guilt, unworthiness, self-doubt, helplessness, loss of confidence, loss of self-esteem and suicidal thoughts. According to the theoretical framework which guided this research, a possible explanation for that is that *taking action*, rather than *remaining silent*, provides better protection from feelings of unworthiness.

Anger was the predominate emotion reported by nurses in this study, and again, a higher percentage of non-whistleblowers experienced anger than whistleblowers. Suppressed anger was shown to provoke ill health (Thomas &

Williams, 1991), and it was considered likely that non-whistleblowers experienced suppressed anger because they did not *directly* express the anger they felt when they identified misconduct.

Nurses who felt supported by colleagues and/or supervisors did not report feeling powerless, whereas nurses with no support system reported feeling powerless. Many of the nurses in this study referred to 'more powerful others', and according a studies on subservience and powerlessness, the expected response would be avoidance (Smith et al., 1996; Thomas & Droppleman, 1997). But that was not the case. The majority of nurses who reported feeling powerless, nevertheless responded to the whistleblowing event with assertive action.

The conceptual model was able to predict the stress reaction of respondents who did not uphold their personal values. The theory suggested that if a stressful encounter interfered with a strongly held commitment, it was evaluated in terms of how far one would be willing to go uphold the commitment. This research confirmed that nurses valued commitment to the code of practice, and those who reported a 'deterioration of personal values' did so because they felt they had not upheld their commitment.

The same percentage of whistleblowers and non-whistleblowers reported fear and intimidation, which leads one to the conclusion that a whistleblowing situation causes fear whether one chooses to blow the whistle or not. This is understandable, since most participants feared retribution, and the alarming list of professional reprisals experienced by whistleblowers indicates that the fear was realistic.

A higher percentage of whistleblowers had negative feelings related to their workplace, and that was expected since many of them received professional reprisals for doing what they believed was the *right* thing to do.

The Professional Effect of Identifying Misconduct at Work

This study confirmed previous findings (Chafey et al., 1998; Dempster, 1997; De Maria, 1994; Duncan, 1992;Glazer & Glazer, 1989; Hunt, 1995; Johnstone, 1994; Kiely & Kiely, 1987; Lennane, 1993; Mohr, 1996; Watt, 1997) that blowing the whistle on misconduct is a risky action that leads to many professional reprisals. The whistleblowers who suffered professional effects (n=63) suffered 138 negative reprisals, including demotion, reprimand, transfer, threats and referral to a psychiatrist. The reprisals are so similar to those received by whistleblowers in other studies that when they are viewed together, a formidable picture emerges of the sort of treatment whistleblowers can expect. It is worthwhile to keep in mind that the whistleblowers depicted in Table 11 all worked in different organisations, even in different countries, yet the reprisals meted out to them were identical.

Table 11

Reprisals Received by Whistleblowers in Different Studies

Reprisal	ThisStudy(n=63) % of W/B	DeMaria(n=72) % of W/B	Lennane(n=31) % of W/B	Soekin (n=87) % of W/B
Demotion	5	8	16	31
Refer to Psych.	10	22	42	26
Threatened	19	18	14	
Forced Transfer	3	31	16	44
Reprimand	13	39		
Isolation	20	31	26	
Scrutiny/work	29	55	29	21
Ostracism	32	23	26	

Non-whistleblowers reported few professional consequences from being involved in a whistleblowing situation and that was expected since they did not test management's reaction by speaking up. However, this finding is interesting because it is contrary to the results concerning the physical and emotional effects of non-whistleblowing. In both the physical and emotional areas of this study, non-whistleblowers were found to experience as many, or *more,* negative effects than whistleblowers. But *professionally*, non-whistleblowers experienced few negative effects.

In this study, only two non-whistleblowers reported serious professional effects: one (case #56) was punitively transferred for reporting a physician "in confidence", and one (case #29) felt 'pressured to resign' because "senior public servants were too difficult to report." All of the other reports of professional reprisals were made by whistleblowers. For that reason, the following discussion will concern the professional reprisals experienced exclusively by whistleblowers.

Official Reprisals.

For this study, official reprisals consist of formal workplace procedures used to discipline employees. No whistleblowers were dismissed, but other official reprisals reported were reprimand (verbal and written), demotion, suspension and referral to a psychiatrist. Twenty-eight per cent of the whistleblowers received official reprisals for reporting misconduct.

Being formally reprimanded was a widely used strategy and that was also true in De Maria's (1994) study of whistleblowers. De Maria suggests that the reprimand strategy is popular because it shocks the whistleblower into understanding that he/she has betrayed the organisation's "requirement for loyalty". Furthermore, "writing-up" employees is easily executed, and strongly intimidating because

reprimands become part of an employee's permanent file, which affect career advancement.

Three whistleblowers were demoted and/or punitively transferred. According to Lazarus and Folkman (1984), both of those events produce major stress, so it is understandable that whistleblowers who were demoted or punitively transferred would suffer many stress-induced symptoms. For example, case # 38 suffered 19 physical symptoms and 42 emotional symptoms, including suicidal thoughts, after she was demoted and transferred for reporting misconduct. The other whistleblowers in this study who were demoted or transferred also reported a large number of physical and emotional symptoms. According to Kiely and Kiely (1987) demotion and reassignment are retaliatory actions that not only affect the whistleblower, but also serve as a warning to potential supporters of the whistleblower. Mohr (1996) described the experience of an outspoken nurse whose concern over patient care was "silenced" when she was reassigned to weekends. Supportive peers of the nurse were given the clear message that they would receive the same treatment if they continued to support her.

De Maria (1994) confirmed that transferring an employee to the 'back of beyond' was the second most common form of reprisal. He also suggests that it provokes a double dose of stress because "transfers, tense experiences in themselves, become even more stressful when the move is ordered out of vindictiveness" (p. 15). Lazarus and Folkman's (1984) position is that a job transfer falls into the stressful category of a "major life event", and therefore the stress associated with it is contingent on circumstantial factors (ie, is the change good for future employment or is it a threat?). Obviously, a punitive transfer would be associated with high levels of stress.

Ten per cent of the whistleblowers in this study were referred to a pyschiatrist for evaluation. According to De Maria (1994) that is a particularly nasty form of punishment since it questions the motivation and sanity of the whistleblower. He suggests that whistleblowers find it intolerable because, as a group, they are known to value honesty and integrity. Furthermore, De Maria believes that being referred to a psychiatrist is a no-win form of punishment for whistleblowers: if they agree to be evaluated, management assumes they have mental problems, but if they refuse to be evaluated, management believes they are uncooperative. Referral to a psychiatrist is also intimidating because it employs the "victim blaming" strategy which insinuates that it is the whistleblower, **not** the system, who is the "sick" one. De Maria described whistleblowers who were given a "psychiatric diagnosis" because they expressed negative feelings to the psychiatrist about being referred to a psychiatrist!

This research could not account for the fact that, in other studies, a higher percentage of whistleblowers were referred to a psychiatrist. A possible, though sinister, explanation may be that this study involved a predominantly female sample, and it was simply easier to intimidate them with unofficial reprisals. De Maria (1994) and Lennane (1993) found that twice as many males become whistleblowers, and questions whether females still find it hard to assert themselves in the workplace. People who feel subordinate and/or oppressed are easily intimidated by more powerful others. There is ample evidence in the literature that nurses feel powerless and that their powerlessness is triggered by feelings of low self-esteem, fear of job loss, lack of autonomy and being in a subordinate position (Bush, 1988; Chafey et al., 1998; Erlen & Frost, 1991; Holly, 1993; Pike, 1991; Thomas & Droppleman, 1997; Wilkinson, 1987/88).

Another explanation for the fact that this study reported a low percentage of whistleblowers who were referred to a psychiatrist is that these participants all worked in the medical field. Perhaps managers believed the reprisal would not be intimidating because of the nurse's professional knowledge. Hunt's (1995) whistleblower study concerned subjects employed in a hospital setting and he does not mention referral to a psychiatrist as a reprisal for whistleblowing.

Unofficial Reprisals, Threats and Ostracism

In all of the whistleblower studies examined, it was clear that unofficial reprisals were the most common form of punishment. They are informal tactics used by employers to silence or intimidate whistleblowers. They differ from *official* reprisals because they do not follow the formal procedures required when an employer wants to dismiss or demote an employee. According to Fiesta (1990), it is not that easy to discharge workers without documenting "just cause". However, *unofficial* reprisals are easily executed and work quickly to reign in a 'dissenter'. Unofficial reprisals are actions such *threatening* the whistleblower with dismissal (or punitive transfer or legal action), labeling them ("traitor, trouble-maker"), and ostracising or discounting them. A common reprisal used by employers in whistleblower cases was to pressure the whistleblower to resign, sometimes by such acts as scrutinising their work, giving them impossible or menial tasks, and/or halting their chance of career advancement.

It is disturbing to put the results of this study next to the results of other whistleblower studies, for a clear picture of victimisation emerges. Of the whistleblowers in this study who were professional affected, 100% reported 'unofficial reprisals' for blowing the whistle on misconduct. That high number is consistent with other whistleblower studies, which found that 97% reported

'unofficial reprisals' (De Maria, 1994; Lennane, 1993). Incredibly, the form of the punishment (threats, isolation, ostracism and pressure to resign) followed the same "blueprint", as managers in many different settings used identical tactics to silence whistleblowers.

In examining the toll of unofficial reprisals experienced by whistleblowers in this study, it appears that there were four major ways in which whistleblowers were punished: they received workplace harrassment, and they were discounted, threatened and ostracised. That is consistent with findings from other whistleblower research (De Maria, 1994; Hunt, 1995; Lennane, 1993) and from patient advocacy literature (Anderson, 1990; Fahy, 1992; Kiely & Kiely, 1987; Mohr, 1996).

Attacks on job security constitute one of the greatest workplace stressors (De Maria, 1994), so *threats* of dismissal, transfer or legal action would be expected to cause fear and intimidation. Poignant descriptions of the stressfulness of the threats were offered by some of the whistleblowers in this study. Case #38 described the powerlessness and hopelessness she felt when threatened with dismissal and transfer. Case #25 reported that the threats and harrassment she experienced were expected because "very senior people were involved", but that the ordeal was, nevertheless, very intimidating.

De Maria (1994) suggests that the covert intention behind threats, as well as behind other reprisal tactics, is to make the work situation so intolerable that the whistleblower resigns. That was evident in this study; all of the nurses who felt 'pressured to resign', also reported other forms of professional harassment. One of the most frequent and "worst" reprisals experienced by De Maria's participants was physical isolation. Lennane (1993) agreed, finding that separating the whistleblower from supportive peers was almost "diagnostic" it was reported so frequently by

whistleblowers. De Maria examined the work values of whistleblowers and believes that the reason physical isolation is so intolerable to them is that it directly attacks their sense of achievement, use of work knowledge and desire to contribute to the welfare of society. A whistleblower in this study who was isolated from peers (case # 40) was so offended by her treatment that she continues to think about it, even though it occurred 12 years ago. She reported that she was "sent to Coventry", "ignored" and "verbally attacked by peers" for reporting a popular nurse who had "geriatric patients living in fear of her bad moods and physical assaults".

Ostracism as a form of professional reprisal is similar to isolation, but different in important ways. To *isolate* dissenters, management moves them to an area that is usually remote and away from known supporters. To ostracise an employee, management ensures that it is the *supporters* who are (emotionally) removed. That is done by giving clear signals to the group that the dissenter is a "traitor" or a "trouble-maker", and if they want to preserve their own jobs, they must socially reject the dissenter (Anderson, 1990; Kiely & Kiely, 1987). Thirty-two per cent of the whistleblowers in this study were ostracised and/or treated as traitors. De Maria (1994) and Lennane (1993) found ostracism a common form of professional reprisal, as did Mohr's (1996) participants, though they termed it "shunning".

Another form of ostracism used in this study to denigrate whistleblowers was to discount and discredit them. According to the theoretical model that guided this research, such disapproval would be an expected punishment for people who did not conform to social rules (in this case, management's expectation of group loyalty). Disapproval threatens the individual's need to belong, and may endanger life-sustaining goals (i.e., a job). If the conflict involves a strongly held value, as it

obviously did in this study, then the model would predict the situation to be perceived as extremely stressful.

All of the studies on whistleblowing and most of the research on patient advocacy found that speaking out incurred stressful disapproval. Seventy-seven per cent of the whistleblowers in this study were subjected to managerial attacks on their credibility, integrity and emotional stability. They were ignored, told to forget it, told they were imagining things and ridiculed. Most upsetting, their motives for reporting the misconduct were questioned, and their integrity was debased. De Maria (1994) found that 82% of his whistleblowers were likewise denigrated. Mohr (1996) described how managers labeled patient advocates as troublemakers, and used decidedly nasty tactics to dishonour them (for example, filed false charges to the Nurses Board against them). Holly (1993) and Wilkinson (1987/88) gave examples of the way a nurse's professional integrity would be assaulted if he/she stood firm on advocacy issues. Kushnir et al., (1997) discussed how nurses were discredited when they were refused decision-making powers on important issues.

Further accounts of the denigration meted out to nurses who speak up are possible, but for these purposes, it is enough to acknowledge that professional rebukes of this kind are common. In this study, they provoked many poignant descriptions of emotional pain reported by nurses who believed they were "doing the right thing". Less self-reliant people might have backed down in the face of such hostility, but their motivation to pursue justice was stronger than their fear of reprisal. Such qualities are described in research that examined the psychological make-up of whistleblowers. It was found that as a group they value personal honour, and their self-worth is crucially linked to their occupation (De Maria, 1994; Dempster, 1997; Glazer & Glazer, 1989). Therefore, attacks on their credibility, and

having their name and reputation damaged is particularly painful for them. They are, in fact, traumatised by the experience. From the many personal reports in this study, and in many other studies, it is apparent that few whistleblowers escape the experience without evidence of long-term emotional effects.

It is alarming to see such a clear portrait of organisational retribution laid against loyal employees. Although the studies mentioned differ on important matters such as method and sample size, they report a similar profile of reprisals, with the devious intent to discredit people who report misconduct. The studies occurred in many different environments, in different parts of the world, yet management's *modus operandi* was the same. Initially the whistleblower was reassured, delayed, obfuscated or ignored. If the whistleblower persisted, professional discipline occurred in the form of identical, mean-spirited reprisals. The lesson to be learned was that any behaviour which threatened group norms would be severely punished with rejection and abandonment.

Clearly, such professional recriminations for blowing the whistle were devastating for the nurses in this study. Those who had the courage to report misconduct suffered profound professional effects. Furthermore, the effects they suffered were identical to those suffered by whistleblowers and patient advocates in many other studies. To explain that phenomenon, this research suggests that universal *social demands*, as defined in the theoretical model which guided this study, present a predictable 'formula' that is followed by organisations to silence people who do not conform to the group norm, in this case, whistleblowers.

Summary.

Whistleblowers in this study received many professional reprisals for reporting misconduct in the workforce. Some of the consequences were considered

'official reprisals', and some were 'unofficial reprisals'. Official sanctions consisted of formal workplace procedures used to discipline employees such as reprimand, demotion, suspension, and referral to a psychiatrist. Unofficial reprisals were informal tactics used to silence whistleblowers such as threats to job security, threats of legal action, ostracism, isolation, and pressure to resign.

Twenty-eight per cent of whistleblowers received official reprisals for reporting misconduct. Reprimand was used to shock the whistleblower into understanding that he/she had betrayed the organisations' requirement for loyalty. Whistleblowers were also 'transferred' to remote areas away from supportive colleagues, and ten per cent were referred to psychiatrists for evaluation. Referral to a psychiatrist is intimidating because it employs the 'victim blaming' strategy which insinuates that it is the whistleblower who is 'sick', not the system.

All of the whistleblowers in this study reported that they experienced unofficial reprisals from their employer when they reported misconduct. Attacks on job security by threats, ostracism and isolation were used to pressure the whistleblower to resign. Seventy-seven per cent of whistleblowers were subjected to managerial attacks on their credibility, integrity and emotional stability. Thirty two per cent of the whistleblowers were ostracised and/or treated as traitors, and these forms of reprisals were seen to be especially difficult for whistleblowers because their self-worth and integrity are crucially linked to their occupation.

Non-whistleblowers reported few professional effects, which was expected since they did not test management's reaction by speaking up.

Ways of Coping and Coping Effectiveness

Because this section concerns the coping behaviours of nurses who were in a stressful (whistleblowing) situation, it is best to discuss their responses in context with Lazarus and Folkman's (1984) stress-coping model. The coping behaviours reported by nurses in this study were taken from Lazarus and Folkman's Ways of Coping checklist, and include problem-focused behaviors and emotion-focused behavious. Coping strategies that are problem-focused are those that define the problem, weigh the alternatives, generate solutions and follow an action. Actions such as "I talked to someone who could do something about the problem" and "I stood my ground and fought for the right thing" are problem-focused coping behaviours. Emotion-focused behaviours are coping strategies such as avoidance, minimization and distancing (among others). Actions such as, "I avoided the patient and/or people involved" and "I got away from it, took time off, or went on a holiday" are examples of emotion-focused coping.

To understand why certain coping behaviours were considered effective, and others ineffective, it is helpful to examine what *worked.* The four coping behaviours which were perceived to be effective by whistleblowers were: (1) stood my ground and fought for what I thought was the right thing to do (2) talked to someone who could do something about the problem (3) asked a friend and relative for support and advice and (4) drew on past experiences to come up with a way to handle the problem. According to Lazarus and Folkman, all of those actions are 'problem-focused' behaviours, and in order to use such strategies, certain personal and environmental resources must be in place.

For example, 'standing one's ground' and 'talking to someone who could remedy the problem' are both actions which require conviction, assertiveness and

self-confidence. These are precisely the personal attributes reported to be necessary for nurses in patient advocacy situations (Chafey et al., 1998; Duncan, 1992; Segesten, 1993). This study does not have the data to confirm whether whistleblowers were more assertive or self-confidant than non-whistleblowers, but their *actions* suggest that they were. In addition, those actions seem to indicate that the nurses were defending strongly held beliefs, which is precisely the action Lazarus and Folkman would predict. Beliefs and commitments motivate problem-focused behaviours because people are attempting to find effective ways to stop the threat to their commitment (Lazarus and Folkman, 1984).

The potent coping actions used by whistleblowers in this study suggests that they did not feel 'subservient' or 'powerless', unlike nurses in Wilkinson's (1987/88) study who reported *unsuccessful* coping. According to the theoretical model, beliefs about personal control determine how one will respond to a stressful event. In addition, those who appraise the event as controllable will have less stress (Lazarus and Folkman, 1984). That seemed to be the case in this research, since whistleblowers who reported effective coping also reported *less* stress-induced emotional problems than non-whistleblowers.

Another possible explanation for why whistleblowers reported effective coping behaviours may be contained in literature which suggests that experience and higher education *increase* a nurse's ability to cope successfully with ethical dilemmas (Chafey et al., 1998; McAlpine, 1996; Soderberg & Norberg, 1993; Uden et al., 1992; Wlody, 1993). In this study, the whistleblowers were more experienced than non-whistleblowers, and a higher percentage of them reported having advanced degrees. Lazarus and Folkman indicate that experience and education are **dispositional variables** which determine how one will respond to a stressful event,

and that problem-focused coping behaviours are used more frequently by people with more experience and education.

An effective coping behaviour reported by a large number of whistleblowers (and non-whistleblowers) in this study was to ask a friend or relative for advice or support. According to Lazarus and Folkman, social supports are an important resource for coping during a stressful encounter. Asking for advice or support falls under the model's early 'appraisal' response, during which time the person gathers information, but has not yet decided a course of action. This response is similar to the other effective coping behaviour reported by a majority of whistleblowers; 'drawing on past experiences to come up with a way to handle the problem'. Both of those coping methods were also reported to be helpful in patient advocacy studies (Erlen & Frost, 1991; Mohr, 1996; Segesten, 1993; Uden et al., 1992; Wlody, 1993).

There were no coping behaviours that were considered effective by a *majority* of non-whistleblowers. However, there were behaviours that were **tried** by a majority of non-whistleblowers (though, reported as **not** helpful), and most of those were *emotion-focused* behaviours. For example, 52% of non-whistleblowers (compared to 29% of whistleblowers) 'tried to forget the whole thing by concentrating on work'. In addition, 36% 'acted like nothing happened' and 'had fantasies about how things might turn out'. According to Lazarus and Folkman, those are forms of avoidance and denial, and people who defend themselves in this way must remain forever on guard, and may experience depleted energy and depression. This could explain why such a high percentage of non-whistleblowers reported fatigue and why a higher percentage of non-whistleblowers (compared to whistleblowers) reported depression. It also supports the findings of patient advocacy studies, which found that nurses who did not speak up as patient advocates

felt fatigue, depression and moral anguish (Chafey et al., 1998; Holly, 1993; Wilkinson, 1987/88).

A disturbing finding in this research is that 45% of the nurses reported that they tried to avoid the patient or the people involved in the whistleblowing event. It makes sense that one would want to avoid a stressful situation, but nurses are obliged to care for patients, and there is cause for concern if nurses are avoiding patients in order to avoid stressful encounters. Wilkinson (1987/88) found that one of the most common, but unsuccessful, coping behaviours of nurses was to avoid patients in stressful patient advocacy situations. Nurses in this study (34%) reported that avoidance did *not* help them feel better. That is in line with the theoretical model's suggestion that avoidance does not help in circumstances where an important commitment is threatened and the stressful event calls for *problem-focused* coping (Lazarus & Folkman, 1984). This research has shown that nurses are committed to a code of conduct which requires patient advocacy. Therefore, it is reasonable to assume that the nurses who did not uphold their commitment with appropriate action were the ones who reported that their efforts were ineffective.

Finally, it is necessary to address the **situational variable** that affected most non-whistleblowers and a large number of whistleblowers in this study. Lazarus and Folkman (1984) define situational variables as the constraints placed on coping efforts by such factors as agencies or institutions. Both whistleblowers and non-whistleblowers described the fear, anxiety and intimidation they felt in the face of their institutions' attempt to silence them. That finding is strongly supported in other whistleblower and patient advocacy literature (De Maria, 1994; Duncan, 1992; Holly, 1993; Hunt, 1995; Lennane, 1993; Mohr, 1996). The dysfunctional activities of institutions that covered up misconduct and threatened employees with severe

forms of censure if they attempted to disclose information was a disturbing and pervasive theme in this research, and all of the related literature. Certainly the saddest aspect of this is the magnitude of the problem. The participants in this study all worked in different areas, in different hospitals, yet they all reported formidable barriers from their institutions when they identified misconduct and wrestled with the ethical dilemmas involved. A poignant finding was that 60% of whistleblowers reported that it was *effective* to "stand firm and fight for the right thing". That is particularly meaningful because the nurses did **not** mean that it was effective in stopping the misconduct, but rather *effective* in satisfying personal values. Furthermore, it was not effective in the sense that the actions of the whistleblower were vindicated, because they were not. Instead, the whistleblower suffered many stress-induced physical and emotional problems, and endured severe and long-term professional consequences.

Summary.

The coping behaviours of whistleblowers and non-whistleblowers were discussed in context with the theoretical model which guided this research, namely Lazarus and Folkman's Stress Coping Model (1984). According to the model, whistleblowers demonstrated problem-focused coping behaviours when they responded to the stress of reporting misconduct. The four coping behaviours which were perceived to be effective by whistleblowers were: (1) stood my ground and fought for what I thought was the right thing to do (2) talked to someone who could do something about the problem (3) asked a friend and relative for support and advice and (4) drew on past experiences to come up with a way to handle the problem.

Those actions are known to require conviction, assertiveness and self-confidence, and are precisely the personal attributes reported to be necessary in patient advocacy situations (Chafey et al., 1998; Duncan, 1992; Segesten, 1993). In addition, those actions seem to indicate that the nurses were defending strongly held beliefs, which Lazarus and Folkman would relate to the protection of commitments.

There were no coping behaviours that were considered effective by a *majority* of non-whistleblowers. However, there were behaviours that were **tried** by a majority of non-whistleblowers (though, reported as not being helpful), and most of those were *emotion-focused* behaviours. For example, many non-whistleblowers 'tried to forget the whole thing by concentrating on work', and 'had fantasies about how things might turn out'. According to Lazarus and Folkman, those are forms of avoidance and denial, and people who defend themselves in that way must remain forever on guard, and may experience depleted energy and depression. That could explain why many non-whistleblowers reported experiencing fatigue and depression.

Many participants avoided the patient or the people responsible for the problem, and this was seen as a natural, but *ineffective* response to the stress of the whistleblowing situation. According to the model, avoidance does not help in such circumstances because the event calls for appropriate, *problem-focused* coping responses (Lazarus & Folkman, 1984).

The model defined situational variables as the constraints placed on a person's coping response by agencies or institutions. Participants were well aware of the constraints placed on them by their workplace, particularly the efforts of their managers to silence their concerns. Nevertheless, many whistleblowers reported that it was effective to 'stand firm and fight for the right thing' despite the negative physical, emotional and professional effects.

Limitations of the Study, Strengths of the Study and Recommendations for Future Research

Limitations of the Study.

1. As with all data reliant on self-report responses, there are limitations related to the respondent's memory, the desire of respondents to present themselves in the best light and language ambiguity. In addition, it is possible that respondents were motivated by particularly strong feelings regarding their whistleblowing experience, a factor which could influence the perception of physical, emotional and professional problems.
2. In surveys, a response rate of 40-50 % is considered good (Warwick & Lininger, 1975). Therefore, the response rate of 20% received by this study may be considered poor. As mentioned previously, the subject of whistleblowing evokes negative connotations and could account for this study's poor response rate.
3. Data for this study was collected from a population of nurses in Western Australia and therefore, broader application of this study cannot be made.
4. Many factors contribute to the manifestation of physical and emotional symptoms of ill-health including genetic predisposition, personality characteristics and environmental problems and/or resources (support systems, the timing of the event, the duration of the event, etc.). The questionnaire did not account for those variables.

Strengths of the Study.

1. The strength of this study was that it described a subject that has not been empirically examined before in the nursing literature. Whistleblowing is not a popular subject and carries with it many negative connotations. However, nurse whistleblowers have been around for a long time, and they have endured

personal and professional pain while attempting to stop wrongdoing in the workplace. No prior research has described the physical, emotional and/or professional effect on nurses when they blow the whistle or remain silent in the face of incompetent, illegal, unethical behaviour in the workplace.

2. This study tested and validated Lazaurus and Folkman's Stress/Coping Model as a framework for empirical research.

Recommendations for Future Research.

1. Further research is needed into the phenomenon of whistleblowing in nursing. This study was the first empirical research into the effects of whistleblowing and non-whistleblowing on a relatively small sample of nurses in Western Australia. Further research on whistleblowing in specific practice areas would define the scope and pattern of the subject. Whistleblowing is known to be risky and further research would provide additional insight into how nurses are affected when they report misconduct. Research initiatives should include quantitative and qualitative data on the frequency, responses and effects of whistleblowing. Hutchinson (1990) found that patient advocacy behaviours were decreased in nurses who had been disciplined for bending rules to protect patients. Findings from this research indicate that many of the nurses involved in whistleblowing felt discouraged enough to want to leave the profession. Therefore, research should include longitudinal studies on the long-term effects of whistleblowing, specifically to determine whether nurses who blew the whistle on misconduct are still nursing, and if so, do they still engage in patient advocacy behaviours.
2. Another focus for future research should be to determine how nurses can report misconduct without sustaining negative consequences. This study found that taking action was more effective than remaining silent, but that it resulted in

personal and professional harm. Therefore, research is needed to determine the most effective *and* least damaging way to report misconduct.

3. Finally, studies should be conducted which examine the education and personal characteristics of nurses who report misconduct. Patient advocacy literature suggests that there are essential qualities required for nurses to act as patient advocates (Chafey et al., 1998; Duncan, 1992; Pike, 1991; Segesten, 1993; Wilkinson, 1987/88). This research supports that finding by identifying certain personal characteristics necessary to engage in whistleblowing behaviour (for example, assertiveness, self- confidence and the conviction of ethical values). Clearly, nurses with strong ethical values and the assertiveness to stand by them are an asset to the profession of nursing. Further research needs to examine how such qualities are developed. Are they unique to personality types, or are they learned responses? If they are learned, are they learned in nursing schools, in practice areas, or from the role modelling of other nurses?

Chapter Seven

Conclusions, Implications and Recommendations

Conclusions

Nurses who blew the whistle on misconduct reported that they experienced many stress-induced physical and emotional problems. This was an expected result, since the literature clearly indicates that whistleblowing causes negative effects for the whistleblower. However, an unexpected finding was that non-whistleblowers also experienced physical and emotional problems. This finding suggests that whistleblowing situations are stressful enough to cause physical and emotional problems *whether one blows the whistle or not.*

A related finding was that whistleblowers experienced many negative professional consequences. Again, this was expected since a common theme in whistleblower literature is that organisations retaliate against whistleblowers with professional reprisals. However, the experience of being professionally affected was not shared by non-whistleblowers. Non-whistleblowers reported few professional reprisals, and their employment was not threatened. From this, it can be concluded that blowing the whistle on misconduct may be professionally damaging, whereas remaining silent will probably not affect one's career.

A disturbing finding in this study was that reporting misconduct did not usually change (or stop) the misconduct and wrongdoers were rarely disciplined. The only conclusion to be drawn from this is that blowing the whistle on misconduct will probably not change anything. That is of concern when viewed with the finding

(mentioned above) that whistleblowers may nevertheless be professionally damaged for making the report.

Whistleblowing is stressful because whistleblowers fear retribution from employers. It is reasonable that whistleblowers would be intimidated and fearful, since they are the ones who risk their career to report misconduct. However, a finding from this study indicates that the *same* percentage of non-whistleblowers reported feeling fear and intimidation. That suggests that whistleblowing situations cause fear and intimidation whether one chooses to blow the whistle or not.

Anger was another feeling reported by a majority of nurses in this whistleblower study. Interestingly, a higher percentage of non-whistleblowers reported anger than whistleblowers. The conceptual framework demonstrated that *suppressed* anger provokes the highest rate of emotional ill health, especially when a person ignores or denies emotionally significant events. Therefore, this study concluded that because non-whistleblowers did not *directly* express their anger, it could be that they experienced higher rates of suppressed anger.

Other emotions reported by a higher percentage of non-whistleblowers were feelings of guilt, shame, unworthiness, loss of confidence, and loss of self-esteem. These findings suggest that when faced with a whistleblowing situation, *taking action,* rather than *remaining silent,* provides better protection from feelings of unworthiness. Nurses who blew the whistle reported less feelings of guilt than non-whistleblowers which suggests that *attempting* to stop a wrong makes one feel **less** guilty than doing nothing.

Powerlessness was reported by an equal percentage of whistleblowers and non-whistleblowers. A majority of those who did not report feeling powerless said that they felt 'supported by colleagues', whereas those who felt powerless, reported

that they had no support system. The conceptual framework supports the conclusion drawn from this finding, namely that nurses cope better if they receive or believe that they will receive support when it is needed.

Another conclusion drawn from this study is that whistleblowers are more likely to be uncertain about their future than non-whistleblowers. This is reasonable since whistleblowers (and **not** non-whistleblowers) experienced professional reprisals which directly threatened their job security.

The coping behaviours that were considered effective by a majority of whistleblowers were *problem-focused* behaviours. These were direct actions which attempted to stop the misconduct, such as 'I talked to someone who could do something about the problem'. On the other hand, most non-whistleblowers tried *emotion-focused* behaviours (such as avoidance or denial), and reported them to be ineffective. This suggests that taking action is considered more effective than avoiding the issue, or remaining silent.

A final conclusion of this study is that the conceptual model provided an appropriate framework to direct this research. For example, the model discussed dispositional and situational variables that related to nurse whistleblowers and non-whistleblowers. The dispositional variables described by the model as necessary for effective coping were assertiveness, self-confidence and persistence. Those were the characteristics found by this study (and other studies) to be required of patient advocates (whistleblowers). Furthermore, one of the situational variables described by the model as causing coping difficulties (institutional constraints) was found to be the primary cause of the coping difficulties experienced by whistleblowers and non-whistleblowers. In addition, the coping responses reported by participants in this

study were modelled after the Ways of Coping described in the theoretical framework (Appendix A).

Many of the conclusions in this study were results that the model would predict. For example, the model indicated that the most damaging life events are those in which commitments are threatened or lost. When whistleblowers and non-whistleblowers were unable to stop misconduct, their responses were in line with the model's expected response, in this case a reduced commitment to work and a deterioration of personal values. The model also predicted that when strongly held commitments are threatened, problem-focused behaviours are required for effective coping, and that was demonstrated by the participants in this study.

Implications and Recommendations

The following section will present implications drawn from the major conclusions of this study. Four of the findings from this research were considered by this researcher to have serious implications for the profession of nursing. The first one is that nurses who identify and/or report misconduct may be harmed by the experience. The second one is that although nurses are expected to uphold ethical codes of conduct, they are often employed in practice settings where they are constrained from doing so. The third finding which has implications for the nursing profession is that nurses may avoid patients and/or people who are involved in ethical dilemmas. The final implication to be discussed concerns the effective and ineffective coping behaviours of nurses.

Implication #1.

It is of grave concern to present results that indicate that nurses may be harmed physically and emotionally if they *identify* misconduct, and harmed professionally if they *report* misconduct. This suggests that nurses might find it

advisable to repudiate workplace behaviour that is illegal, incompetent or unethical. However, such a suggestion is deeply disturbing because it is incompatible with a nurse's code of conduct, and more importantly, it debases the role of nurse as patient advocate. It is especially repugnant to suggest that nurses should turn their back on misconduct which takes place within a patient care setting, where vulnerable patients may be involved.

Unfortunately, the dilemma exists that when misconduct occurs, nurses are faced with two options: reporting the misconduct or remaining silent, and *both options cause harmful effects*. This has disturbing implications for the profession of nursing because how nurses respond to ethical dilemmas significantly affects standards of care and ethical practice. This study found that when nurses were harmed by their responses to ethical problems, they became bitter, cynical, fearful and disillusioned. Some wanted to leave nursing rather than wrestle with such feelings. Yet nurses who are moral enough to understand ethical issues and courageous enough to speak up for vulnerable patients need to be retained and supported. These are the very nurses who are needed to provide moral leadership for the profession of nursing.

Recommendations.

Despite identifying the professional harm caused by speaking up, this research cannot recommend nurses to remain silent in the face of misconduct. Such a recommendation would violate human rights issues and denigrate the profession of nursing. Furthermore, findings from this research suggest that the emotional effects of *not* speaking up can also be harmful, so remaining silent when misconduct is identified is **not** recommended as a course of action. A more responsible recommendation would be to ensure that local nurse-whistleblower networks were

put in place to provide support and guidance for others engaged in the process of reporting misconduct.

Nurse managers should be encouraged to examine the values they want their nurses to uphold and then reward and commend those values. Characteristics such as morality, assertiveness, self-confidence and accountability are qualities required of patient advocates. Those qualities should be role-modelled by nurse managers and encouraged to flourish in all nurses.

Finally, nursing education must include all aspects of patient advocacy, including whistleblowing. Students need to be aware of the predictable reprisals that will occur if they choose to blow the whistle on misconduct, as well as the physical and emotional trauma they could experience if they do **not** follow the voice of their own moral values.

Implication #2.

Upholding ethical codes in nursing must be discussed in relation to the environment where nurses work. As the literature review found, widespread abuse has occurred in hospitals across Australia, the United Kingdom and the United States. As much as one would like to think of the healthcare setting as being altruistic and humane because it offers care for people in need, it has also been shown to exploit and abuse patients. Nurses working in dysfunctional corporations are often aware of abuses taking place, but feel powerless to respond because of the risk involved in 'rocking the boat'. Blowing the whistle on misconduct is fraught with danger because institutions do not like employees who expose behaviour that reflects badly on the institution. For this reason, whistleblowers are castigated as *trouble-makers* or *traitors,* and may receive personal and professional reprisals. In this study, both whistleblowers and non-whistleblowers described the fear, anxiety

and intimidation they felt in the face of their institutions' attempt to silence them. In fact, the dysfunctional activities of institutions which threatened employees with reprisals if they reported misconduct was a disturbing and pervasive theme in this research and all of the related literature (De Maria, 1994; Duncan, 1992; Holly, 1993; Hunt, 1995; Lennane, 1993; Mohr, 1996).

Yet nurses are *expected* to safeguard patients from incompetent, unethical or illegal practices. This mandate has been set out in ethical codes of conduct requiring nurses to act as patient advocates. Patient advocacy involves supporting the wishes of patients, defending their rights and protecting their well being. The imperative of advocacy assumes that the nurse has the autonomy to make ethical decisions within a practice setting that is *supportive* of independent action. However, as was demonstrated above, this is **not** a realistic description of the practice settings described by nurses in this study, or by any of the nurses in the extensive studies reviewed in the patient advocacy literature. The reality is that hospital power structures limit the moral authority of nurses and require obedience and loyalty to group norms that are often in conflict with patient advocacy issues. Furthermore, nurses risk extreme consequences if they make independent decisions regarding patient advocacy issues. A good example of that is the experience of nurses in this study who suffered devastating personal and professional consequences when they reported misconduct at work.

Unfortunately, the implication of this to the profession of nursing has been discussed in the literature for many years without apparent resolution. The constraint placed on nurses by bureaucratic forces is not a new subject in nursing literature, nor is the subject of a nurse's lack of autonomy. What *is* comparatively recent is the addition of ethical codes for nurses which require patient advocacy. As this research

found, the mandate of patient advocacy has serious ramifications in practice settings where employers **do not** support nurses as patient advocates. Therefore, until nurses have achieved autonomy and independent decision making powers, it is incumbent on the profession to examine whether it is reasonable to hold nurses accountable to codes that cannot be upheld without sustaining severe personal and professional harm.

Recommendations.

Research that examines the *real* environment of nursing and explores ways for nurses to work in that environment as autonomous and ethical caregivers is a priority. Discussion in the literature and in nursing boardrooms should concern the dilemma of mandating ethical codes that cannot be upheld without personal and/or professional harm. It does little good to support patient advocacy if it is truly an unattainable goal in a hostile environment. Mohr (1995b) goes so far as to question whether the current corporate ideology of hospitals, where primary value is placed on profit, can coexist with the moral ideologies inherent in nursing codes. Ethical problems are significantly shaped by the institutions in which they occur, so research that examines the complex nature of authority and conflicting ideologies needs to be conducted. Finally, further research into the phenomenon of whistleblowing in nursing is needed to support and validate these findings.

Nursing organisations should apply strong pressure within the nursing community to support only those organisations which believe in ethical and autonomous nursing conduct. For example, they could issue 'report cards' of healthcare settings, and strongly advise nursing leaders *not* to become part of an organisation unless it is wholly supportive of patient advocacy (in action, not in lip service). It also means that nursing leaders should role-model assertive, risk-taking

behaviour and make it clear that they will support other nurses who follow their lead. Student nurses should be informed about which organisations support ethical nursing practice. Ethical committees should be set up in all nursing departments to provide a forum for nurses to air ethical concerns. The chair of the committee should be a nurse who has experience in bio-ethical issues and has no vested interest in promoting administrative or hierarchic constraints.

Finally, to reiterate, local and state organisations of nurse-whistleblowers should be in place to support and guide other nurses who elect to report misconduct. State Boards of Nurses should adopt a positive platform toward reporting misconduct, and offer guidance and commendation to nurses who blow the whistle. In addition, national and state nurse's associations should lobby for legislation to protect nurse whistleblowers.

Implication #3.

A disturbing finding in this research was that 45% of the nurse participants reported that they tried to avoid the patient or the people involved in the whistleblowing event. This finding was supported in other studies of nurses in ethical dilemmas (Mohr, 1996; Wilkinson, 1987/88). It makes sense that one would want to avoid a stressful situation, but nurses are obliged to care for patients, and there is cause for concern if nurses are avoiding patients in order to avoid stressful situations.

Recommendations.

Nursing managers should be aware that staff nurses frequently encounter ethical dilemmas, and may need a non-judgemental forum to discuss their concerns. They could offer self-help or discussion groups within or outside work hours, and be open to such problem-solving solutions as re-assigning patients or forming a

coalition of support for nurses with concerns. One forward-thinking nursing department in a large children's hospital had a 'nurse advocate' on staff to listen to the concerns of nurses and to help mediate solutions. Holly (1993) advocated unit-based ethics rounds, and/or nursing grand rounds on ethical issues to provide a forum for the discussion of ethical issues.

Another recommendation would be for nursing managers to role-model and reward assertive action. Assertiveness training could be part of continuing education courses, along with empowerment and leadership skills. Higher education was found to be significantly linked to professional autonomy, so nurse administrators should consider providing support such as flexible scheduling and tuition benefits to nurses who want to further their education.

Implication #4.

The coping behaviours considered most effective by nurses in this study were *problem-focused* actions. These actions are known to require conviction, assertiveness and self-confidence, and are precisely the personal attributes reported to be necessary in patient advocacy situations (Chafey et al., 1998; Duncan, 1992; Segesten, 1993). In addition, those actions seem to indicate that the nurses were defending strongly held beliefs, which Lazarus and Folkman (1984) found to be the actions used when a person attempts to protect commitments. The coping behaviours **not** considered effective by nurses in this study were *emotion-focused* actions such as avoidance and denial. Research shows that new graduates do not feel prepared to address ethical issues (Wlody, 1993). Furthermore, taking an ethical stance in an environment which is hostile to autonomous decision-making can be physically, emotionally and professionally damaging (De Maria, 1994; Hunt, 1995).

Recommendations.

It is incumbent on nurse educators to specifically teach problem-focused behaviours that will facilitate effective coping when ethical decisions are required. Nurse educators should then expect and reward assertive problem-focused behaviours. In addition, nursing students need to learn the communication and social skills necessary to speak up when faced with an ethical dilemma, and to support other colleagues who speak up. The ability to make ethical decisions in adherence to one's ethical values is a skill that can be learned (McAlpine, 1996). Based on this research, and the stress-coping model, it is recommended that two interrelated skills should be taught: responsible assertive action and the importance of seeking support from others. Nurse administrators may need to confront their own inadequacies in demonstrating assertive action, since nurses in this study and many other studies, indicated that they felt unguided and unsupported by nursing management.

References

Allmark, P. & Klarzynski, R. (1992). The case against nurse advocacy. British Journal of Nursing, 2(1), 33-36.

American Nurses Association (ANA). (1985). Code for nurses with interpretive statements. Kansas City, Mo.: American Nurses Association.

Anderson, S. L. (1990). Patient advocacy and whistle-blowing in nursing: Help for the helpers. Nursing Forum, 25,(3), 5-13.

Anisman, H., Kokkinidis, L., & Sklar, L. S. (1985). Neurochemical consequences of stress. In S. Burchfield (Ed.) Stress, psychological and physiological interactions. Washington: Hemisphere Publishing Corp.

Anonymous (1989). Blowing the whistle on incompetence. Nursing 89, July, 47-50.

ARAFMI: Association of Relatives and Friends of the Mentally Ill. (n.d.) . About anorexia and bulimia. [Brochure]. Dickinson, J.: Author.

Ballou, K. A. (1998). A concept of analysis of autonomy. Journal of Professional Nursing, 14(2), March-April, 102-110.

Bandman, E. L. & Bandman, B. (1990). Nursing ethics through the life span. East Norwalk, CT.: Appleton & Lange, A Publishing Division of Prentice Hall.

Besomo, V. S. (1996) . Codependent concersn among Nurses. Unpublished master's thesis, Edith Cowan University, Perth, Western Australia, Australia.

Bishop, A. H. & Scudder, J. R. (1990). The practical, moral and personal sense of nursing; a phenomenological philosophy of practice. State University, Albany: New York Press

Borda, R. G. & Norman, I. J. (1997). Factors influencing turnover and absence of nurses: a research review. International Journal of Nursing Standards 34(6), 385-394.

Bramlett, M. H., Gueldner, S. H. & Sowell, R. L. (1990). Consumer centric advocacy; its connection to nursing frameworks. Nursing Science Quarterly 3(4), 156-161.

Brink, P. J. & Wood, M. J. (1989). Advanced design in nursing research. Newbury Park, California: SAGE Publications.

Brunner, L. S. & Suddarth, D. S. (1980). Medical-surgical nursing. Philadelphia: J. B. Lippincott.

Burns, N. & Grove, S. K. (1993). The practice of nursing research, conduct, critique & utilization. (Second Edition). Philadelphia: W. B. Saunders Co.

Bush, J. P. (1988) . Job satisfaction, powerlessness, and locus of control. Western Journal of Nursing Research, 10, (6), 718-731.

Carmines, E. G. and Zeller, R. A. (1979) . Reliability and validity assessment. Series: Quantitative applications in the social sciences. Beverly Hills, CA: Sage Publications, Inc.

Carpenter, M. A. (1991). The process of ethical decision making in psychiatric nursing practice. In Issues in mental health nursing, 12, 179-191.

Chafey, K., Rhea, M., Shannon, A. M., & Spencer, S. (1998). Characterizations of advocacy by practicing nurses. Journal of Professional Nursing14(1), 43-52.

Corley, K. C. (1985). The psycopathology of stress; autonomic involvement in myocardial dysfunction and pathology. In S. Burchfield (Ed.) Stress, psychological and physiological interactions. Washington: Hemisphere Publishing.

Curtin, L. (1979). The nurse as advocate: a philosophical foundation for nursing. Advances in Nursing Science 1(3), 1-10.

Curtin, L. (1993). Damage control and the whistleblower. Nursing Management 5, 33-34.

Daugherty, S. R., Baldwin, D. C., & Rowley, B. D. (1998). Learning, satisfaction and mistreatment during medical internship; A national survey of working conditions. JAMA 279(15), 1194-1199.

Davis, A. J. & Aroskar, M. A. (1991). Ethical dilemmas and nursing practice (3rd ed.). Norwalk, CT: Appleton & Lange.

Deffenbacher, J. L. (1994). Anger reduction: Issues, assessment, and intervention strategies. In A. W. Siegmann and T. W. Smith (Eds.), Anger, Hostility, and the Heart (pp. 239-267). Hillsdale, N.J.:. Lawrence Erlbaum Associates.

De Maria, W. (1994). Queensland whistleblower study: Unshielding the shadow culture (Result Release One; April 1994). University of Queensland, Department of Social Work and Social Policy.

De Maria, W. and Jan, C. (1994). Queensland whistleblower study: Wounded workers (Result Release Two: October 1994). University of Queensland, Department of Social Work and Social Policy.

Dempster, Q. (1997). Whistleblowers. Sydney: Australian Broadcasting Corp.

De Vaus, D. A. (1985). Surveys in social research. Sydney: Allen & Unwin.

Diaz, A., & McMillin, J. (1991). A definition and description of nurse abuse. Western Journal of Nursing Research 13(1), 97-109.

Duncan, S. M., (1992). Ethical challenge in community health nursing. Journal of Advanced Nursing, 17, 1035-1041.

Dwyer, J. (1994). Primum non tacere: An ethic of speaking up. Hastings Center Report 24(1), 13-18.

Dyck, D. G., Yuen, S. A., Schonwetter, D. J., & Janisse, M. P. (1991). Type A behavior, self-reference, and the activation of anger and agression. In C. D. Spielberger and I. G. Sarason (Eds.). Stress and Emotion: Anxiety, Anger, and Curiosity. New York: Hemisphere Publishing.

Edwards, S. D. (1996) . What are the limits to the obligations of the nurse? Journal of Medical Ethics, 22, 90-94.

Erlen, J. A. & Frost, B. (1991). Nurses' perceptions of powerlessness in influencing ethical decisions. Western Journal of Nursing Research 13(3), 397-407.

Fagan, D. (1996, November 30). Watchdog lashes hospital cover-up. The Australian.

Fahy, K. (1992). Advocacy? Reflections on the risks and rewards. The Australian Nurses Journal 21(11), June.

Fiesta, J. (1990). Whistleblowers: Heros or stool Pigeons?-Part I. Nursing Management, 21(6), 16-17.

Fimian, M. J., Fatenau, P. S., & Thomas, J. A. (1988). Stress in nursing and intentions of leaving the profession. Psychological Reports, 62, 499-506.

Flanigan, J. V. and Sandman, C. A. (1985). Neuroendocrine relationships with stress. In S. Burchfield (ed.) Stress, psychological and physiological interactions. Washington: Hemisphere Publishing Corporation.

Forchuk, C. (1991) . Ethical problems encountered by mental health nurses. Issues in Mental Health Nursing, 12, (4), 375 - 381.

Fry, S. T. (1989). Whistleblowing by nurses: A matter of ethics. Nursing Outlook, Jan./Feb., Vol. 37, No. 1

Gadow, S. (1980) . Existential advocacy: Philosophical foundations of nursing. In T. Pence & J. Cantrall (Eds.), Ethics in nursing, An anthology (pp. 30-51) . New York, N.Y.: National League for Nursing.

Gentry, W. D., Chesney, A. P., Gary, H., Hall, R. P., and Harburg, E. (1982). Habitual anger-coping styles: Effect on male/female blood pressure and hypertension status. Psychosomatic Medicine, 44, 195-202.

Gibson, R. (1997, April 26). Sex disgrace for doctor. The West Australian, p. 3.

Glazer, M. P. and Glazer, P. M. (1989). The whistleblowers. Exposing corruption in government & industry. Basic Books: Harper Collins Publishers.

Gunning, C. S. (1983) . The profession itself as a source of stress. In S. F. Jacobsen & H. F. McGrath (Eds.), Nurses under stress (pp. 113 - 125). New York: John Wiley Sons, Inc.

Haney, T. L. and Blumenthal, J. A. (1985). Stress and Type A behavior pattern. In S. R. Burchfield (ed.). Stress and Emotion; Anxiety, Anger, and Curiosity. New York: Hemisphere Publishing Corp.

Harburg, E., Blakelock, E. H., & Roeper, P. J. (1979). Resentful and reflective coping with arbitrary authority and blood pressure. Pyschosomatic Medicine, 41, 189-202.

Hayne, Y., Moore, S., and Osborne, M. (1990). Nursing ethics: A turning point. Nursing Forum, Vol. 25, 4.

Health Visitor (1993). Your rights at work special; Whistleblowing, sounding the alarm. (No specified author). Vol.66, No. 8, August.

Hipwell, A. E., Tyler, P. A. and Wilson, C. M. (1989) . Sources of stress and dissatisfaction among nurses in four hospital environments. British Journal of Medical Psychology, 62, 71-79.

Holly, C. M. (1993). The ethical quandaries of acute care nursing practice. Journal of Professional Nursing, Vol. 9, No. 2 (March-April), 110-115.

Horowitz, M. J. (1982). Psychological processes induced by illness, injury, and loss. In T. Millon, C. Green & R. Meagher (eds.), Handbook of Clinical health psycholgy. New York: Plenum.

Hunt, G. (1995) . Whistleblowing in the health service. Accountability, law and professional practice. London: Edward Arnold.

Hutchinson, S. (1990). Responsible subversion: A study of rule-bending among nurses. Scholarly Inquiry for Nursing Practice: An International Journal, 4 (1), 3-17.

Irurita, V. (1996) . Preserving integrity, A theory of nursing. In J. Greenwood (Ed.), Nursing Theory in Australia, Development & Application, (pp. 264-299) . Sydney, NSW, Australia: Harper Collins Publisher.

Jameton, A. (1984) . Nursing practice: The ethical issues, Englewood Cliff, N. J.: Prentice - Hall, Inc.

Janis, I. L., & Man, L. (1977). Decision making. New York: The Free Press. Cited in R. S.Lazarus & S. Folkman, Stress, Appraisal and Coping, 1974, New York: Springer Publishing Co., p.60.

Johnstone, M. J. (1994) . Nursing and the injustices of the law. Orlando, Florida: Harcourt Brace & Company.

Johnstone, M. J. (1998). Advancing nursing ethics: time to set a new global agenda? International Nurses Review, 45, 2, p. 43.

Kelly, B. (1996). Speaking up: A moral obligation. Nursing Forum, 31, 2, April - June, 31 - 34.

Kendrick, K. (1994). An advocate for whom-doctor or patient? How far can a nurse be a patient's advocate? Professional Nurse, September.

Kiely, M. A. & Kiely, D. C. (1987) . Whistleblowing: Disclosure and its consequences for the professional nurse and management. Nursing Management, 18, 5, 41 - 45.

Kinsman, R. A., Dirks, J. F., Jones, N. F., & Dahlem, N. W. (1980). Anxiety reduction in asthma: Four catches to general application. Psychosomatic Medicine, 42, 397-405.

Kohnke, M. F. (1982) Advocacy: Risk and Reality. CC Mosby Co., St. Louis.

Kushnir, T., Rabin, S. and Azulai, S. (1997). A descriptive study of stress management in a group of pediatric oncology nurses. Cancer Nursing, 20 (6), 414-421.

Lazarus, R. S. & Folkman, S. (1984) . Stress, appraisal, and coping. New York: Springer Publishing Co., Inc.

Lennane, K. J. (1993) . Whistleblowing: A health issue. British Medical Journal, 307, 667-670.

Linden, W., Leung, D., Chawla, A., Stossel, C., Rutledge, T. & Tanco, S. A. (1997). Social Determinants of experienced anger. Journal of Behavioral Medicine, (1) 415-433.

Lunn, J. E. (1995). Whistleblowing: A legal perspective. British Journal of Nursing, Vol. 4, No. 17.

Lynn, M. R. (1986). Determination and quantification of content validity . Nursing research, Nov.-Dec., Vol. 35, No. 6., pp. 382-385.

Maas, M. L. (1998). Professional practice for the extended care environment: Learning from one model and its implementation. Journal of Professional Nursing, 5, 66-76.

Mackay, L. (1993) Conflicts in care; Medicine and nursing. Chapman and Hall, London.

Mallik, M. (1997) Advocacy in nursing-a review of the literature. Journal of Advanced Nursing, 25, 130-138.

Manderino, M. A. and Berkey, N. (1997). Verbal abuse of staff nurses by physicians. Journal of Professional Nursing, Vol. 13, No. 1 (Jan-Feb), 48-55.

Marshall, C. (1994). The concept of advocacy. British Journal of Theatre Nursing, May; 4 (2).

Martin, D. A. (1989). Nurses' involvement in ethical decision-making with severely ill newborns. Issues in Comprehensive Pediatric Nursing, 12, 463-473.

Martin, J. P. (1985). Hospitals in trouble. Blackwell, Oxford.

Mason, J. W., Maher, J. T., Hartley, L. H., Mougey, E. Perlow, M. J., & Jones, L. G. (1976). Selectivity of corticosteroid and catecholamine response to various natural stimuli. In G. Serban (ed.), Psychopathology of Human Adaptation. New York: Plenum.

McAlpine, H. (1996). Critical reflections about professional ethical stances: Have we lost sight of the major objectives? Journal of Nursing Education,Vol. 35, No. 3.

McAlpine, H., Kristjanson, L. & Poroch, D. (1997). Development and testing of the ethical reasoning tool (ERT): an instrument to measure the ethical reasoning of nurses. Journal of Advanced Nursing, 25, 1151-1161.

McDonald, S. (1994) . An ethical dilemma: Risk versus responsibility. Journal of psychosocial nursing and mental health services, 32, (1) 19 - 25.

Melia, K. M. (1989) . Everyday nursing ethics. London: The Macmillan Press Ltd.

Miller, B., Mansen, T. & Lee, H. (1983) Patient advocacy: do nurses have the power and authority to act as patient advocate? Nursing Leadership 6 (2), 56-60.

Mohr, W. K. (1995a) . Misery, mendacity, morals and money; Lessons from a Texas health care scandal. Texas Nursing, Feb., 8-9.

Mohr, W. K., (1995b). Multiple ideologies and their proposed roles in the outcomes of nurse practice settings: The for-profit psychiatric hospital scandal as a paradigm case. Nursing Outlook, Sept./Oct., 43, 215-223.

Mohr, W. K. (1996) . Psychiatric nursing in troubled environmental contexts. Archives of psychiatric nursing, 10, 4, 197-206.

Mohr, W., K. and Mahon, M. M. (1996). Dirty hands: The underside of marketplace health care. Advances in Nursing Science, 19, (1), 28-37.

Montgomery, J. (1992). Doctors handmaidens – the legal contribution. In Law, Health and Medical Regulations (McVeigh, S. & Wheeler, S., eds.) Davenmouth Publishing Co., Aldershot.

Morse, J. M. (1991) . Negotiating commitment and involvement in the nurse-patient relationship. Journal of Advanced Nursing, 16, (4), 455-468.

Murphy, E. K. (1987). The professional status of nursing: a view from the courts. Nursing Outlook, 35 (1), 12-15.

Nelson, M. L. (1988). Advocacy in nursing. How has it evolved and what are its implications for practice? Nursing Outlook, 36, (3), 136-141.

Norbeck, J. S. (1985). Perceived job stress, job satisfaction and psychological symptoms in critical care nursing. Research in Nursing and Health, 8, 253-259.

Nurses Board of Western Australia. (1995) Nurses code of practice [Brochure].

Nurse's Legal Handbook. (Third Ed.). (1996) Springhouse, Pa.: Springhouse Corp.

Orem, D. E. (1994). Self-care deficit theory of nursing. In Nursing Theorists and Their Work (Eben, J. D. et al, authors) A. M. Tomey, ed.; Mosby, Third Edition, St. Louis.

Pike, A. W. (1991). Moral outrage and moral discourse in nurse-physician collaboration. Journal of Professional Nursing, 7, (6), 351-363.

Polit, D. F. and Hungler, B.P. (1995) . Nursing research, principles and methods. (Fifth Ed.). Philadelphia: J. B. Lippincott Company.

Price, J., Price, D., Williams, G. & Hoffenberg, R. (1998) . Changes in medical student attitudes as they progress through a medical course. Journal of Medical Ethics, 24, 110-117.

Roberts, S. J. (1996) Breaking the cycle of oppression: Lessons for nurse practitioners? Journal of the American Academy of Nurse Practitioners, 8(5), 209-214.

Schizophrenia Australia Foundation. (1994) . Care of the seriously mentally ill in Australia: A rating of state and regional programs. North Fitzroy, Victoria, Australia.

Segesten, K. (1993). Patient advocacy-An important part of the daily work of the expert nurse. Scholarly Inquiry for Nursing Practice, 7, 129-135.

Sellin, S. C. (1995). Out on a limb: A qualitative study of patient advocacy in institutional nursing. Nursing Ethics, 2:19-22.

Seyle, H. (1976). The Stress of Life. New York: McGraw-Hill Book Company.

Seyle, H. (1952). The Story of the Adaptation Syndrome. Montreal: Acta Inc.

Sigg, E., B. (1975). The organization and functions of the central sympathetic nervous system. In L. Levi (ed.), Emotions-Their Parameters and Measurement. New York, Raven Press.

Simoni, P. S. & Paterson, J. J. (1997). Hardiness, coping and burnout in the nursing workplace. Journal of Professional Nursing, Vol. 13, No. 3 (May-June), p. 178-185.

Smith, M., Droppleman, P. & Thomas, S. P. (1996). Under assault: The experience of work-related anger in female registered nurses. Nursing Forum, Vol 31, No. 1, Jan.-March, 22-33.

Soderberg, A. and Norberg, A. (1993). Intensive care: situations of ethical difficulty. Journal of Advanced Nursing, 18, 2008-2014.

Soeken, K. and Soeken, D. (1987) . A survey of whistleblowers: Their stressors and coping strategies. Laurel, Maryland: Association of Mental Health Specialities. Unpublished manuscript. Results printed in the Age, August 8, 1988. p. 11.

Solomon, G. F., Amkraut, A.A., Rubin, R. T. (1985). Stress, hormones, neuroregulation, and immunity. In S. Burchfield (ed.) Stress, psychological and physiological interactions. Washington: Hemisphere Publishing Corp.

Spielberger, C. D, Crane, R. S., Kearns, W. D. Pellegrin, K. L., Rickman, R. L., and Johson, E. H. (1991). Anger and anxiety in essential hypertension. In C. D. Spielberger and I. G. Sarason, (eds.). Stress and Emotion; Anxiety, Anger, and Curiosity.New York: Hemisphere Publishing Corp.

Stein, L. (1967). The doctor-nurse game. Archives of General Psychiatry, 16, 699-703.

Stein, L., Watts, D. & Howell, T. (1990) The doctor-nurse game revisited. New England Journal of Medicine 322 (8), 546-549.

Tanner, C. A., Benner, P., Chesla, C., & Gordon, D. (1993). The phenomenology of knowing the patient. Image-The Journal of Nursing Scholarship, 25, 273-280.

Thomas, S. P., and Droppleman, P. (1997). Channeling nurses' anger into positive interventions. Nursing Forum, Vol. 32, No. 2, April-June, 13-21.

Thomas, S. P. and Williams, R. L. (1991). Perceived stress, trait anger, modes of anger expression, and health status of college men and women. Nursing Research, Sept./Oct., Vol. 40, No. 5., 303-307.

Thomas, S. P. (1997). Women's anger: Relationship of suppression to blood pressure. Nursing Research, Nov./Dec., Vol. 46, No. 6, 324-330.

Trandel-Korenchuk, K., and Trandel-Korenchuk, D. M. (1982). Conflicting loyalties of the nurse. Nursing Administration Quarterly, 6:2 (Winter): 63.

Uden, G., Norberg, A., Lindseth, A. & Marhaug, V. (1992). Ethical reasoning within nurses' and physicians' stories about care episodes. Journal of Advanced Nursing, 17 (9), 1028-1034.

Uzych, L. (1996, April - June) . Whistleblowing [Letter to the editor] . Nursing Forum, 31, 2, p. 36.

Warwick, D. P. and Lininger, C. A. (1975). The sample survey: Theory and practice. New York. McGraw-Hill Book Co.

Watt, E. (1997) An exploration of the way in which the concept of patient advocacy is perceived by registered nurses working in an acute care hospital. International Journal of Nursing Practice, 1997, 3, 119-127.

Whiteman, M. C., Deary, I. J., Lee, A. J., and Fowkes, F. G. R. (1997). Submissiveness and protection from coronary heart disease in the general population: Edinburgh Artery Study. The Lancelet, Vol. 350, August 23, p. 541-545.

Wilkinson, J. M. (1987/88) . Moral distress in nursing practice, experience and effect. Nursing Forum, 1, 23, 16 - 29.

Williamson, A. (1994). A hard day at the office. HQ Magazine, September-October, p. 95.

Wilson, M. M. (1985). Hippocampal inhibition of the pituitary-adrenocortical response to stress. In S. Burchfield (ed.) Stress, psychological and physiological interactions. Washington: Hemisphere Publishing Corporation.

Witt, P. (1983) . Notes of a whistleblower. In American Journal of Nursing, 83, 12, 1649 - 1651.

Witts, P. (1992) Patient advocacy in nursing. In Themes and Perspectives in Nursing (Soothill, K., Henry C. & Kendrick, K. eds). Chapman and Hall, London.

Wlody, R. K. (1993). Models of patient advocacy as perceived by critical care and non-critical care nurses. Unpublished ED.D. thesis, Pepperdine University.

Wood, G. L. and Haber, J. (1998). Nursing research. St. Louis: Mosby.

Woodrow, P. (1997). Nurse advocacy: is it in the patient's best interest? British Journal of Nursing, Vol. 6, No. 4.

APPENDIX A

Lazarus & Folkman (1984) Ways of Coping Checklist

Ways of Coping (Revised)

Please read each item below and indicate, by circling the appropriate category, to what extent you used it *in the situation you have just described.*

		Not used	Used somewhat	Used quite a bit	Used a great deal
1.	Just concentrated on what I had to do next—the next step.	0	1	2	3
2.	I tried to analyze the problem in order to understand it better.	0	1	2	3
3.	Turned to work or substitute activity to take my mind off things.	0	1	2	3
4.	I felt that time would make a difference—the only thing to do was to wait.	0	1	2	3
5.	Bargained or compromised to get something positive from the situation.	0	1	2	3
6.	I did something which I didn't think would work, but at least I was doing something.	0	1	2	3
7.	Tried to get the person responsible to change his or her mind.	0	1	2	3
8.	Talked to someone to find out more about the situation.	0	1	2	3

(continued)

Ways of Coping (continued)

		Not used	Used somewhat	Used quite a bit	Used a great deal
9.	Criticized or lectured myself.	0	1	2	3
10.	Tried not to burn my bridges, but leave things open somewhat.	0	1	2	3
11.	Hoped a miracle would happen.	0	1	2	3
12.	Went along with fate; sometimes I just have bad luck.	0	1	2	3
13.	Went on as if nothing had happened.	0	1	2	3
14.	I tried to keep my feelings to myself.	0	1	2	3
15.	Looked for the silver lining, so to speak; tried to look on the bright side of things.	0	1	2	3
16.	Slept more than usual.	0	1	2	3
17.	I expressed anger to the person(s) who caused the problem.	0	1	2	3
18.	Accepted sympathy and understanding from someone.	0	1	2	3
19.	I told myself things that helped me to feel better.	0	1	2	3
20.	I was inspired to do something creative.	0	1	2	3
21.	Tried to forget the whole thing.	0	1	2	3

(continued)

Ways of Coping (continued)		Not used	Used somewhat	Used quite a bit	Used a great deal
22.	I got professional help.	0	1	2	3
23.	Changed or grew as a person in a good way.	0	1	2	3
24.	I waited to see what would happen before doing anything.	0	1	2	3
25.	I apologized or did something to make up.	0	1	2	3
26.	I made a plan of action and followed it.	0	1	2	3
27.	I accepted the next best thing to what I wanted.	0	1	2	3
28.	I let my feelings out somehow.	0	1	2	3
29.	Realized I brought the problem on myself.	0	1	2	3
30.	I came out of the experience better than when I went in.	0	1	2	3
31.	Talked to someone who could do something concrete about the problem.	0	1	2	3
32.	Got away from it for a while; tried to rest or take a vacation.	0	1	2	3
33.	Tried to make myself feel better by eating, drinking, smoking, using drugs or medication, etc.	0	1	2	3

(continued)

Ways of Coping (continued)		Not used	Used somewhat	Used quite a bit	Used a great deal
34.	Took a big chance or did something very risky.	0	1	2	3
35.	I tried not to act too hastily or follow my first hunch.	0	1	2	3
36.	Found new faith.	0	1	2	3
37.	Maintained my pride and kept a stiff upper lip.	0	1	2	3
38.	Rediscovered what is important in life.	0	1	2	3
39.	Changed something so things would turn out all right.	0	1	2	3
40.	Avoided being with people in general.	0	1	2	3
41.	Didn't let it get to me; refused to think too much about it.	0	1	2	3
42.	I asked a relative or friend I respected for advice.	0	1	2	3
43.	Kept others from knowing how bad things were.	0	1	2	3
44.	Made light of the situation; refused to get too serious about it.	0	1	2	3
45.	Talked to someone about how I was feeling.	0	1	2	3
46.	Stood my ground and fought for what I wanted.	0	1	2	3

(continued)

Ways of Coping (continued)		Not used	Used somewhat	Used quite a bit	Used a great deal
47.	Took it out on other people.	0	1	2	3
48.	Drew on my past experiences; I was in a similar situation before.	0	1	2	3
49.	I knew what had to be done, so I doubled my efforts to make things work.	0	1	2	3
50.	Refused to believe that it had happened.	0	1	2	3
51.	I made a promise to myself that things would be different next time.	0	1	2	3
52.	Came up with a couple of different solutions to the problem.	0	1	2	3
53.	Accepted it, since nothing could be done.	0	1	2	3
54.	I tried to keep my feeling from interfering with other things too much.	0	1	2	3
55.	Wished that I could change what had happened or how I felt.	0	1	2	3
56.	I changed something about myself.	0	1	2	3
57.	I daydreamed or imagined a better time or place than the one I was in.	0	1	2	3

(continued)

Ways of Coping (continued)		Not used	Used somewhat	Used quite a bit	Used a great deal
58.	Wished that the situation would go away or somehow be over with.	0	1	2	3
59.	Had fantasies or wishes about how things might turn out.	0	1	2	3
60.	I prayed.	0	1	2	3
61.	I prepared myself for the worst.	0	1	2	3
62.	I went over in my mind what I would say or do.	0	1	2	3
63.	I thought about how a person I admire would handle this situation and used that as a model.	0	1	2	3
64.	I tried to see things from the other person's point of view.	0	1	2	3
65.	I reminded myself how much worse things could be.	0	1	2	3
66.	I jogged or exercised.	0	1	2	3
67.	I tried something entirely different from any of the above. (Please describe).	0	1	2	3

APPENDIX B

Research Questionnaire

For This Study

Edith Cowan University

Whistleblower Research Questionnaire

Nurses have a code of ethics which requires them to act as patient advocates. However, there are times when nurses encounter unethical conduct in their workplace which is not in the best interest of the patient, and/or others. Nurses must then choose whether to report it or not.

The purpose of this study is to examine the experience of nurses who, in the course of their career, "blew the whistle" or chose not to "blow the whistle" on incompetent, illegal or unethical situations they encountered in their workplace.

Research indicates that whistleblowing situations are stressful for whistleblowers, and for non-whistleblowers. This study seeks to describe the physical, emotional and professional stress experienced by nurses who were in a whistleblowing situation.

Whistleblowing Defined

Whistleblower: **A nurse who identifies an "incompetent", "unethical", or "illegal" situation and reports it to someone who may have the power to stop the wrong.**

Non-Whistleblower: **A nurse who identifies an "incompetent", "unethical", or "illegal" situation, but does not openly report it. Non-whistleblowers may use other methods to handle the situation.**

From the above definitions, do you consider yourself to be a whistleblower, or a non-whistleblower? Please tick (√) the box which best describes your actions.

1 ☐ **Whistleblower**

2 ☐ **Non-Whistleblower**

If you have never experienced unethical conduct in your workplace, please pass this questionnaire on to a colleague who may be able to respond. Thank you very much.

Section One: Demographics

Please tick (√) the response that best indicates your status **at the time of the whistleblowing event** (it may **NOT** be your current status):

1. Age: $_1$☐ 18-35 $_2$☐ 36-50 $_3$☐ 51-65 $_4$☐ 66+

2. Sex: $_1$☐ M $_2$☐ F

3. Number of Years in Nursing: $_1$☐ 0-5 $_2$☐ 6-10 $_3$☐ 11-15 $_4$☐ 16 +

4. Education:
   - $_1$☐ Hospital-Trained
   - $_2$☐ Tertiary Diploma
   - $_3$☐ Bachelors Degree
   - $_4$☐ Honours Degree
   - $_5$☐ Post-Graduate Diploma
   - $_6$☐ Masters Degree
   - $_7$☐ Ph.D.
   - $_8$☐ Other _____

5. Employment Location:
   - $_1$☐ Public Hospital
   - $_2$☐ Private Hospital
   - $_3$☐ Clinic
   - $_4$☐ Agency
   - $_5$☐ Occupational Health
   - $_6$☐ Nursing Home
   - $_7$☐ School
   - $_8$☐ Other _____

6. Employment Level:
   - $_1$☐ Level 1
   - $_2$☐ Level 2
   - $_3$☐ Level 3
   - $_4$☐ Level 4
   - $_5$☐ Level 5
   - $_6$☐ Other _____

7. Registration: $_1$☐ General $_2$☐ Mental Health $_3$☐ Midwifery

8. Area of Nursing:
   - $_1$☐ Neonatal
   - $_2$☐ OB/GYN
   - $_3$☐ Med/Surg
   - $_4$☐ ICU/CCU
   - $_5$☐ Recovery
   - $_6$☐ Neuro
   - $_7$☐ Adult Psych
   - $_8$☐ Geriatrics
   - $_9$☐ Neonatal Intensive Care
   - $_{10}$☐ Paediatric
   - $_{11}$☐ Ortho/Rehab
   - $_{12}$☐ Oncology
   - $_{13}$☐ Operating Room
   - $_{14}$☐ Emergency Dept.
   - $_{15}$☐ Child/Adolescent Psych
   - $_{16}$☐ Outpatient
   - $_{17}$☐ Other _____

Section Two: Whistleblowing Event:

The following are examples of illegal, incompetent or unethical conduct. Please think of ONE event to report and tick (√) the response (s) which best describe THAT event:

- ☐ Non-compliance with hospital policy
- ☐ Non-compliance with nursing standards
- ☐ Sex Discrimination
- ☐ Race Discrimination
- ☐ Theft
- ☐ Assault
- ☐ Sexual misconduct
- ☐ Impaired condition at work (from alcohol and/or drug use)
- ☐ Physical harassment
- ☐ Concealment of wrongdoing
- ☐ Improper training
- ☐ Incompetent person allowed to work with patients
- ☐ Abusive person allowed to work with patients
- ☐ Inability to obtain a physician's order
- ☐ Inadequate or unsafe staffing patterns
- ☐ Incompetent or hostile management
- ☐ Time-card mismanagement
- ☐ Favouritism and/or nepotism
- ☐ Violation of Patient's Rights or Requests
- ☐ Violation of Patient Confidentiality
- ☐ Poor Quality of Patient Care
- ☐ Poor Quality of Patient Accommodation
- ☐ Lying to a patient and/or to a patient's family
- ☐ Unnecessary treatment and/or tests ordered
- ☐ Misuse/waste of public money
- ☐ Other _____

_____

Section Three: Whistleblowing and Non-Whistleblowing Actions

Please tick (√) the action (s) you took.

- ☐ Refused to carry out an order or follow instructions.
- ☐ Spoke directly to the person or people involved in the wrongdoing.
- ☐ Told my supervisor.
- ☐ Told the administrator of nursing.
- ☐ Told the administrator of the organisation.
- ☐ Told a physician, or other professional.
- ☐ Complained to an authority within the organisation.
- ☐ Complained to an authority outside the organisation.
- ☐ Wrote an incident report or letter explaining the problem.
- ☐ Went to the media.
- ☐ Told the next shift the situation to ensure proper patient care
- ☐ Pretended to misunderstand an order, then did it another way.
- ☐ Pretended to follow an order, but did not.
- ☐ Quietly did the right thing, but didn't tell anyone.
- ☐ Used humour to change someone's mind.
- ☐ Used manipulation to change the situation.
- ☐ Made an anonymous written report or telephone call.
- ☐ Told a "higher-up" in confidence.
- ☐ Pretended to agree with something, but privately supported the opposite.
- ☐ Other _____

3A. What happened after the whistleblowing event?

1 ☐ continued unchanged	4 ☐ stopped immediately
2 ☐ decreased	5 ☐ increased
3 ☐ eventually stopped	6 ☐ don't know

3B. What happened to the wrongdoer(s)?

1 ☐ subject to disciplinary action	4 ☐ nothing
2 ☐ promoted	5 ☐ left the organisation
3 ☐ demoted	6 ☐ don't know

Section Four: Physical and Emotional Effects

Stress is associated with many physical and emotional conditions of health. Being involved in a whistleblower situation is stressful, and you may believe that it affected your physical and/or emotional health.

If you had any of the following stress-related conditions, please tick (√) the ones which you believe were (or are) directly caused by your whistleblowing experience.

Physical Effects:

- ❒ abdominal cramps
- ❒ acne
- ❒ addictions
- ❒ alcoholism
- ❒ allergies
- ❒ appetite loss
- ❒ asthma
- ❒ backache
- ❒ bladder problems
- ❒ blood pressure (increased)
- ❒ bowel problems
- ❒ chest pains
- ❒ colds/flu (increased number)
- ❒ cold sores
- ❒ colon (irritable)
- ❒ conjunctivitis
- ❒ constipation
- ❒ decline in sex drive
- ❒ digestive disorders
- ❒ diarrhoea
- ❒ dizziness
- ❒ drug overuse
- ❒ eating disorders
- ❒ exhaustion
- ❒ fatigue
- ❒ headaches (not migraine)
- ❒ heart attack
- ❒ heartburn
- ❒ haemorrhoids
- ❒ hypertension
- ❒ indigestion
- ❒ insomnia
- ❒ lethargy
- ❒ migraine headaches
- ❒ nausea
- ❒ palpitations
- ❒ rashes/skin problems
- ❒ respiratory problems
- ❒ restless sleep
- ❒ sexual problems
- ❒ shortness of breath
- ❒ sinus problems
- ❒ sleep disturbances (nightmares)
- ❒ smoking (increased)
- ❒ stomach problems
- ❒ stuttering
- ❒ tics, twitches
- ❒ ulcers
- ❒ weight gain
- ❒ weight loss

Emotional Effects

- ❒ anger
- ❒ anorexia
- ❒ anxiety
- ❒ apathy
- ❒ attempted suicide
- ❒ bitterness
- ❒ bulimia
- ❒ constantly relives W/B experience
- ❒ conflict with others (increased)
- ❒ coping difficulties
- ❒ cries easily
- ❒ cynical
- ❒ depression
- ❒ disillusioned
- ❒ distrustful of others
- ❒ deterioration of personal values
- ❒ emotional withdrawal
- ❒ feeling of guilt
- ❒ feeling of shame
- ❒ feeling of stress
- ❒ feeling of unworthiness
- ❒ frightened
- ❒ intimidated
- ❒ helpless feeling
- ❒ high strung
- ❒ grief reaction
- ❒ inability to relax
- ❒ irritability (increased)
- ❒ listlessness
- ❒ loss of confidence
- ❒ loss of emotional control
- ❒ loss of respect for workplace
- ❒ loss of satisfaction in job
- ❒ loss of satisfaction in life
- ❒ loss of satisfaction in workplace
- ❒ loss of self-esteem
- ❒ manic behaviour
- ❒ memory loss
- ❒ mood swings
- ❒ panic attacks
- ❒ physical withdrawal from people
- ❒ positive outlook reduced
- ❒ powerlessness
- ❒ reduced attention span
- ❒ reduced commitment to work
- ❒ sadness
- ❒ self-doubt
- ❒ short-tempered
- ❒ suicidal thoughts
- ❒ suspiciousness
- ❒ thoughts of flight
- ❒ thoughts of retaliation
- ❒ unable to function in work setting
- ❒ uncertain about future
- ❒ unhealthy eating/drinking
- ❒ unhealthy family relationships (fighting, separation or divorce)

Section Five: The Professional Consequences of Being Involved in a Whistleblowing Event

Please tick (√) the professional consequence (s) you received:

- ❒ Privately praised for my action.
- ❒ Publicly praised for my action.
- ❒ Received an official commendation.
- ❒ Given a pay-rise.
- ❒ Given a promotion.
- ❒ Told I was imagining things.
- ❒ Told to forget it.
- ❒ Verbal reprimand.
- ❒ Written reprimand.
- ❒ Punitive transfer.
- ❒ Demotion.
- ❒ Suspension.
- ❒ Dismissal.
- ❒ Pressured to "voluntarily" resign.
- ❒ Charged or sued.
- ❒ Threatened with transfer.
- ❒ Threatened with dismissal.
- ❒ Threatened with legal action.
- ❒ Referred to a counsellor and/or a psychiatrist.
- ❒ Career advancement halted.
- ❒ Physically isolated (removed from peer group).
- ❒ Socially isolated (rejected by peer group).
- ❒ Given impossible or menial tasks.
- ❒ Work performance scrutinised and/or written-up as inferior.
- ❒ Treated as a traitor.
- ❒ Ignored.
- ❒ Other _____

Section Six: Ways of Coping and Coping Effectiveness

Please tick (√) a response for each statement.

1. I expressed my concern to the person or people who caused the problem.
   - 1 ☐ It's something I tried, and it helped me feel better.
   - 2 ☐ It's something I tried, but it did **not** help me feel any better.
   - 3 ☐ It's **not** something I tried.

2. I tried to get the person responsible to change his or her mind
   - 1 ☐ It's something I tried, and it helped me feel better.
   - 2 ☐ It's something I tried, but it did **not** help me feel any better.
   - 3 ☐ It's **not** something I tried.

3. I tried to keep my feelings to myself, and not let others know how I felt.
   - 1 ☐ It's something I tried, and it helped me feel better.
   - 2 ☐ It's something I tried, but it did **not** help me feel any better.
   - 3 ☐ It's **not** something I tried.

4. I tried to forget the whole thing by just concentrating on my work.
   - 1 ☐ It's something I tried, and it helped me feel better.
   - 2 ☐ It's something I tried, but it did **not** help me feel any better.
   - 3 ☐ It's **not** something I tried.

5. I talked to someone who I thought could do something about the problem.
   - 1 ☐ It's something I tried, and it helped me feel better.
   - 2 ☐ It's something I tried, but it did **not** help me feel any better.
   - 3 ☐ It's **not** something I tried.

6. I stood my ground and fought for what I believed was the right thing to do.
   - 1 ☐ It's something I tried, and it helped me feel better.
   - 2 ☐ It's something I tried, but it did **not** help me feel any better.
   - 3 ☐ It's **not** something I tried.

7. I found myself avoiding the patient and/or the people involved.
   - 1 ☐ It's something I tried, and it helped me feel better.
   - 2 ☐ It's something I tried, but it did **not** help me feel any better.
   - 3 ☐ It's **not** something I tried.

8. I had fantasies/wishes about how things might turn out.
   - 1 ☐ It's something I tried, and it helped me feel better.
   - 2 ☐ It's something I tried, but it did **not** help me feel any better.
   - 3 ☐ It's **not** something I tried.

9. I tried not to burn my bridges and went on as if nothing had happened.

1 ☐ It's something I tried, and it helped me feel better.

2 ☐ It's something I tried, but it did **not** help me feel any better.

3 ☐ It's **not** something I tried.

10. I asked a friend or relative I respected for advice and support.

1 ☐ It's something I tried, and it helped me feel better.

2 ☐ It's something I tried, but it did **not** help me feel any better.

3 ☐ It's **not** something I tried.

11. I prayed that it would end up all right.

1 ☐ It's something I tried, and it helped me feel better.

2 ☐ It's something I tried, but it did **not** help me feel any better.

3 ☐ It's **not** something I tried.

12. I got away from it for awhile; I took time off, or went on holiday.

1 ☐ It's something I tried, and it helped me feel better.

2 ☐ It's something I tried, but it did **not** help me feel any better.

3 ☐ It's **not** something I tried.

13. I tried to make myself feel better by eating, drinking, smoking, using drugs.

1 ☐ It's something I tried, and it helped me feel better.

2 ☐ It's something I tried, but it did **not** help me feel any better.

3 ☐ It's **not** something I tried.

14. I drew on my past experiences to come up with a way to handle the problem.

1 ☐ It's something I tried, and it helped me feel better.

2 ☐ It's something I tried, but it did **not** help me feel any better.

3 ☐ It's **not** something I tried.

15. Which aspect of the whole experience was the most difficult to cope with?

_____

_____

16. What and who did you find most helpful?

_____

_____

Section Seven: Personal Beliefs

For each question, please tick (√) the response that best describes your belief.

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
1. A nurse's primary responsibility is to the patient.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. Nurses are sometimes powerless to control events because others (eg. doctors, administrators, etc.) are more powerful.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. A nurse is obligated to follow a physician's order at all times.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. A nurse must be equally responsible to the patient, the physician, and the employer.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. A nurse must ensure that no unfair advantage is taken of a patient.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Protecting a patient from incompetent or unethical people is a nurse's responsibility.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. In a whistleblowing situation, there is a strong fear of being fired or reprimanded.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. In a whistleblowing situation, you can count on nursing administration for support.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9. A nurse should support a patient's wish, even it goes against the wishes of the family or the physician.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10. Being a patient advocate could harm a nurse's career if it means going against the orders or plan of others.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Section Eight: Personal Feelings

Please tick (√) the response that best describes your personal feelings.

	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
1. I was afraid of being labelled a "troublemaker".	1☐	2☐	3☐	4☐	5☐
2. I was afraid of being "blacklisted", or loosing career options.	1☐	2☐	3☐	4☐	5☐
3. It was made clear to me that my job was at risk if I protested further.	1☐	2☐	3☐	4☐	5☐
4. One of the worst things about the way I was treated was having my professional integrity questioned.	1☐	2☐	3☐	4☐	5☐
5. I felt so alone; I had no support from colleagues and/or supervisors.	1☐	2☐	3☐	4☐	5☐
6. Everyone else was "keeping their head down", not wanting to get involved.	1☐	2☐	3☐	4☐	5☐
7. The incident taught me that there are times when nurses are restricted from offering the best patient care.	1☐	2☐	3☐	4☐	5☐
8. Until nurses get better support, I would not recommend being a whistleblower.	1☐	2☐	3☐	4☐	5☐
9. I believe there needs to be whistleblower legislation to protect nurses in these situations.	1☐	2☐	3☐	4☐	5☐
10. I felt hurt when workmates I trusted would not support me in front of others.	1☐	2☐	3☐	4☐	5☐

Section Nine: Open-Ended Questions

1. How long ago did the incident you described in this questionnaire occur?

2. How often do you still think about it?

3. Are you still employed at the place where the incident occurred? Yes_____ No____

4. What were your reasons for reporting the event, or not reporting the event?

5. Knowing what you know now, would you have done the same thing?

6. What advice would you give to someone who was in a similar situation?

7. As a nurse, do you believe you were damaged or strengthened by the experience?

Thank you very much for taking the time and effort to complete this questionnaire. Your honest and thoughtful responses are greatly appreciated. Please use the postage-paid envelope to return the questionnaire to the researcher.

APPENDIX C

Lennane's (1993) Questionnaire

Whistleblower questionnaire

One of the functions of Whistleblowers Anonymous is to promote research into whistleblowing. The most pressing area of research is the effect that it has on the whistleblowers and their families, if their employing organization reacts badly to the issues they have raised.

We would therefore appreciate your taking the time to fill in and return the attached questionnaire. Questionnaires are anonymous, and will be kept entirely confidential. The research is being conducted by Dr Jean Lennane, a Vice-president of WBA, and a whistleblower herself.

The information asked for, if all put together, could identify some people. If you feel that could be a problem, just leave out enough answers to remove the possibility of identification, and mark those question(s) with an asterisk.* We would prefer the information to be as complete as possible, and suggest the best answer to omit, if you have this concern, is No 4. Please remember however that all information will be kept strictly confidential, and questionnaires will be destroyed once the information has been collated. The results will be published only in group form,(e.g. % from each State, % in each age group, % experiencing a particular problem). Questionnaires are being sent to over 150 whistleblowers, from a wide variety of States and occupations.

Whistelblowing is defined as occurring when a present or former employee discloses information "which the employee reasonably believes evidences a violation of any law, rule, or regulation, or gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety." (US Whistleblower Protection Act, 1989.)

We are including in this survey people who did not in fact disclose such information, but were treated by their employer as if they had.

Please answer all questions if possible, by circling the correct response (for some of them, you can circle more than one response), and use the space for comments if there is anything you wish to add, or if the question doesn't really apply to your particular situation.

1. Age: (i)18-35 (ii)36-50 (iii) 51-65 (iv)66+

2. Sex: (i) M (ii) F

3. Marital status: (i)married (ii)never married (iii)separated
(iv)widowed (v) divorced (vi) de facto

4. State/Territory: (current)
(i)NSW (ii)Vic (iii)SA (iv)WA (v)Tas (vi)Qld (vii)ACT (viii)NT

5. How long ago did your whistleblowing occur? (Or you started being treated as if you had blown the whistle)
(i)less than 2 years (ii)2-4 years (iii)5-10 years (iv)11-20 (v)over 20

6. What type of employment were you in at that time?
(i) private sector - specify type (e.g. banking).....

(ii) State public sector - specify field (e.g. Health, Education).....
.....
(iii) Federal public sector - specify field (e.g. Defence, Customs).....
.....

7. What type(s) of wrongdoing was involved within the organization you were working for? (If you were not working for the organization you blew the whistle on, please give some details of your situation under 'other')
(i) corruption (ii) waste (iii) incompetence
(iv) danger to public (v) mismanagement (vi) breach of law
(vii) abuse of power
(viii) other (please specify).....

8. If the wrongdoing involved financial loss to the public/taxpayer, what sort of figures were involved? (approx., in $thousands, $millions etc) .....

If the wrongdoing involved danger or damage to the public, what type of danger or damage?.....
.....
.....

9.What form(s) did your whistleblowing take?
(i) wrote report in normal course of duty
(ii) complained to higher authority(s) within the organization (please give details).....
.....
.....
.....
.....
(iii) complained to authority(s) outside the organization (please give details).....
.....
.....
.....
.....
.....

(iv) went to media (please give details).....
.....
.....
.....
.....
(v) other (please give details).....
.....
.....
.....
.....

10. Did your whistleblowing cause you to experience any adverse effects or victimization? (i) yes (ii) no

11. If you experienced adverse effects from your whistleblowing, when did they start in relation to when it occurred?
(i) before (ii) immediately after
(iii) delayed (please specify the delay, in ..... weeks, ...months or ..... years)

12. If you experienced any form of victimization at work following your whistleblowing, what form(s) did this take?
(i) dismissal or pressure to resign

(ii) other formal disciplinary action (please describe).....
.....
.....
.....
(iii) legal action against you (e.g. defamation - please specify)

(iv) informal tactics: (please circle and give details)
*physical isolation.....
*personal isolation.....

*abuse.....
*scrutiny of time-sheets and work records.....

*demanding or impossible orders.....

*removal of normal work.....

*referral to psychiatrist(s).....
*threats of disciplinary action.....

*other.....

13. How did your colleagues/workmates treat you after the trouble started? (Please circle one response for each of the following)

.openly supportive	most	some	a few	none
.supportive when not observed	most	some	a few	none
.ostracized you	most	some	a few	none
.active in victimization	most	some	a few	none
.betrayed you (people who were close to you beforehand)	most	some	a few	none

14. What is your current employment status?
(i)employed full-time (ii) employed part-time
(iii)self-employed full-time (iv) self-employed part-time
(v) unemployed (vi) other (please specify).....

15. Are you still working for the organization on which you blew the whistle?
(i) yes (ii) no
IF YES: Have you been (i) promoted (ii) demoted (iii)no change?

IF NO: Were you (i)dismissed (ii)pressured to resign
(iii) resigned because of victimization
(iv) resigned because of ill-health related to victimization
(v) left for reasons unrelated to whistleblowing
(vi) other (please specify)
.....
.....

16.Has your present level of income been affected by your whistleblowing?
(i) yes (ii) no

IF YES, has it (i)increased (ii)decreased?
IF decreased, estimate by approximately how much:
(i)less than 1/4 (ii)1/4 (iii)1/2 (iv)3/4 (v)more than 3/4

17. Have you incurred financial loss other than income? (e.g. legal costs, hospital etc) (i) yes (ii)no
IF YES :Please specify.....

18. On the whole, has your whistleblowing resulted in
(i)financial loss (ii) financial gain (iii) no effect?

IF A LOSS, what would you estimate as your total financial loss? (Include loss of income, divorce settlement, legals, etc - approximately, in $thousands/$tens/$hundreds of thousands).....

IF A GAIN, what would you estimate?.....

19. Were you married/in a long-term relationship at the time you blew the whistle?
(i)yes (ii)no
IF YES, are you still in that relationship? (i)yes (ii)no

IF still in that relationship, what effect has the whistleblowing had on it?
(i) positive (ii) neutral (iii) negative
Please explain.....

IF NO, did whistleblowing contribute to the break-up?
(i) wholly (ii) partly (iii) slightly (iv) not at all
Please explain.....
.....
.....

20. Do you have any children? (i) yes (ii)no
IF YES: a. How many? .....
b. How old are they?.....
c. Has your whistleblowing had any adverse effects on any of your children?
(i) yes (ii) no
IF YES, please describe.....
.....
.....
.....
.....

21. Did you ever have any treatment for nervous illness, or see a psychiatrist before the issues that led to your whistleblowing arose? (i) yes (ii) no
IF YES, please specify.....

22. Have you had any treatment for nervous illness or seen a psychiatrist since?
(i) yes (ii) no

23. Did you ever have to see a psychiatrist at your employer's insistence?
(i)yes (ii)no
IF YES: a. How many times?.....
b. Were the consultation(s) (i)helpful (ii)neutral (iii) unhelpful
(iv)distressing (v) other.....

24. Have you experienced any adverse effects on your health because of whistleblowing? (i.e. physical or emotional problems either not present at all before, or that have got worse because of it.)
(i) yes (ii) no
IF YES: Please specify.....

25. Are you taking any medication now that you were not taking before the whistleblowing, related to the above adverse effects?
(i) yes (ii) no
IF YES: Please specify.....

26. Which, if any of the following symptoms have been a problem since the whistleblowing, that were not a problem before?
(i)difficulty sleeping (ii)anxiety (iii) panic attacks
(iv)depression (v)feelings of guilt and unworthiness
(vi)nervous diarrhoea (vii)trouble breathing
(viii)stomach problems (ix)loss of appetite (x)palpitations
(xi)high blood pressure
(xii) other symptoms attributable to nervous tension (please specify)..... .....

27. Which, if any, of the symptoms are still present?
(i) difficulty sleeping (ii) anxiety (iii)panic attacks
(iv)depression (v) feelings of guilt and unworthiness
(vi) nervous diarrhoea (vii) trouble breathing
(viii)stomach problems (ix) loss of appetite (x) palpitations
(xi) high blood pressure
(xii) other symptoms attributable to nervous tension (please specify) .....
.....
Are they currently (i) getting better (ii) stable
(iii) getting worse (iv) variable (v) no symptoms?
Are they (i) mild (ii)moderate (iii)severe (iv) no symptoms?

28. Did you ever consider suicide before the whistleblowing?
(i)yes (ii) no
Have you ever considered suicide since the whistleblowing?
(i) yes (ii) no
IF YES: was this (i)occasional (ii)frequent?
Did you get as far as seriously considering how to do it?
(i) yes (ii) no
IF YES: a. please describe.....

b. Did you actually attempt it? (i) yes (ii) no
IF YES: please describe.....

29. How often do you now think about the whistleblowing and its aftermath?
(i) never (ii)every day (iii)several times a week
(iv)approx. weekly (v)perhaps once a month
(vi) variable.....
If you still think about it every day, how much of the day would you be thinking about it? Please estimate.....

30. Do you drink alcohol? (i) yes (ii) no
IF YES: then how many days per week do you drink (on average)?.....
How much do you drink on an average drinking day? (State type of beverage and quantity) .....

Has your drinking changed since the whistleblowing? (i)yes (ii)no
IF YES: has it (i)increased (ii)decreased?
IF INCREASED: Do you think you have been using alcohol to cope with some of the stresses? a. (i)yes (ii)no
b. Has this become a problem? (i)yes (ii)no

32. Do you smoke? (i)yes (ii)no
IF YES: Since the whistleblowing has your consumption
(i)decreased (ii) increased (iii)stayed the same?

33. What has happened regarding the wrongdoing that led you to blow the whistle?
Has it: (i)continued unchanged (ii) increased
(iii)decreased (iv)stopped (v)don't know?

What has happened to the wrongdoer(s)? Have they been
(i)charged with any relevant offence
(ii) subject to disciplinary action at work
(iii)demoted
(iv)promoted
(v)other? Please specify.....

34. What bodies/organizations, internal or external, did you appeal to for help in your case? (e.g. your union, State Ombudsman, Federal Ombudsman, Anti-discrimination Board, ICAC). Please list, and state whether that body, overall, was helpful to your case, harmful, or neither helpful nor harmful:

a.....	helpful	harmful	neither
b.....	helpful	harmful	neither
c.....	helpful	harmful	neither
d.....	helpful	harmful	neither
e.....	helpful	harmful	neither
f.....	helpful	harmful	neither
g.....	helpful	harmful	neither
h.....	helpful	harmful	neither

Any comments?.....

35. Have you been to any formal Court or Tribunal regarding your case?
(i) yes (ii) no
IF YES: please list, and state whether, overall, that court/tribunal was helpful to you, harmful, or neither; and state roughly how long, in months, the process took. If it is still proceeding, mark "p".

				months to date
a.....	help	harm	neither	"
b.....	help	harm	neither	"
c.....	help	harm	neither	"
d.....	help	harm	neither	"

Any comments?.....

36. Which one of each of the following four pairs of characteristics best describe your personality?
a) Are you more (i) introverted (reserved, cautious, interested in ideas), or (ii) extroverted (confident, active, sociable) ?

b) Are you more (i) observant of facts, things, live life in the present, or (ii) imaginative and independent of your physical surroundings?

c)Which is more important to you? (i) logic or (ii) feeling?

d) Do you (i) make decisions quickly and stick to them? or (ii) like to keep your options open?

37.Do you have any formal religious belief? (i)yes (ii)no
IF YES: please specify (e.g. Christian, Muslim).....

Do you go to a church? (i)regularly (ii)sometimes (iii)never

38. What was your main motive(s) for blowing the whistle?
Please explain.....

39. Knowing now what was going to happen when you did, would you do it again?
(i)yes (ii)no (iii)not sure
Why?.....

40. What aspect(s) of the whole episode have you found the most upsetting and difficult to cope with?.....

41. What and who did you find helped you the most?.....

42.What advice would you give someone in your situation who was considering doing what you did?.....

43. What help/protection would you like to see available to whistleblowers?.....

44. Do you think you have been damaged or strengthened as a person by the experience? (i)damaged (ii)strengthened (iii)no change
Please describe.....

45. Have you been affected in any other way(s) we haven't mentioned?
(i)yes (ii)no
IF YES: please describe .....

46. Have there been any personal benefits from the whistleblowing?
(i)yes (ii)no
IF YES: please specify.....

47. Is there anything else you would like to add?

Please return as soon as possible to:
[redacted]

APPENDIX D

References Used to Develop

Section Two of the Questionnaire

APPENDIX D

Section Two of the Questionnaire	Relevant Literature Source
Non-compliance with hospital policy Non-compliance with nursing stand.	De Maria, 1994; Hunt, 1995; Mohr, 1996; Wilkinson, 1987/88.
Sex/race discrimination	Daugherty et al., 1998; De Maria, 1994
Theft	De Maria, 1994; Hunt, 1995
Assault	Daugherty et al., 1998; De Maria, 1994; Hunt, 1995
Sexual misconduct	De Maria, 1994; Lennane, 1993.
Impaired condition at work	Daugherty et al., 1998; De Maria, 1994; Hunt, 1995.
Physical harassment	Daugherty et al., 1998; Holly, 1993; Hunt, 1995; Wilkinson, 1987/88.
Concealment of wrongdoing	Daugherty et al., 1998; De Maria, 1994; Lennane, 1993.
Improper training	De Maria, 1994; Hunt, 1995; Lennane, 1993; Wilkinson, 1987/88.
Incompetent person with patients	Daugherty, 1998; Holly, 1993; Hunt, 1995; Lennane, 1993; Wilkinson, 1987/88.
Abusive person with patients	Daugherty, 1998; Holly, 1993; Hunt, 1995; Lennane, 1993; McDonald, 1994; Mohr, 1996; Wilkinson, 1987/88.
Inability to obtain Dr.'s order; Unsafe staffing pattern; Mismanagement	De Maria, 1994; Hunt, 1995, Lennane, 1993.
Incompetent, hostile management	Daugherty et al., 1998, De Maria, 1994; Holly, 1993; Lennane, 1993; Wilkinson, 1987/88.
Favourtism and/or nepotism	De Maria, 1994; Lennane, 1993.
Violation of patient's rights, requests, confidentiality	Daugherty et al., 1998; Holly, 1993; Hunt, 1995; McDonald, 1994; Mohr, 1996; Wilkinson, 1987/88.

Poor quality patient care: Poor quality patient accomodation	Holly, 1993; Hunt, 1995; Mohr, 1996; Wilkinson, 1987/88.
Lying to a patient; Unnecessary treatment and/or tests.	Hunt, 1995; Holly, 1993; McDonald, 1994; Mohr, 1996; Wilkinson, 1987.
Misuse / waste of public money	De Maria, 1994; Lennane, 1993.

APPENDIX E

References Used to Develop

Section Three of the Questionnaire

APPENDIX E

Section Three of the Questionnaire	Relevant Literature Source
Refused to carry out an order	De Maria, 1994; Holly, 1993; Hunt, 1995; Lazarus & Folkman, 1984; Segesten, 1993; Wilkinson, 1987/88.
Spoke directly to the person involved	Chafey et al., 1998; De Maria, 1994; Hunt, 1995; Lazarus & Folkman, 1984; Lennane, 1993; Wilkinson, 1987/88.
Told my supervisor; Told the administrator of nursing; Told the administrator; Told a physician or other professional.	Chafey et al., 1998; De Maria, 1994; Holly, 1993; Hunt, 1995; Lazarus & Folkman, 1984; Lennane, 1993; Wilkinson, 1987/88.
Complained to an authority inside org; Complained to an authority outside the organisation; Wrote an incident report.	Chafey et al., 1998; De Maria, 1994; Holly, 1993; Hunt, 1995; Lazarus & Folkman, 1984; Lennane, 1993; Wilkinson, 1987/88.
Went to the media.	De Maria, 1994; Hunt, 1995; Lennane, 1993.
Told the next shift; Pretended to misunderstand, and did it another way	Chafey et al., 1998; Lazarus & Folkman, 1984; Segesten, 1993.
Pretended to follow an order; Quietly did the right thing, but didn't tell.	Chafey et al., 1998; Lazarus & Folkman, 1984; Segesten, 1993; Watt, 1997.
Used humour and/or manipulation to change the situation.	Chafey et al., 1998; Holly, 1993; Lazarus & Folkman, 1984; Watt, 1997; Wilkinson, 1987/88.
Made an anonymous report; Told a higher up in confidence; Pretended to agree, but privately supported the opposite.	Chafey et al., 1998; Erlen & Frost, 1991; Holly, 1993; Lazarus & Folkman, 1984; Watt, 1997; Wilkinson, 1987/88.

APPENDIX F

Instructions Given to the Panel of Three Experts To Rate the Content Validity Of the Questionnaire

Appendix F

Dear Questionnaire Rater:

In order to assess the content validity of the attached questionnaire, each item must be scored by three expert raters. The Content Validity scoring scale is from Lynn (1986), and I have attached a copy of her article for reference. The scoring guide is:

1 = item not relevant

2 = item needs major revision

3 = item needs minor revision

4 = item relevant and succinct

Please place one of the above scores in each box next to each item on pages 3, 4, 5, 6 and 7 of the questionnaire, and return your results to me via email.

Thank you very much for your time and effort.

Sincerely,

Sally McDonald

APPENDIX G

Table of Rating Scores

How the Panel of Experts Rated the Content Validity of Sections 2, 3, 4, 5 and 6 of the Questionnaire

Appendix G

Rating Scores for Content Validity

Question Numbers	**Rating Score Given ByPanel of 3 Experts***			
	4	**3**	**2**	**1**
Section Two Questions				
1-16, 18-22, 24-26	xxx			
17	x	xx		
23	xx	x		
Section Three Questions				
1-11, 13-20	xxx			
12	xx	x		
Section Four Questions				
Physical Effects (1-50)	xxx			
Emotional Effects (1-50)	xxx			
Section Five Questions				
1-27	xxx			
Section Six Questions				
1-16	xxx			

*Scoring Guide:
1= not relevant
2= unable to assess without major revision
3= needs minor alteration
4= relevant and succinct

APPENDIX H

Content Validity Tool

Given to Panel of Three Experts

to Rate Section Six of the Questionnaire

Appendix H

Coping Response on Questionnaire	Literature Source	Lazarus & Folkman (1984) Ways of Coping	Content Validity Rating Score (Please circle)
1.) I expressed my concern to the person who caused the problem.	Chafey et al., '98 De Maria, '94 Manderino & Berkey, '97, Segesten, '93	#17 I expressed anger to the person(s) who caused the problem.	1 = not relevant 2 = needs major revision 3 = needs minor revision 4 = relevant and succinct
2.) I tried to get the person responsible to change his or her mind.	Chafey et al., '98; Erlen & Frost, 91 Segesten, 1993; Soderberg 1993; Watt, 1997	#7 I tried to get the person responsible to change his or her mind.	1 = not relevant 2 = needs major revision 3 = needs minor revision 4 = relevant and succinct
3.) I tried to keep my feelings to myself, and not let other know how I felt.	Manderino & Berkey, 1997; Smith & Thomas, 1996; Wilkinson, 1988; Watt, 1997	#14 I tried to keep my feelings to myself.	1 = not relevant 2 = needs major revision 3 = needs minor revision 4 = relevant and succinct
4.) I tried to forget the whole thing by just concentrating on my work.	Erlen & Frost, 1991; Holly, 1993; Segesten , 1993;Wilkinson, 1988	#3 Turned to work…to take my mind off things.	1 = not relevant 2 = needs major revision 3 = needs minor revision 4 = relevant and succinct
5.) I talked to someone …who could do something ….	De Maria, 1994; Hunt, 1994; Lennane, 1993; Watt, 1997.	#31 Talked to someone who could do something….	1 = not relevant 2 = needs major revision 3 = needs minor revision 4 = relevant and succinct
6.) I stood my ground and fought for what I believed was right.	Chafey et al., '98; De Maria, 1994; Segesten, 1993; Soderberg & Norberg, 1993.	#46 Stood my ground and fought for what I wanted.	1 = not relevant 2 = needs major revision 3 = needs minor revision 4 = relevant and succinct

…Continued/

7.) I found myself avoiding the patient ..& others.	Holly, '93;Smith/ Thomas, 1996; Wilkinson, 1988	#40 Avoided being with people in general.	1 = not relevant 2 = major revis. 3 = minor revis. 4 = relevant and succinct
8.) I had fantasies/wishes about how things might turn out.	Holly, '93; Simoni/Paterson, '97; Smith & Thomas, 1996.	#59 Had fantasies/wishes about how things might turn out.	1 = not relevant 2 = major revis. 3 = minor revis. 4 = relevant and succinct
9.) I tried not to burn my bridges and went on as if nothing had happened.	Erlen & Frost,91; Manderino/Berkey, '97;Soderberg & Norberg, '93; Wilkinson 1988	#10 Tried not to burn my bridges, but leave things open somewhat.	1 = not relevant 2 = major revis. 3 = minor revis. 4 = relevant and succinct
10.) I asked a friend or relative I respected for advice/support.	Manderino/Berkey, '97; Simoni & Paterson, 1997; Uden et al., 1992	#42 I asked a friend or relative I respected for advice.	1 = not relevant 2 = major revis. 3 = minor revis. 4 = relevant and succinct
11.) I prayed that it would end up all right.	Chafey et al, '98; Manderino & Berkey, 1997.	#60 I prayed.	1 = not relevant 2 = major revis. 3 = minor revis. 4 = relevant and succinct
12.) I got away from it for a while; took time off, or went on holiday.	Chafey et al,1998 Holly, 1993; Manderino/Berkey, 1997.	#32 Got away from it for a while; tried to rest or take a holiday.	1 = not relevant 2 = major revis. 3 = minor revis. 4 = relevant and succinct
13.) I tried to make myself feel better by eating, drinking, smoking, using drugs.	De Maria, 1994; Lennane, 1993; Manderino & Berkey, 1997;	#33 Tried to make myself feel better by eating, drinking, smoking using drugs.	1 = not relevant 2 = major revis. 3 = minor revis. 4 = relevant and succinct
14.) I drew on past experiences to come with a way to handle problem.	Chafey et al., '98; Duncan, 1992; Manderino/Berkey, '97; Segesten, 1993; Uden et al., 1992.	#48 Drew on past experiences; I was in similar situation before.	1 = not relevant 2 = major revis. 3 = minor revis. 4 = relevant and succinct

APPENDIX I

Cover Letter Sent to Participants

November 1997

Dear Nurse:

Your name was one of 500 randomly selected from The Nurses Board of W.A. registration list to participate in a research survey. **The research is completely anonymous and there is no way to identify individuals who have been selected.**

My name is Sally McDonald and I am a graduate student in the School of Nursing at Edith Cowan University, in Perth, Western Australia. I am conducting a research study on the effects of whistleblowing and non whistleblowing on nurses in Western Australia.

Whistleblowers are people who disclose information about misconduct or incompetence in their workplace which they feel violates the law, or endangers the welfare of others. This would seem to be an honourable thing for people to do, especially for nurses, who may feel they are protecting the rights of their patients. Yet whistleblowers do not always receive support from their employers or colleagues when they identify and report wrongdoing. Studies on whistleblowing show that it is a very difficult thing to be involved in, sometimes causing the whistleblower distress and harmful consequences.

The purpose of this study is to find out what the experience of being in a whistleblower situation is like for nurses in Western Australia. It will ask the nurses to define what the ethical dilemma was like for them, and how they felt it affected them physically, emotionally and professionally.

The study consists of a mailed questionnaire which will ask for information and opinions. It will not ask for names, or identify locations, and it will **not** publish anything which could identify a whistleblowing event. Published information will be in the form of graphs and tables, such as "70% of whistleblowers felt angry", "50% of whistleblowers had trouble sleeping", etc.

If you have been involved in a whistleblowing situation, or wanted to report wrongdoing but felt unable to do so, please take 20 minutes to complete the encosed questionnaire. You may feel some discomfort in recalling painful memories, but studies of whistleblowers reveal that sharing the experience with others who have been in similar situations is rewarding, and validates the strong feelings. Furthermore, this research may lead to the development of policies to support future whistleblowers.

Your experience will offer valuable information for this research. **Your name, address, or place of employment is not known to the researcher and no information which could identify your experience will be published.** After the information is entered into the computer, the questionnaire will be shredded. Return of the questionnaire will mean that you consent to be a part of the study. Enclosed please find a postage-paid return envelope for the completed questionnaire. Thank you very much for your time and consideration.

Sincerely,

[redacted]

Sally McDonald
Principal Investigator, Whistleblower Study
Edith Cowan University
Churchlands Campus, Pearson Street
Western Australia 6050