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Exploring confidentiality in the context of nurse whistle blowing: issues for nurse managers

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Aim The aim of this paper is to reveal the experiences and meaning of confidentiality for Australian nurses in the context of whistle blowing.

Background Despite the ethical, legal and moral importance of confidentiality within the health-care context, little work has addressed the implications of confidentiality related to whistle-blowing events.

Methods The study used qualitative narrative inquiry. Eighteen Australian nurses, with first-hand experience of whistle blowing, consented to face-to-face semi-structured interviews.

Results Four emergent themes relating to confidentiality were identified: (1) confidentiality as enforced silence; (2) confidentiality as isolating and marginalizing; (3) confidentiality as creating a rumour mill; and (4) confidentiality in the context of the public’s ‘right to know’.

Conclusions The interpretation and application of confidentiality influences the outcomes of whistle blowing within the context of health-care services. Conversely, confidentiality can be a protective mechanism for health-care institutions.

Implications for nursing management It is beholden upon nurse manager to care fully risk manage whistle-blowing events. It is important that nurse managers are aware of the consequences of their interpretation and application of confidentiality to whistle-blowing events, and the potentially competing outcomes for individuals and the institution.

Keywords: confidentiality, nursing, qualitative study, whistle blowing

Introduction and background

Wrong-doing in the health sector becomes public knowledge when health-care professionals report outside their organization, often because internal avenues of reporting have failed. In Australia, these incidents have become increasingly prominent owing in part to a number of high-profile cases reported in the media (Faunce & Bolsin 2004, Johnstone 2004, Van Der Weyden 2005). Whistle blowing has been broadly
Confidentiality has been defined as ‘the ethical principle or legal right that a physician or other health professional will hold secret all information relating to a patient unless the patient gives consent permitting disclosure’ (Barrett 2007). While the definition is clear, in real terms, health professionals do sometimes have cause to disclose or share private patient information with another health professional on a ‘need-to-know’ basis. However, notwithstanding issues related to technology (Rock & Congress 1999), disclosure of personal patient information is generally only shared among treating health professionals. Such information sharing takes place where it has been decided to be in the best interests of patients and does not generally extend beyond those professionals directly involved in the care of a patient.

However, confidentiality is not always directly connected to patient information and there are other ways that confidentiality is applied in the health environment. For example, confidentiality can be used to protect healthcare providers and organizations from public scrutiny, and this may mean the intentional withholding of information to protect either the interests of individuals or the organization itself. While confidentiality in healthcare is generally viewed positively, these less positive or harmful consequences of confidentiality warrant consideration.

Balancing the obligation to report concerns against the obligation to maintain confidentiality is a challenging ethical issue faced by nurses (Firtko & Jackson 2005). For nurse managers, it is important to understand the ways in which workplace dynamics and structures, both formal and informal, influence how confidentiality is enacted within an organization and the capacity and willingness of nurses to act upon perceived wrongdoing (Orbe & King 2000). Invoked to protect organizational interests, confidentiality can limit public scrutiny and increase the likelihood of unethical consequences (Anand & Rosend 2008). It can also be used as a way of silencing people and even of protecting wrongdoers. These forms of confidentiality have strong associations with secrecy, which relates to withholding risky, or potentially stigmatizing disclosures (Ellenchild Pinch 2000).

Nurses and nurse managers are obliged to adhere to relevant organizational protocols, and their employment contracts possibly include confidentiality, non-disclosure or gagging clauses. In this context, nurse managers may be vulnerable to pressures that lead them to prioritize organizational interests over those of staff or patients. It is therefore crucial for nurse managers to reflect upon the consequences of confidentiality in circumstances such as whistle blowing. In this study of nurses’ experience of whistle blowing, confidentiality was revealed as problematic and was invoked as a means to silence and isolate nurses.

In health care, confidentiality refers to patients’ rights to have their personal information protected and held in trust by health professionals. Indeed, confidentiality is one of the major cornerstones of health care and is ingrained into the ethos of health professional education and practice. Given that confidentiality is so intrinsic to the provision of health care and health services, it is surprising that there is very little critical literature written about it. A search of the literature reveals that confidentiality is widely accepted as good and necessary and, as a concept, it is seldom critiqued.

In the health literature, confidentiality is discussed in relation to patients’ rights and is an essential aspect of the trusting relationship that patients have with their health-care providers (Dobrowolska et al. 2007, Neitzke 2007). There is an understanding that patients have the right to privacy and the right to expect personal information about them to be held in trust, with security of records, and that access to such information is in some way protected (Rock & Congress 1999, Frewer & Fahr 2007). This idea that confidentiality is essential to the formation of the therapeutic relationship holds for individual health-care providers and extends to health-care institutions, whereby there is an understanding that professional individuals and organizations will maintain confidentiality of patient information (Rock & Congress 1999).

Confidentiality has been characterized as reporting misconduct in the workplace (Ahern & McDonald 2002). Near and Miceli (1985) characterize whistle blowing as reporting ‘illegal, immoral or illegitimate practices under the control of their employers, to persons that may be able to effect action’. Jubb (1999) proposes whistle blowing as a ‘dissenting act of public accusation against an organization which necessitates being disloyal to that organization’, emphasizing the dilemma raised by conflicting loyalties. Firtko and Jackson (2005) proposed whistle blowing as occurring when ‘parties take matters that would normally be held as confidential to an organization, outside that organization despite the personal risk, and potentially negative sequelae associated with the act’. For the purposes of this paper, we define whistle blowing as being a conscious act of disclosure about organizational or individual practices and behaviours to those who could achieve positive change.

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Aim

This paper is drawn from a larger qualitative study that sought to explore and describe nurses’ experiences of whistle blowing. Elsewhere we have published findings related to reasons for whistle blowing (Jackson et al. 2010a), and effects of whistle blowing on collegial relationships (Jackson et al. 2010b). In this current paper, we present findings pertaining to participants’ experiences of confidentiality in the context of whistle blowing and explore/critique confidentiality in the context of whistle blowing and organizational wrongdoing.

Method

Study design

This study is derived from a much larger project in which nurses’ experiences of whistle blowing were explored (Jackson et al. 2010a,b), underpinned by qualitative narrative inquiry from the perspectives of health-care organizations and nursing. Narrative inquiry supports a relational interview where the story is co-constructed. Importantly, for this research, narrative inquiry enabled the participants to tell their stories and make sense of life events (Vaquez 2009) contextualized to the social context within which they occurred. Furthermore, it is a congruent approach to a sensitive issue such as whistle blowing. The research team consisted of nurse academics who had been made aware of the issue in discussion with clinicians and in reading the extensive media coverage of whistle-blowing incidents in the Australian health system in the past decade.

Participants

Eighteen registered and enrolled nurse participants from across Australia were recruited through advertisements placed in professional journals as well as local in media. In the first instance, interested potential participants contacted a member of the research team, with most participants making contact within 2 days of the advertisement being published. Participants identified whether they had been whistle-blowers (W), bystanders to a whistle-blowing event (B), or subjects of a whistle-blowing complaint (S), when they made first contact with the research team. Several nurses who were considering becoming whistle-blowers also expressed an interest in participating in the study but were excluded from participation, as this aspect of whistle-blowing was outside the scope of the current study. After making initial contact, potential participants were sent an information sheet and consent form and invited to contact the research team for additional information if necessary, and to arrange an appointment for interview. Following receipt of signed voluntary consent forms, a convenient interview time was arranged with each participant. Interviews were conducted in a private setting outside the workplace, as determined by the participant, or by telephone.

The participants’ nursing specialities spanned acute and non-acute settings, including medical/surgical, operating theatre, intensive care, mental health, geriatrics, midwifery and community health. Participants had varying levels of qualifications, training and experience. All participants met the selection criteria of living the experience of being a W (n = 11), B (n = 4) or S (n = 4), with one participant having had direct experience of whistle blowing as both W and S. Of the 18 participant nurses, 17 were female and 1 was male.

Data collection and analysis

During the interview, and consistent with narrative inquiry (Duffy 2007), each participant told their story thereby capturing their unique, complex, subjective meaning of the W, B or S event (Carter 2008). The interviews, lasting between 40 and 120 minutes, were semi-structured, relational conversations between the interviewing researcher and the participants. Consistent with narrative inquiry (Duffy 2007), the participants were asked to recount their experiences of being a W, B or S. To enable participants to further describe their experience, probes were used during the interview. Interviews were digitally recorded and transcribed verbatim. Data were de-contextualized and re-contextualized iteratively and thematic analysis of participants’ stories provided information upon which the researchers could reflect (Lee & Feilding 2004). Data were analyzed independently by two (2) members of the research team and discussed until consensus was reached. Importantly, the narratives revealed how the meaning and knowledge of the experience of W, B or S was embedded in social convention and the culture of nursing (Stanley 2008). Sections of the transcripts that best represented all participants’ experiences are pre-sented in the findings.

Ethics

All aspects of this project were guided by the ethical principles of social justice, beneficence/non-malificence,
and autonomy as expressed in the National Statement on Ethical Conduct in Human Research (2007). These principles shaped trust, mutual responsibility and equality, reflecting the importance of respect for individual autonomy, research merit, providing fair treatment in recruiting participants, and distributing the benefits and burdens related to the project. These principles were upheld through strict adherence to the care and support of individual participants, providing a confidential and non-judgemental space to disclose what, for some, may have been distressing experiences and ensuring that their voices were heard unimpeded. Beneficence involved assessing the risks of harm with potential benefits to participants and the wider community and showing sensitivity to the welfare and interests of those involved in the project.

Whistle blowing or organizational wrongdoing is a very emotive issue, so it behoves the researchers to treat the participants, their stories and the data with particular sensitivity. Further, great attention was paid to the process and analysis of the participant’s stories to avoid acting as ‘horror magnets’ (Carter 2008) and to accurately represent their authorial voice. In the process of participants telling their stories there was a potential for the participants to become distressed. Acknowledging this, the interviewing researcher was a member of the research team highly skilled in interviewing and narrative research. In addition, owing to the sensitive nature of the participants’ stories, all identifying material was removed from the raw data before analysis. The names of institutions and colleagues were removed and participant’s names were replaced with pseudonyms. To ensure confidentiality and anonymity only the principal and interviewing researcher had access to the raw data (Polit & Beck 2008). All participants were given details of a confidential counselling service if they felt they needed this support. Ethical approval was received from the relevant organizational Human Ethics Research Committee.

Rigour

As stated, interviews were conducted by an experienced qualitative interviewer, data analysis was undertaken by two members of the research team and discussed until agreement was reached, adding to the dependability and credibility of the study (Holloway & Freshwater 2007a,b). Confirmability was supported through the use of an audit trail, and using verbatim excerpts from the participants narratives, enhancing authenticity and confirmability (Polit & Beck 2008).

Findings

The participants in this study revealed their experiences of confidentiality in the context of whistle-blowing events. In what follows we detail four emergent themes relating to confidentiality: (1) confidentiality as enforced silence; (2) confidentiality as isolating and marginalizing; (3) confidentiality as creating a rumour mill; and (4) confidentiality in the context of the public’s right to know. The findings presented bring to the forefront the dilemmas regarding the use and potential misuse of confidentiality within health-care organizations.

Confidentiality: enforced silence

Participants were asked to maintain confidentiality in relation to the whistle-blowing event. This was expressed as a sense of enforced silence in which participants felt they could not speak of the matters at all. On being informed she was the subject of a whistle-blowing accusation and that she was to leave the premises immediately, ‘Diana’ was also advised that the matter was highly confidential, and that she was not permitted to discuss it with anyone. Although she was shocked and visibly distressed, she felt unable to explain her distress to concerned colleagues.

’So I went back to my office, packed up a few things, I was absolutely in tears. The Clinical Nurse Specialist came in and said what’s going on? What’s wrong? And … I couldn’t even talk and like it’s highly confidential, I’m not supposed to share it with anyone…’

(Diana – S)

Investigation of whistle blowing situations can be extensive, complicated, and take quite long periods of time. For those who remained at work, there was an expectation that they would carry on as usual in the workplace, and participants reported having to hold their silence and carry on as normal over many months while investigations took place behind the scenes. This took its toll and, on occasions, participants reported experiencing distress they could not hide from colleagues. However, even then they felt unable to explain themselves or give voice to their distress because of the need to maintain their silence.

’I just got really upset … this Nurse Unit Manager sat (and this friend) with me, and I said, ‘There’s a whole lot of stuff going on and I can’t say any-thing about it’. And she was the only person that I
said anything to in that 6 or 9 months or whatever it was that I was left there on that ward without any support’

(Karen – W)

Two participants reported occasions where staff meetings had been called by hospital management to discuss matters associated with the whistle-blowing event. ‘Maree’ was a bystander to a very public whistle-blowing event that had attracted widespread media coverage. Although she herself was not directly involved in any accusations, Maree’s position as a nurse in the area under investigation meant that she too was si- lenced.

‘They [management] called us for a meeting and they told us basically to shut up. That was the clear message that came out of it, like you don’t talk to anyone, you don’t answer phones of course because the media was going berserk and they tried many tricky ways, which I can understand, not to talk to them. I wouldn’t like to anyway. But also basically just shut your mouth, do your work …That was the clear message’

(Maree – B)

The need for silence and secrecy continued even years after the whistle-blowing event. ‘Rita’ had been the subject of a whistle blowing accusation, and had subsequently been exonerated. On being cleared, the health service sought to reintroduce Rita to the workplace, into a different role. However, Rita still had to maintain her silence.

‘When I read that article about whistle blowing …it was like, this is me. This is what happened to me but then, to come out the other side, and be more or less told here’s a better job, keep your mouth shut, the job description and everything was all for me and I would be the only likely candidate’

(Rita – S)

The enforced silence and lack of opportunity for open discussion meant that being involved in a whistle-blowing situation was experienced as a shameful and secretive event. The need for secrecy continued even after the event was long over, periods of time had elapsed and people had moved on to new positions in different health services.

‘And even here (in the new job) I’ve told a couple of people and both their reactions were exactly the same, so do the nursing hierarchy here know?

They wouldn’t have employed you if they knew’

(Lorraine – W)

The impost of confidentiality had a significant adverse effect on the nurses and in all cases they were not clear of the context of the confidentiality, which in most cases again appeared to be directed at protecting the organization’s reputation rather than staff or patients’ rights in the organization. Many participants described feeling let down by their organization as they were given no opportunities to debrief or openly discuss the situation with anyone other than those conducting the investigation.

Confidentiality: isolating and marginalizing

The on-going need for silence meant that participants became increasingly marginalized and isolated from their usual sources of collegial support. Before the whistle-blowing event, participants had been able to raise work-based matters of concern with colleagues and this had been an important source of professional support for them. ‘Karen’ identified professional isolation as being among the most difficult aspects of her whistle-blowing experience.

‘Being isolated through process because of confidentiality – the whole time nobody knew because I wasn’t allowed to speak to anyone, say anything.’

(Karen – W)

The secrecy surrounding the whistle-blowing events and the need for confidentiality meant that this source of support was closed to them and they became increasingly professionally isolated. The degree of secrecy meant that participants’ individual aloneness was invisible.

‘We’ve all been treated in an isolated fashion, so that we weren’t able to talk to one another that we were going through this. We all thought we were on our own…’

(Valerie – W)

‘Carolyn’ had lost her job and career as a result of a whistle-blowing event, and had experienced significant feelings of isolation and marginalization that had extended for many months.

‘Certainly I had very little support from any of the hierarchy except for (name withheld) who actually, because we were both implicated, really was not in a position to be able to talk to me, which was very unfortunate. We were all placed in a
situation where we really couldn’t talk to each other’

(Carolyn – S)

‘Diana’ had been working in quite a small community when she became the subject of a whistle-blowing complaint. For her, the isolation extended beyond the workplace – the size of her community meant that work relationships merged with social connections and so she had avoided talking to people socially as well as at work.

‘When it’s finished and I will be able to go [out] and I’ll be able to see the people … I could actually say hello because previously I couldn’t speak to them because of the confidentiality thing’

(Diana – S).

Confidentiality: creating a rumour mill

Adhering to the organizational requirement of confidentiality meant that participants were unable to engage in open discussion with colleagues. This created an environment in which rumours, misinformation and hearsay flourished.

‘Anyway, this investigation was going on and people were talking about it at work and it was supposed to be confidential, but it wasn’t’

(John – B)

‘Diana’ had been escorted from the premises in the wake of a whistle-blowing complaint and remained out of her usual workplace while investigations were underway. She was unable to discuss her situation with colleagues, yet rumours about her sudden absence circulated through the hospital.

‘Within hours there’s a phone call back to one of the staff saying did you hear about Diana, she was escorted off the premises kicking and screaming’

(Diana – S)

Within the context of maintaining confidentiality, the nurses had no one with whom they could discuss their place as possibly the central figure in this rumour mill.

‘Apparently it was about the unit that she [colleague] was on probation and it was my fault. And people started treated me differently and just being cold and distant’

(Karen – W)

The effect of the rumours was to further marginalize participants. Although they were at the centre of the gossip, their need to adhere to confidentiality meant that they had no recourse to squash rumours or correct misinformation.

‘because of the confidentiality… I didn’t discuss it with anyone at work. I didn’t want the rumours… to spread, but he [colleague] was spreading rumours… I know from the rumours that are going around how much he dislikes me now’

(Lorraine – W)

Confidentiality: the public’s ‘right to know’

For some of the participants, the secrecy and enforced confidentiality was complicated by very public and sometimes frenzied media exposure. In these situations, even though participants were unable to speak up to explain their situations to even close colleagues, friends and family, they were effectively ‘outed’ in the media. After being advised that she was to keep all matters pertaining to the whistle blowing event secret and not discuss them, ‘Mary’ was advised that she was to be named by the media.

‘Anyway he just said, you know the media is going to print your name tomorrow, how do you feel about that? I just about died. I thought what, I just started bawling, I was just crying. I was incon-solable and there was nothing, that was it. I thought wow. I got home later on that evening after trying to then say something to my family who aren’t supposed to know anything, my name might then be put in the newspaper’

(Mary – W)

As a bystander to a whistle-blowing situation in which a particular hospital was named as being a site of organizational wrongdoing resulting in very poor patient care, ‘Maree’ had endured months of innuendo and comments about the hospital from social acquaintances, and neighbours, arising from media reports. Furthermore, Maree and her colleagues had also experienced verbal abuse, abusive graffiti attacks and other distressing events as the direct result of whistle blower accusations. Maree believed that the hospital she worked in had been misrepresented in the media, and was distressed at on-going media coverage, especially given that hospital staff could not openly challenge these reports.

‘I’m angry many times when the media flares up because [hospital] is always a good topic to the media. This happened, again and they are not representing us very well….what happened just
recently in the media, we can’t present our case… we can’t say a thing. (Maree – B).

The findings presented bring to the forefront the dilemmas regarding the use and potential misuse of confidentiality within health-care organizations. Focusing attention upon confidentiality in the context of nurse whistle-blowing, we provide insight into the complex nexus between confidentiality, secrets, silence and voice within health-care organizations. We also highlight the way that confidentiality, sanctioned by insiders to protect insiders or the organization, can breach the bounds of ethicality by legitimizing secrets as confidential. We identify how this corruption of confidentiality serves to routinize the keeping of secrets and risks setting in place a spiral of events that provides precedence to keep more secrets, regardless of the collateral damage. In drawing attention to the formal sanctioning of secrets as confidential, this study raises important issues for nurse managers and health-care organizations.

Discussion

The narratives of nurses with experience of whistle-blowing draw attention to the overlapping and underexplored relationship between confidentiality and secrets in health-care organizations. In the health field, confidentiality is generally considered a ‘professional and moral obligation’ (Ellenchild Pinch 2000). Participants reflected this understanding of confidentiality as a strategy for maintaining the standards of nursing care by being confidential about patient care. It is important that nurse managers question the ethicality of secrets, are mindful of how a culture of confidentiality can promulgate secrecy, and consider whose interests are being served by the keeping of such secrets.

With regard to whistle-blowing incidents, confidentiality may be enacted to protect individuals from harm, be sanctioned by law, or relate to due process in investigative procedures. In these instances, confidentiality can be a strategy to protect whistle blowers. Brown (2008) noted that confidentiality was a key priority of managers who managed whistle-blowing events. When dealing with situations such as whistle blowing, and notwithstanding organizational policies that may require confidentiality, nurse managers can advocate to ensure that there are safe spaces in which open dialogue can occur.

However, confidentiality may actually benefit managers in that it allows investigative processes and reduces the possibility for conflict as well as the risk of scrutiny and censure of managers. Gray (2008) raises the idea of ambiguity around ethical issues associated with confidentiality and comments that in some circumstances, there are no clear ‘right or wrong answers’.

When considering whistle blowing, one could argue that if the issue is about a particular person, one can see the argument (need) for confidentiality. Conversely, if it is about organizational practices, the need for confidentiality is rather less clear and the enforcement of confidentiality can be construed as silencing and oppressive, as experienced by participants in this study.

A cornerstone of confidentiality is the control of information (Ellenchild Pinch 2000). Confidentially invoked in the formal sanctioning of secrets can be a form of censorship used within organizations to prevent disclosure and control perceived risks to the ‘good’ name of the organization. The motivation for invoking confidentiality can cross the bounds of ethicality if managers or the organization benefit at the expense of the whistle blower, or the whistle blower is harmed through the process. This corruption of confidentiality can provide a cover of legitimacy for processes that protect organizations and potentially harm individuals.

Secrets are the intentional ‘withholding of information from specific individuals’ at an individual or organizational level (Anand & Rosend 2008). At an individual level, a secret involves the decision by an individual to withhold personal information, whereas at an organizational level, insiders privy to information elect to sanction something as secret from others inside or outside the organization. Secrets sanctioned by insiders in the interests of the organization are those most at risk of breaching ethical standards (Anand & Rosend 2008). Withholding or distorting information in the ‘public interest’ as experienced by participants in this study is an example of a secret that crosses legal and ethical boundaries. In this context, framing secrets as confidential legitimized both the secret and the secret holder.

The findings also draw attention to the life cycle and toxicity of secrets (Reis et al. 2007) enacted under the veneer of confidentiality. When the keeping of secrets becomes routinized and legitimized as ‘confidential’, ethical questions about the behaviour are effectively circumvented. By invoking secrets as confidential, unethical practices can ‘slip under the radar’ and be incorporated into organizational routines and norms as legitimate. In this way, the legitimizing of secrets as ‘confidential’ routinizes the behaviour, setting in place a spiral of events that provide precedence to keep more secrets, regardless of the collateral damage. Consequently, individuals may invoke secrets as confidential without recognizing the ethical issues involved.
Conversely, for those who realize they are breaching ethical standards, the risks of being detected may be outweighed by the benefit of engaging in the behaviour.

The keeping of secrets as ‘confidential’ may invoke a chain of events that influences the climate of the organization and set in place self-perpetuating justification for their continued use. It is evident that confidentiality can be used to isolate nurses and create environments in which rumour and hearsay flourish. Nurse managers can help to promote well-being of staff and create a supportive environment by ensuring that people who are bound by confidentiality have at least one safe person to whom they can go to debrief, seek counsel and raise issues. This may be a counsellor, a member of the organizational human resources staff or, depending on the circumstances, and if appropriate, their manager.

Conclusions

This paper highlights the complexity of confidentiality when applied to whistle-blowing events in the healthcare context. There has been little work on the immediate, short-term and ongoing negative consequences for the whistle blower, bystander of a whistle-blowing event, or the subject of a whistle-blowing complaint.

This aspect of whistle blowing has remained invisible, hidden by the implicit or explicit application of confidentiality. Importantly, we reveal insights into how confidentiality is culturally constructed by nurses and the workplace, and even in the face of poor practice or wrong-doing, whistle blowing can have detrimental consequences for those directly involved. The high personal costs can include individual feelings of distress, marginalization and isolation, and can lead to tarnished reputations and loss of careers. The outcome for the institution, however, may include protection of reputation and risk management of potentially adverse financial outcomes. As revealed by this study, confidentiality can be used as a tool to silence individuals and protect the health-care institution, or particular members within the institution, to the detriment of the whistle blower, bystander of a whistle-blowing event or the subject of a whistle blowing complaint. It is clearly imperative that individuals, nurse managers and institutions thoughtfully apply the ethics of confidentially to whistle-blowing events, cognisant of the potential outcomes.

References


Exploring confidentiality in whistle blowing


