Employee Silence in Healthcare: Charting New Avenues for Leadership and Management

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Abstract

Issue: Healthcare management is faced with a basic conundrum about organizational behavior; why do professionals who are highly dedicated to their work choose to remain silent on critical issues that they recognize as being professionally and organizationally significant? Speaking up interventions in healthcare achieve disappointing outcomes because of a professional and organizational culture which is not supportive.

Critical Theoretical Analysis: Our understanding of the different types of employee silence is in its infancy and more ethnographic and qualitative work is needed to reveal the complex nature of silence in healthcare. We use sensemaking theory to elucidate how the difficulties to overcoming silence in health care are interwoven in healthcare culture.

Insight/Advance: The relationship between withholding information and patient safety is complex, highlighting the need for differentiated conceptualizations of silence in healthcare. We present three Critical Challenge points to advance our understanding of silence and its roots by (1) challenging the predominance of psychological safety, (2) explaining how we operationalise sensemaking, and (3) transforming the role of clinical leaders as sensemakers who can recognize and reshape employee silence. These challenges also point to how employee silence can also result in a form of dysfunctional professionalism that supports maladaptive healthcare structures in practice.

Practice Implications: Delineating the contextual factors that prompt employee silence and encourage speaking-up among healthcare workers is crucial to addressing this issue in healthcare organizations. For clinical leaders, the challenge is to valorize behaviors that enhance adaptive and deep psychological safety among teams and within professions, while modeling the sharing of information that leads to improvements in patient safety and quality of care.

Keywords: employee silence, speaking-up, healthcare, psychological safety

Issue

Healthcare management is faced with a basic conundrum about organizational behavior; why do professionals who are highly dedicated to their work choose to remain silent on critical issues that they recognize as being professionally and organizationally significant? Employee silence denotes the withholding of genuine expressions about employees' evaluations of personal, social, and/or organizational circumstances at work from persons who are capable of effecting change (Pinder & Harlos, 2001). The need to focus independently on employee silence (as opposed to voice) is highlighted by a recent meta-analysis (Sherf et al., 2021) indicating that employee silence and voice are (a) independent, (b) differentially predicted by perceived impact and psychological safety, and (c) have different effects on employee burnout.

Silence in healthcare involves not elevating concerns up the organizational hierarchy to people who can act on it and can take a number of forms including being silent about patient safety concerns, ethical issues, discrimination issues, inappropriate supervisor behavior, neglected care, and lack of resources. Silence in healthcare has been related to concealing personal errors and covering errors made by other (Edmondson, 2019; Maxfield et al., 2005) as well as reduced patient safety (Henriksen & Dayton, 2006).

Silence among healthcare workers is ubiquitous (Mannion & Davies, 2015) and one important challenge is to understand the way that individual perspectives are driven by and connected with organizational polices in healthcare. The most recent evidence highlights that speaking-up interventions in healthcare are muzzled by a global pervasiveness and dominance of professional cultures that are inimical to speaking-up interventions (Jones et al, 2021). Moreover, Jones et al. (2021) conclude that researchers consistently overlook how otherwise well-conceived individual components of training interventions (such as improved

communication skills) are often usurped in practice by complex inter-relationships between training components and contextual issues, such as pre-existing socio-cultural relationships, workplace hierarchies, and perceptions of speaking-up. The importance of complex social structures suggests that macro issues (e.g., professional culture) can have a correspondingly pervasive and enduring effect that is often missed by focusing on more micro team and organizational culture. For example, a meta-analysis on team training in healthcare (Hughes et al, 2016) found (unexpectedly) that training that involved feedback exhibited weaker effects than training that did not involve feedback, with the authors not understanding why, but suggesting that feedback is less effective when self-directed and hierarchy is a factor. Thus, policies and rules aimed at promoting speaking-up will fail if recipients receive double-messages whereby they understand that they should remain silent about some issues (e.g., equipment shortages), but speak-up about others (e.g., overtime).

The challenge going forward is to elucidate why speaking-up interventions are failing and how can we bring clarity to the key issues in employee silence. To this end, we have structured the paper in three parts. Firstly, we start by clarifying why we need to understand employee silence in healthcare by locating it within the well-known scandals in patient care. The objective is to sensitize the reader to the fact that employee silence is at the kernel of healthcare breakdowns and has gained renewed importance during the COVID-19 pandemic. Secondly, we examine a number of theoretical issues within employee silence, including; what drives employee silence, whether we need a different conceptual approach, the role of leaders, and the problem of translating good practice from other industries. Within this section, we will use sensemaking theory (Weick et al., 2005) to elucidate how the difficulties of overcoming silence in health care (e.g., the limited success of speaking-up interventions) are interwoven in healthcare culture. A central issue here is that the relationship between

withholding information and patient safety is complex, highlighting the need for differentiated conceptualizations of silence in healthcare. We argue that sensemaking represents the most promising way to address employee silence from both a theoretical and practical basis, leading to our third section which outlines the ways managers and leaders can be sensemakers.

In the third part of the article, we will elaborate on ways to address silence in health care within the sensemaking framework. Specifically, we argue that we need to emphasize and extend the role of clinical leaders and managers beyond their traditional role as target for, facilitator, or inhibitor of voice. Moreover, we propose to transform the role of clinical leaders as sensemakers who can reshape employee silence from being a latent integral aspect of healthcare culture into a phenomenon which is visible and discussed. Policies or interventions to give employees opportunities to voice may not effectively reduce silence, and therefore fail to reduce burnout, if employees still withhold issues they do not feel comfortable sharing (Detert & Burris, 2016). However, supporting clinical leaders to act as sensemakers could remove this barrier to silence by creating cultures which promote open discussion. We present three Critical Challenge points to advance our understanding of silence and its roots by (1) challenging the predominance of psychological safety, (2) explaining how we operationalise sensemaking, and (3) transforming the role of clinical leaders as sensemakers. The problems around silence are accepted as real and continuous in healthcare, but there is a paucity of directions for finding solutions.

Why is understanding employee silence important in healthcare?

Employee silence in healthcare is not new. While there has been progress in terms of open communication and the reporting of errors via the media, and through whistleblowers, which has improved procedures and fostered learning (e.g., Dellve et al., 2017; Edmondson,

2019), there has been little progress in patient safety as healthcare organizations have failed to engage with expertise in the safety sciences (Wears & Sutcliffe, 2020). The impact of silence is most clearly revealed when compromised healthcare workers and suboptimal quality of care have tragic consequences. Inquiries into the Bristol Royal Infirmary Pediatric Scandal, the serial killer Dr. Harold Shipman, and the Mid-Staffordshire NHS Foundation Trust have all confirmed that whistleblowers played a crucial and constructive part in the identification of poor patient care leading to death and patient harm. The inquiry in the case of Dr. Jayant Patel, a surgeon at Bundaberg Hospital, Australia (Edwards et al., 2016) provides us with specific insight on how employees responded to failings in patient care over time. The role of whistleblowing here was crucial, but an analysis of the events that led to the inquiry shows at the level of informal communication, employees were unofficially discussing their concerns during the period of sense-making, which led to either silence or formal reporting or whistleblowing (Edwards et al., 2016). When adverse events started occurring, employees engaged in discussions regarding Dr. Patel's behaviors, performance, and decisions amongst themselves. It becomes clear how the initial informal communication in the form of gossiping about the newly arrived surgeon was in fact the unofficial attempt of the staff to make sense out of decisions made by the hospital leaders. Testimonies provided by employees indicated that Dr. Patel's behavior became a frequent topic of discussion until the appropriate people were ready to share their concerns formally. The important question is why it takes until a disaster point is reached before staff voice concerns are acted upon. Staff tend to delay voicing concerns until situations reach a crisis and this has been previously explained to be a result of the culture in healthcare which discourages transparency (Jones et al., 2021). This is consistent with the evidence of information sharing as a collective and interactional process rather than a one-time dyadic event (Satterstrom et al., 2020), that

gradually becomes voiced. Additionally, while all the aforementioned scandals were characterized by informal chats about the problems, they still involved the withholding of information from the relevant people. Thus, employee silence is not the opposite of whistleblowing per se, but rather silence can be expressed and observed in intense informal chats and gossip.

Effective healthcare delivery is dependent on effective communication and so the impact of employee silence on information sharing is important. Inhibiting the expression of one's positive or negative emotions can result in the sympathetic activation of the cardiovascular system, meaning that employees that keep silent may experience ongoing heightened arousal, associated stress, and concomitant burnout (Gross & Levenson, 1997). Thus, if employees believe that certain forms of silence based on loyalty or "not breaking ranks" are expected of them, they may experience a negative impact on their own wellbeing. Employee silence may also affect individuals when they return home as it may lead to rumination and reduced recovery from work events (Maxfield et al., 2005).

Employee silence represents a loss for the organization in terms of missed opportunities to share valuable information about work practices and to learn from errors. When coupled with the cumulative impact on employees, silence represents a significant problem for organizations, with far-reaching consequences. Silence at the 'collective' level has been studied as organizational silence (Morrison & Milliken, 2000), an ineffective aspect of the organizational culture that can have serious implications in healthcare (Pope, 2019). During the ongoing COVID-19 pandemic, evidence has arisen that healthcare employees are being asked to keep silent about the availability of personal protective equipment (PPE) (Dyer, 2020) and recent research has linked a lack of PPE with PTSD symptoms (Gilleen et al., 2020).

Theoretical Analysis

What drives employee silence in healthcare?

Research on silence in organizations reveals motives for why employees are silent (e.g., Knoll & van Dick, 2013; Morrison, 2014; Van Dyne et al., 2003). We think knowing about different motives for remaining silent is key for clinical leaders and policy makers to address the phenomenon in healthcare. Our understanding of the different types of employee is silence is in its infancy and more ethnographic and qualitative work is a necessary way forward in terms of revealing the complex nature of silence in healthcare.

Knowing which types of silence are prevalent in a healthcare organization implies very different solutions. Some of these motives for silence were evident in a review of speaking up behaviors in healthcare (Creese et al., 2021; Okuyama et al., 2014). This review identified several factors influencing the likelihood of raising concerns, including: the perceived efficacy of speaking up (including concerns about lack of action and perceptions of personal control and impact), perceived safety of raising concerns (related to fear of reprisal, appearing incompetent, and team conflict), motivation to speak up and clinical context (related to perceived patient risk and clinical clarity/ambiguity), contextual factors (including organizational/administrative support, policy, leader attitudes, and team culture), individual differences (including professional identification, responsibility towards patients, communication skills, confidence related to experience and education, and job satisfaction), and tactics and target (including collecting facts, explaining positive intent to help and selecting a target for voicing concerns). Yet we still know relatively little about the gap between being silent and speaking-up, and we cannot assume they are a simple continuum.

Do we need a different conceptual approach to silence in healthcare?

We may need to start from a different theoretical point; one that acknowledges the fact that employee silence is a norm in healthcare, and in organizations generally (Mustard, 2009). Indeed, the difficult journeys that whistleblowers experience may be indirect evidence that organizational silence is expected and part of the psychological contract in health care work. Thus, delineating the contextual factors that prompt employee silence and encourage speaking-up among healthcare workers is crucial to addressing this issue in healthcare organizations. In this vein, Tangirala and Ramanujam (2008) in a sample of nurses found that a climate of high procedural justice moderated the relationship between professional commitment and employee silence. To put this in practical terms, in the absence of procedural justice high levels of professional commitment and employee silence can co-exist together, meaning that interventions that focus on individual expression of professional values are likely to be less effective. This paper from 2008 is an example of the persistent lack of integration between research about employee silence and recent interventions to encourage speaking-up in healthcare. This further connects with our earlier point about how training interventions are often usurped in practice by complex inter-relationships between training components and contextual issues (Hughes et al., 2016; Jones et al., 2021).

We need an approach that is more distinct, can be contextualized in varying healthcare contexts, and provides a foundation for a culture of safety. Quantitative (frequency) approaches to employee silence provide information on its occurrence, but we need to view silence as contextual, collective, and gradual (Satterstrom et al., 2020), which might be better served by qualitative/ethnographic approaches. For example, Pinder and Harlos (2001) note that if an employee perceives that an injustice has occurred, a secondary appraisal process occurs, where the employee must assess what to do – to speak-up or remain silent. As noted

by Sherf et al. (2021), scholars may benefit from examining how different targets shape the relationships among voice and silence and their predictors.

Silence can also be viewed as an iterative process, constructed by different perspectives, the unfolding of emergent events and ongoing interactions with colleagues (Blenkinsopp & Edwards, 2008). In this regard, the concept of sensemaking (Weick et al., 2005) provides a way to understand employee silence as an ongoing process rather than a static event. This theory may help to explain why remaining silent means different things to different healthcare workers who work in different disciplines and have varying training backgrounds. According to the sensemaking approach, when an individual is faced with a decision to be silent or speak-up they seek to explain what is happening using cues from the situation, preexisting views and beliefs about the world, communication with others, and previous interactions with social actors (Weick, Sutcliffe & Obstfeld, 2005). In terms of sensemaking, the decision to speak-up or remain silent probably passes through three iterative phases; firstly, the person tries to make sense of an adverse event alone (in their own mind); secondly, they start to discuss the event with trusted colleagues; and thirdly they explore how they can report the event as either an individual or as a team. If the outcome of this sensemaking is a decision to whistleblow due to an unresponsive system– this represents a failure of leadership.

Sensemaking may provide a useful way to understand the reported differences between physicians and nurses in their frequency of speaking-up. For example, physicians generally view whistle-blowing as unethical and disloyal to colleagues, and express a preference to keep adverse events “in house;” whereas nurses are more accepting of the need for a reporting system (Kingston et al., 2004). In terms of sensemaking, nurses are more likely to interpret adverse incidents as “reportable”, while physicians are more likely to

interpret them as “known complications” (Kingston et al., 2004). In healthcare, who we think we are (i.e., our identity) as an organizational actor (i.e., I’m a doctor) shapes what we enact and how we interpret events, which affects what outsiders think we are (image) and how they treat us, which stabilizes or destabilizes our identity (Weick et al., 2005). However, the healthcare hierarchy and power differential across professional boundaries continues to influence the tendency to speak up (Morrow et al., 2016). An excellent example of this is the research by Tamuz et al. (2011) indicating that four sets of healthcare professionals applied four different event classifications, and chose four different courses of action in response to the same adverse event.

Sensemaking, with its focus on how meaning influences action, also provides a way to understand the evolution of employee silence in healthcare organizations. Sensemaking is not about truth and getting it right, but about the way people develop their own narratives. Firstly, it is about continued redrafting of an emerging story so that it becomes more comprehensive, incorporates more of the observed data, and is more resilient in the face of criticism (Weick et al., 2005). Secondly, the language of sensemaking captures the realities of agency, flow, equivocality, transience, reaccomplishment, unfolding, and emergence, realities that are often obscured by the language of variables, nouns, quantities, and structures (Weick et al., 2005). Indeed, the approach dovetails with the healthcare literature on hierarchical effects of not speaking-up, including gender, race/ ethnicity, language, personal cultural background and personality, as well as the personality of those in higher power roles, microclimate factors of the team and care unit, and overall organizational culture (Katz et al., 2019).

Leaders have a role to play as sensemakers

Clinical leaders are important role models in terms of their willingness to listen to staff concerns, admit mistakes and report concerns about suboptimal quality of care and patient safety. The way that leaders help employees make sense of events at work may point them in a particular direction. There are different kinds of subjectivities involved in the decision of an individual to speak up that construct the individuals' identity and the way they perceive the act itself as a way to live ones' beliefs and professional ideals. For example, even the simple question 'Why didn't you speak up?' prompts the individual to focus on the idea that they did something wrong and were to blame. Thus, 'old' models of safety thinking are adopted that focus on what the healthcare professional could have done differently, rather than new safety thinking (Karanikas et al., 2020) where the focus is on understanding individual actions in the context of the connected wider system. In Table 1 we present typical questions that are asked after an adverse event in healthcare and alternative phrasing of each question. These alternatives are more likely to prompt contextual answers that will lead to the collection of better data about the event and will also help the individual to make better sense of the event in a non-threatening way. Sensemaking lays the groundwork for sensegiving, whereby leaders and managers in healthcare have a symbolic role that goes beyond merely expressing values, and symbolic constructions are instrumental to creating meaning for others (Gioia & Chittipeddi, 1991; Parzefall & Jacqueline, 2011). In this way, we are arguing for leaders and managers to be more skillful sensemakers and sensegivers for their employees and colleagues.

Staff who trust their leaders still might not raise concerns if they are worried about the reaction of their colleagues, so leaders have to be receptive and foster environments where speaking-up is welcome (Edmondson, 2019). Mannion and Davies (2015) note that assessments of whistleblowers are strongly shaped by discursive power rather than facts,

meaning that “control over the narrative, managing ambiguity and handling contestation are likely to be central” (p. 504). Leaders do not have full control of these factors, but their powerful positions allow them to influence the process, engaging in sensegiving – meaning they help people to fashion a vocabulary and framework capable of facilitating a deeper understanding of what whistleblowing (or other forms of speaking up) is for, and when and how it should happen. In terms of sensemaking, healthcare staff understand that healthcare is intolerant of mistakes and leaders are rewarded for 'moving on' before the extent of the problem becomes unmanageable. The idea that problems with quality and safety in healthcare are rooted in organizational and systemic issues is a relatively new way of thinking (Montgomery et al., 2020), and to date whistleblowing has not been seen as important feedback to the system but rather the actions of a maverick individual, which partially explains the antipathy associated with it. The ongoing movement within healthcare towards standardizing procedures and digitizing communications within healthcare means that communication routes which would be considered employee silence within this framework (such as non-disclosure, informal chats, and gossip) are likely to become even more important as overburdened healthcare workers seek alternative ways to feel in control of their own narratives and safely share sensitive information about work practices. The use of informal chats fits with the literature on voice cultivation within healthcare (Satterstrom et al., 2020), which highlights how informal collective roots can gradually reverse silence. This returns to our point about the need for leaders to be “sensemakers” as not respecting these different forms of withholding information runs the risk of missing out on important sources of ‘soft intelligence’ in healthcare.

Sensemaking is driven by plausibility rather than accuracy which is in contrast to managerial practices that assume that the accuracy of managers’ perceptions determine the

effectiveness of outcomes. In this regard, Weick and Sutcliffe (2003) highlight how in the case of the Bristol Royal Infirmary there was continuation of a pediatric cardiac surgery program for almost 14 years despite the data showing a mortality rate roughly double the rate of any other center in England. Thus, it would appear the actors were viewing events through a 'plausibility' lens rather than an 'accuracy' lens. Being quite stressed from work and focusing on their patients means they may "choose their battles" and choose to not speak up against their leads and managers about a poor working schedule, understaffing, and shortages.

The aforementioned emotional burden plays a significant role in choosing to speak up or remain silent. Given the nature of the work, healthcare employees are trained for low tolerance of adverse events or errors, and an inability to speak about such events leads to the experience of excessive emotional and psychological turbulence. Kirrane et al. (2017) concluded that fear had a significant role to play in silence behavior whereas anger was an antecedent emotion to speaking up. Leaders in their sensemaking roles can calibrate the impact of their questions and take care to avoid the creation of a fearful environment, and thereby bypass silence behaviors. The role-modeling of leaders also shapes the social norms which can govern more informal, low level speaking up behaviors, helping to build a culture in which patient safety is prioritized (Morrow et al., 2016). Healthcare professionals often fear blame, loss of jobs, legal issues, or breaking the hierarchy as they hesitate to speak about errors and transgressions.

Critical Challenge Point One: **Our theory, research, and practice needs to reflect that medical leaders are continuously engaging in sensemaking and sensegiving on a daily basis (whether they accept this or not).** In this sense, we argue that medical leaders

need to be trained during their healthcare education (and beyond) to improve their sensemaking and sensegiving. So, we need to go beyond simply recognizing that sensemaking happens, and propose that this is a skill set that can be improved, taught, and developed - which will result in less employee silence.

Developing healthcare professionals as effective sensemakers can be approached by redesigning healthcare education (at all career stages) to include the following; (1) Educating senior staff about their role as a sensemaker, and making students aware of how their clinical knowledge is calibrated by the reactions of and through interactions with their mentors, (2) Teaching students via role-modeling and simulations as to how their verbal and non-verbal behaviors directly influence how healthcare teams share and understand information, (3) Inserting 'sensemaking' and 'sensegiving' analyses in case reviews of critical incidents that demonstrate positive and negative examples. Future research can explore the consequences of such interventions qualitatively and quantitatively.

Why can't healthcare learn from other industries?

Since understanding employee silence in healthcare is so critical for employee well-being and patient safety, what can we learn from other industries? In aviation, for example, Crew Resource Management (CRM) was prompted by a 1977 tragic accident involving two passenger jets colliding on a runway in Tenerife where a key factor was the failure of a subordinate copilot to challenge or speak up to the captain. CRM is an approach and philosophy that includes explicit values and principles, procedures supported by purpose-designed checklists and other tools, and regularly scheduled mandatory simulation-based training and assessment that together contribute to an existing safety culture in pilots and across the organization (Helmreich & Merrit, 2000).

The phenomenon of not challenging authority is also characteristic of healthcare. There is accumulated evidence that large power discrepancies are ingrained in medical culture and adversely affect ‘low power’ members' perception regarding their willingness to speak up, which inhibits productive communication (Creese et al., 2021; Pattni et al., 2019). Especially in surgical teams, a negative hierarchical culture (i.e., fear and intimidation perceived by junior members) can adversely impact patient safety, trainee learning, and team function. As noted by Edmondson (2003), without a clear or compelling reason to offer one's views in a supportive environment, the effort and risk involved with speaking up make it unlikely to happen, even without large power differentials.

The hierarchal nature of healthcare can contribute to the phenomena of risk blindness and safety drift (Goh et al, 2012). CRM principles have been applied to healthcare teams with the development of the TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety), but there is evidence that they are difficult to implement in healthcare (e.g., Stewart, Manges & Ward, 2015).

A CRM approach is obviously useful, but might be difficult to implement also due to the presence of ostensibly beneficial effects of employee silence in healthcare settings. For example, healthcare delivery is significantly more complex and less predictable compared with aviation and the associated slow progression of care delivery to many patients (and frequent delays) adds to the high workload of many healthcare professionals. In this context, ‘speaking up’ will usually increase delays and increase workloads – and silence helps keep ‘business as usual’ going at a normal pace. The simplest example of this is the existence and frequent use of ‘work arounds’ in healthcare, whereby staff develop creative solutions to resource and/or staff shortages. Thus, there is acceptance that being ‘silent’ about gaps in care is practical and solution-focused. Work arounds present an interesting paradox; on the

one hand there may be an underlying driver of professional shaming that could help to explain the silence around them, but on the other they could be viewed as an organic response to silence (i.e., apathy) – that because change will not ever be forthcoming the problem needs to be "worked around". Ultimately, they may not be spoken about because they grow out of the situation the staff are in, and they are seen as natural necessities rather than as true innovations. In other words, the gap between silence and innovation may rely on reframing and reappraising context-driven adaptations.

Furthermore, healthcare work involves a high degree of emotional labor which is associated with burnout. Speaking up outside of a peer group is very unlikely. A possible explanation is the high group-level social capital among health care professionals, which can support dialogues in the improvement of work but can also hinder the reporting of error outside the group (Strömgren, 2017). Thus, the "positive" side of employee silence probably has psychological, political/legal, and cultural functions that enables healthcare organizations to operate more smoothly. In settings with low psychological safety, silence becomes a seemingly beneficial strategy for employees; they do not speak up because they do not believe it would lead to change and they deem it personally safer to stay silent.

Critical Challenge Point Two: **We need to reassess the way we view psychological safety as a panacea for reducing employee silence**. Although psychological safety has consistently demonstrated individual and team-level benefits, it does not necessarily and sufficiently explain or address the ubiquitous, cross-cultural and macro-level high prevalence of employee silence among healthcare professionals. Moreover, we have limited insights on the degree to which healthcare professionals as individuals are aware that they need psychological safety in the workplace and actually genuinely "care" about it, and as a result

we need to better understand what healthcare professionals are learning during medical education and what they learn as being valued explicitly and implicitly. ‘Work arounds’, which are creative but an accepted form of employee silence, have their roots in the socialization of healthcare workers. That is, healthcare professional culture has a larger and more pervasive effect on voice/silence behavior than team-level psychological safety. Therefore, as long as specific forms of speaking up, asking questions, sharing concerns and identifying errors are not valued by the profession – meaning they are not taken into account for promotions, evaluation and assessment, etc. – psychological safety at the team level will remain a necessary but insufficient condition for reducing widespread, culturally-grounded silence and promoting voice. Therefore we need deeper conceptual development and empirical assessment of the macro and professional culture factors that shape psychological safety and the behaviors that result from it.

Silence and voice are also shaped by the legal ramification of sharing information that may identify the malpractice of a coworker or put the organization in legal jeopardy. Thus, we also need work that systematically explores how the political and legal systems shape silence and speaking up. The aforementioned presents us with the challenge of whether we need a less threatening approach to the subject. For example, do we need to focus on enabling employee voice rather than employee silence? Additionally, we may need to examine the degree to which related concepts (e.g., psychological safety, social capital, organizational citizenship behavior) have a symmetrical or asymmetrical relationship with employee silence.

Implications for Practice: Managers as Facilitators for Ending Silence and Empowering Voice

The positive side of employee silence indicates that not all silences in healthcare are the same. Leader and management approaches need to invite conversations about what employees perceive to be appropriate and inappropriate forms of silence. Initiatives to address silence in healthcare need to enable employees to understand the conflicting messages they may be receiving about being silent and speaking-up. For clinical leaders, the challenge is to facilitate and valorize behaviors that enhance psychological safety among teams (both in terms of silence and voice), while modeling the sharing of information that leads to improvements in patient safety and quality of care. The challenge for top management is to hold the external and internal communication open and authentic and to hold a safe flow of internal communication about errors and problems while also addressing the roots of silence and voice behavior in professional culture.

It is necessary to outline both the practical implications and future areas for research in parallel, as they have a symbiotic relationship. There is not enough accumulated evidence to inform leaders on how to reduce different forms of silence. Additionally, a recent review on ‘speaking-up’ interventions concluded that there was very little evidence of researchers critically reviewing extant studies when preparing and designing new projects, with the result that many of the flaws of previous study designs were overlooked and previous findings were not used to build new questions (Jones et al., 2021).

Key messages for clinical leaders and policy makers

The culture of medicine itself appears to be more important than cross-cultural factors. A recent paper examining employee silence in 33 countries found relatively little evidence that employee silence was strongly connected with power/cultural factors with only three out of the nine cultural dimensions included in the study significantly explaining variance in employee silence (Knoll et al., 2021). The authors conclude that proximal factors

such as leadership and team psychological safety have a stronger influence on employees' fears than more distal factors such as societal culture. We would add that professional culture represents a more proximal macro factor that likely plays a significant role shaping silence, leader styles and behaviors, and the perception of psychological safety.

The aforementioned suggests that aspects of organizational culture can go beyond national borders. There is evidence that healthcare is a culture where non-disclosure is valorized and those who find themselves lower in the hierarchy are less assertive and identify a knowledge gap between their superiors and themselves (O'Donovan & McAuliffe, 2020). Given the widespread nature of silence in healthcare, organizational norms shape behaviors – as can be understood via surgical practice. Perioperative care has been identified as the time when patients are more likely to experience preventable harm (Wacker, 2020). Surgical safety checklists (SSC) are the most widely used tool to avoid adverse events, however when used in isolation or implemented incorrectly, checklists are not effective (Weinger et al., 2015). There is an unequivocal hierarchy effect in the surgical environment—and individuals with the least 'power' (i.e., low in hierarchy) are the least likely to report an error (Muensterer et al., 2021). The use of checklists in healthcare has been influenced by their use in aviation, an industry that has a substantially better safety record. The failure of the checklist approach to match the effectiveness found in aviation indicates that silence behaviours are entangled within ways of working, and will be limited unless they are implemented using whole-system approaches that are accompanied by policies that flatten hierarchies and encompass 'speaking-up' training that focuses more on sensitivity/receptiveness than assertiveness (e.g., CUSS approach for challenging senior people - Weinger et al., 2015; and visual management tools in improvement work – Williamsson et al., 2019).

Examples such as preoperative care underline why withholding important information is a barometer of a dysfunctional organizational and professional culture. The fact that the withholding of such information is so endemic and deep means that clinical leaders need to meaningfully collaborate with researchers to understand the phenomenon, as a starting point to address it, which in turn can be a platform to invite all other stakeholders to contribute. We need more strategic collaboration between frontline leaders and researchers, as employee silence needs to be studied as field research in the context where it occurs with leaders positioned as sensegivers for their employees. It is an opportunity to treat leadership and management as an evidence-based practice that involves the need for continuous engagement with evaluation and reflection. In this sense, we need to ensure that clinical leaders and health care management researchers are not operating in silos.

Current developments in leadership and management have led us to theories and approaches that no longer view leadership and management as top-down processes. Shared and distributed leadership are two clear examples that inform management strategies that are built around the assumption that employees can be expected to speak up and voice concerns about issues that are important to them (Anderson, 2018). Ethical leadership, on the other hand, requires that the leaders and the management are proactive and develop trusting relationships that will enable followers to have authority to act (Peng & Kim, 2018). Following on from these three approaches – elements of which managers nowadays claim to be incorporating in their leadership practice – we should expect they contribute to more speaking up and less silence. In this sense, if leaders and managers claim they are integrating elements of distributed/shared leadership, we would expect more voice as a behavioral outcome compared to more top-down leadership approaches. Equally, integrating elements of an ethical leadership style would be expected to prevent the prevalence and occurrence of

employee silence in order to minimize the occurrence of moral distress among employees. Thus the existence of employee silence is important feedback for leaders who are attempting to integrate elements of shared, distributive, and ethical leadership in their organizations. The relationship among these leadership styles and silence merits further research.

Critical Challenge Point Three: **In terms of reversing employee silence in healthcare, a key challenge is identifying how leaders and managers can reaccomplish voice and/or sustain norms that reduce silence.** Additionally, there is need to reflect on the cultural and contextual differences in the antecedents, types and consequences of silence in different areas of healthcare (e.g., social care, elderly care, primary and secondary care, mobile care, psychiatry), or across different national settings. The behavior and styles of clinical leaders and managers in the workplace reflects what was learned in training, primarily through role-modeling. As such, clinical leaders and managers should not be expected to figure out reducing silence and sustaining voice independently , but they need opportunities to train in low threat situations (e.g., simulations) how they can make sense of critical incidents involving the potential for silence. Figure 1 depicts the processes by which critical/memorable incidents are processed by healthcare professionals and transfer to real world contexts. Thus, developing and becoming a leader is connected with their conceptualizations of how they made sense of leadership and prior incidents as well as how feelings of psychological safety are intertwined with their sense of agency to yield less silence. Healthcare organizations strive to be high reliability organizations and to ‘prove’ this they seek to generate error-free performance, but the innate complexity of healthcare means this the need to appear ‘safe’ fosters silence (Vogus & Iacobucci, 2016).

Conclusions

Increasing voice and decreasing silence among healthcare professionals, patients, relatives and decision-makers can improve physical and mental wellbeing via the positive effects it can have on organizational adaptability, efficiency, and culture. Moreover, there is a 'fall-out' from employee silence in that withholding information can harm others and radiate outwards (Edmondson, 2019). Promoting healthy work places where all the actors in healthcare are encouraged to voice concerns can provide opportunities for external agents (e.g., janitors, catering staff) to share important information that may not have been noticed by nurses/doctors. Indeed, the out-sourcing of cleaning staff in hospitals, meaning employees are more detached from the organization, has been associated with higher levels of health care–associated infections (Litwin et al, 2017). Additionally, in terms of leadership this has the added benefit of democratizing the workplace and reinforcing dignity among individuals who are perceived as having low status roles in healthcare.

From a theoretical perspective, we have yet to fully exploit qualitative approaches that can provide a more fine grained analysis of silence/voice. In particular, approaches such as sensemaking in organizations with its focus on how meaning feeds into action will lead to a better understanding of how leadership and management contributes to the phenomenon. Moreover, it touches on a key aspect of organizational life – that our stories about events at work are largely influenced by the stories that our leaders tell us and the professional cultures that shape us.

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Table 1 Using Sensemaking to understand Employee Silence

Typical questions following an adverse event	**Questions that enable sensemaking**
Why did you prescribe the wrong medicine?	What was going on here?
Why didn't you notice that the vital signs of the baby had changed?	What was happening during the period when the vital signs changed?
What was your mental state during the surgical procedure?	Was there anything unusual or different about the working conditions during the surgical procedure?
Did you notice anything unusual about the patient?	Thinking about the patient, what were you worried about most?