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Whistleblowing in Health Care Organizations: A Comprehensive Literature Review

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Abstract

Purpose: To receive the answers to the following research problems: (1) How is the interest of researchers in whistleblowing in health care organizations developing? (2) How do researchers define whistleblowing in health care? (3) What are the main problems (limitations) of whistleblowing in health care organizations? (4) What factors affect whistleblowing in health care organizations?
Design/methodology/approach: The method of systematic literature review based on the PRISMA model was used. To identify the factors affecting whistleblowing, McKinsey's 7S framework was used.
Findings: The researchers from the UK definitely dominate, and the papers from Central European countries seem to be invisible. The vast majority of works came from the 2010s. Whistleblowing serves the good and safety of the patient; however, there are staff concerns about the consequences they may face. 'Style', 'staff' and 'shared values' seem to be the most crucial for whistleblowing, and these are factors considered 'soft'.
Research limitations: The access to databases managed by the home University. In future studies, there is a need to take into account other databases, including additional sources of knowledge, like books and grey literature.
Originality/implications: Identifying the state and place of research worldwide on whistleblowing in health care, and a proposal of the whistleblowing verification matrix. New definitions of whistleblowing and whistleblowers were proposed. The above may be considered theoretical contribution to science.

Keywords: whistleblowing, health care organization, McKinsey's 7S model, verification matrix.

JEL: M12; M14

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Whistleblowing w organizacjach opieki zdrowotnej: przegląd literatury

Streszczenie

Cel: uzyskanie odpowiedzi na pytania: (1) jak rozwija się zainteresowanie badaczy whistleblowingiem w organizacjach opieki zdrowotnej; (2) jak badacze definiują whistleblowing w opiece zdrowotnej; (3) jakie są podstawowe problemy (ograniczenia) dotyczące whistleblowingu w organizacjach opieki zdrowotnej; (4) jakie czynniki wpływają na whistleblowing w organizacjach opieki zdrowotnej?
Projekt/metodyka/podejście: wykorzystano metodę systematycznego przeglądu literatury przedmiotu w oparciu o model PRISMA. W identyfikacji czynników wpływających na whistleblowing zastosowano model 7S McKinseya.
Wnioski: zdecydowanie dominują prace naukowców z Wielkiej Brytanii, natomiast opracowania z krajów Europy Centralnej wydają się być niezauważalne. Większość prac pochodzi z pierwszej dekady XXI wieku. Whistleblowing przyczynia się do zapewnienia dobrostanu i bezpieczeństwa pacjenta, jednak istnieją obawy personelu związane z konsekwencjami, jakich mogą doświadczyć w tym względzie. 'Styl', 'kadry' i 'wspólne wartości' jawią się jako krytyczne dla whistleblowingu i zaliczają się one do czynników „miękkich".
Ograniczenia badania: dostęp do bazy danych tylko macierzystego Uniwersytetu. W przyszłych badaniach należy uwzględnić inne bazy danych, w tym dodatkowe źródła, jak książki i tzw. literaturę szarą.
Oryginalność/implikacje: zidentyfikowanie stanu i miejsca światowych badań na temat whistleblowingu w opiece zdrowotnej i zaproponowanie macierzy do weryfikacji wdrożenia whistleblowingu. Propozycja nowej definicji whistleblowingu i whistleblowera. Powyższe może być uznane jako wkład do nauki.

Słowa kluczowe: whistleblowing; organizacje opieki zdrowotnej; model 7S McKinseya, macierz weryfikacyjna.

1. Introduction

Every activity offered by an organization should benefit its stakeholders, including customers, but some activities may also cause harm. Despite everyone's best efforts, it is not always possible to foresee potential errors and various types of the consequences resulting from them. This phenomenon depends on many factors which became particularly important during the COVID-19 pandemic, and above all in health care organizations. The problems of staff shortages due to coronavirus infections, fear of getting infected, abnormally long shifts at work, equipment shortages, work under constant stress and pressure, and greater fatigue and frustration significantly increase the risk of medical errors and adverse events (Tejos et al., 2020). The topic of errors and learning from errors is increasingly gaining attention in management sciences. Errors are a rich source of information, as they unveil that something went wrong. As Horvath, Klamar, Keith, and Frese (2020) argue, an organization's attitude toward errors can be traced back to one fundamental question: should errors be tolerated/accepted or not?, and this question is especially important in the medical sector when talking about medical errors (Levine, Carmody, & Silk, 2020). Thus, a special role is played by whistleblowing, which is a prerequisite for effective communication and a key component of patient safety (Blenkinsopp et al., 2019). This

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value should be particularly protected during the COVID pandemic due to the observed negligence in this regard, confirmed both in practice (e.g. Anon, 2020) and in scientific literature (e.g. Li, Cui, & Zang, 2020). The term whistleblowing comes from the English phrase 'blow the whistle' and the probable origin of this concept can be found in England, where a perpetrator's escape from the scene of an incident was signaled by blowing a whistle in order to notify policemen and passers-by about the incident (Kobroń, 2015). The International Labour Organization (ILO) defines whistleblowing as 'the reporting by employees or former employees of illegal, irregular, dangerous or unethical practices by employers' (ILO Theasurus, 2021). According to Transparency International, whistleblowing refers to 'communicating information on breaches to individuals or entities believed to be able to effect action' (https://images.transparencycdn.org..., 2020). Whistleblowing is considered to be an important tool that supports effective management in the organization, including health care. It can serve as an internal control system to detect and prevent wrongdoings in the workplace (Hamid & Zainudin, 2015; Asaoka, 2020). Whistleblowing is an important means of recognizing quality and safety matters in health care (Ekpenyong, Nyashanu, Ibrahim, & Serrant, 2020). The benefits of reporting are significant in this area, especially in the context of improving the quality of services, risk management, and risk prevention (Rauwolf & Jones, 2019). According to Schein (2016), whistleblowing reflects 'the culture of voice' as opposed to 'the culture of silence', described as an unethical indifference to activities that are harmful and dangerous to others. It is vitally important for employees to feel that they can speak out and raise concerns when they see poor quality care and/or unsafe practices (Mannion & Davies, 2015). Whistleblowing as a phenomenon is well known in various areas of application (e.g. financial and banking institutions, aviation, nuclear energy); however, more research is needed in the area of health care (Blenkinsopp et al., 2019). Therefore, the aim of this article is to receive the answers to the following research problems: (1) How is the interest of researchers developing in whistleblowing in health care organizations? (2) How do researchers define whistleblowing in health care? (3) What are the main problems (limitations) of whistleblowing in health care organizations? (4) What factors affect whistleblowing in health care organizations? To resolve the problems, the method of systematic literature review based on the PRISMA model and McKinsey's classical 7S framework were used. The systematic review (SR) methodology articulates a replicable approach for collecting, analyzing and synthesizing literature with clear audit trails about what is and what is not known regarding a research question or set of questions (Rojon, Okupe, & McDowall, 2021). The structure of the article is as follows: after the introduction section, the methodology and assumptions of the study are discussed; the next two sections concentrate on theoretical aspects of whistleblowing, and on presenting and discussing

the research results. Finally, the whistleblowing verification matrix (WVM) is proposed and explained. The article ends with conclusions and indications for possible further research.

2. Methodology

The review was carried out with queries of the resources of scientific databases available in the knowledge repository of the home University: Complementary Index, JSTOR Journals, MEDLINE, Academic Search Ultimate, Directory of Open Access Journals, and Emerald Insight (with a multi-search option). The research agenda covered the period 2000–2021 (as of April–May 2021). The complete time span of 2000–2021 was subdivided into: phase 1 (2000–2004); phase 2 (2005–2009); phase 3 (2010–2014); phase 4 (2015–2019); and phase 5 (2020–2021). Only full-text publications in scientific journals both in English and in Polish were taken into account. From the phrases 'whistleblowing and/in health care' ('whistleblowing i/w opieka zdrowotna/opiece zdrowotnej') and 'whistleblowing and/in medical services' (whistleblowing i/w usługi medyczne/usługach medycznych), searched in both the keywords and titles of the studies, 681 records were returned. The search was limited to relevant papers (health care only articles), then to peer-reviewed journals, and available as open via the home University repository, yielding 113, and then 57 publications respectively. After removing duplicates, 38 papers were selected for further review. All final papers included in the study were prepared for analysis by a pre-determined checklist. The checklist included the title of the article/journal, year of publication, names of the authors, and authors' country and region of origin.

Taking into account the indications outlined by Rojon et al. (2021), the systematic review (SR) and further considerations by the author of this article were carried out according to five successive steps presented in Table 1.

Step	Description
1. Review scope & questions	5W+H: 'What?', 'Why?', 'When?', 'Where?', 'Who?' and 'How?'. • What articles are of interest? What database is the basis of the search? • Why is the problem under study important? • When, in what period, were the articles written? • Where were the individual works created, in which country, region, and where were they published? • Who is dealing with this problem? • How is whistleblowing defined in health care?

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Table cont.

Step	Description
2. Literature searches	Complementary Index, JSTOR Journals, MEDLINE, Academic Search Ultimate, Directory of Open Access Journals, and Emerald Insight (with a multi-search option). The phrases: 'whistleblowing and/in health care' and 'whistleblowing and/in medical services' in English and in Polish. The time span: phase 1 (2000–2004); phase 2 (2005–2009); phase 3 (2010–2014); phase 4 (2015–2019); and phase 5 (2020–2021).
3. Initial review	Reading titles and key words; and first review of the articles;
4. Further review	Implementation of inclusion and exclusion criteria; preparation of the target list of publications for in-depth analysis; preparation of the checklist.
5. Analysis & synthesis	In-depth analysis; descriptive statistics: arranging the results; searching for answers to research questions (1, 2, 3 and 4). Narrative integration of qualitative content: description and summary of papers; identification of relationships between articles; identification and prioritization of key factors; consulting the final results with experts; synthesizing the results; development of conclusions.
6. Conceptualization	Development of a proposal for the WVM matrix.

Tab. 1. Overview of systematic review process. Source: Author's elaboration based on Rojon et al. (2021).

SR was used to answer the research problems, therefore it was necessary to determine the scope of the research and review questions. For this purpose, the 5W+H rule was followed: 'What', 'Why', 'When', 'Where', 'Who', and 'How'. The author of this paper used the method of SR based on the PRISMA model (see Figure 1) (Liberati et al., 2009).

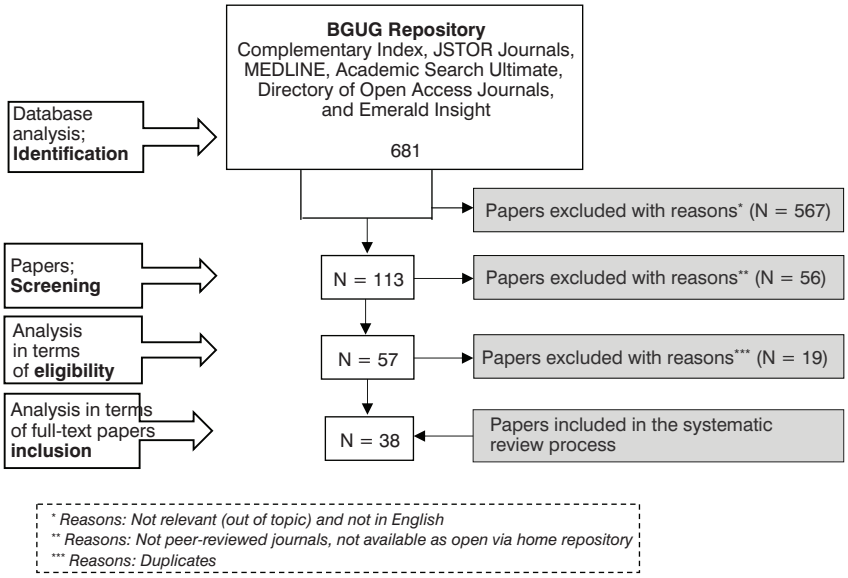

Fig. 1. Papers selecting process diagram based on the PRISMA model. Source: Author's elaboration.

Content analysis was used and then the method of data synthesis as it sought to summarize and critique the research literature about whistleblowing (Jackson et al., 2014). Thanks to this, considerations of an analytical-synthetic nature are conducted on the basis of the seven components of the McKinsey model. This model postulates that organizational performance, regardless its specificity, depends on: shared values, strategy, structure, system, staff, style, and skills (Waterman, Peters, & Phillips, 1980). In McKinsey's model, the factors are divided into the 'soft' and 'hard' areas. Strategy, structure and systems are hard elements, and style, staff, skills and shared values are soft ones (Lima, 2020). After completing the review and synthesis processes, the author used the method of conceptual work to present the WVM matrix.

3. Results and Discussion

3.1. How is the Interest of Researchers Developing in Whistleblowing in Health Care Organizations?

First of all, it was necessary to recognize the development of research addressing whistleblowing in health care over the years. Ten of the works identified within the PRISMA model were created in the 2000s, i.e. in phases 1 and 2; however, it is possible to observe a visible growth tendency

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in the 2010s, especially in phase 4 (20 papers). As a result of the literature review (see Table 2), it appears that the vast majority of works comes from the International Journal of Health Policy and Management. It can also be noted that most of the authors chose journals representing the broadly understood management and/or quality and safety management sciences (18) and next medicine/psychology (15), and others. On this basis, one may conclude that the subject of whistleblowing in health care is very broad and interdisciplinary. In research on whistleblowing in health care, researchers representing the academic centers from the UK definitely dominate (17 papers). Australian (8 papers) and North American (USA) (4 papers) teams are represented to a lesser extent, followed by Irish (2 papers), Israeli, Canadian, Finnish, Italian, Hong Kong, Ghanaian, and Egyptian researchers (1 article each).

Characteristics	No.
Type of paper	
Qualitative studies: interviews/semi-structured Interviews, focus groups, cross-sectional studies, literature review, case studies	12
Commentary	9
Theoretical	8
Questionnaire survey/random sampling	5
Questionnaire survey/convenience sampling	3
Conceptual	1
Journal title	
International Journal of Health Policy and Management	10
Journal of Advanced Nursing	4
Clinical Governance. An International Journal	2
Best Practice & Research: Clinical Anaesthesiology	1
BMJ Open	1
Contemporary Nursing	1
Future Hospital Journal	1
Indian Journal of Medical Ethics	1
Interface: A Journal on Social Movements	1
International Journal of Healthcare Management	1
International Journal of Nursing Studies	1
Journal of Clinical Nursing	1
Journal of Health Organization and Management	1

Table cont.

Characteristics	No.
Journal of Nursing Management	1
Journal of Professional Nursing	1
Journal of Medical Ethics	1
Medical Education	1
Physiotherapy	1
Public Administration Quarterly	1
Quality and Safety in Health Care	1
Safety in Health	1
Sociology of Health and Illness	1
The Australian Journal of Advanced Nursing: A Quarterly Publication of the Royal Australian Nursing Federation	1
The Journal of the Royal Society of Medicine	1
The TQM Journal	1
Phase	
phase 4 (2015–2019)	20
phase 3 (2010–2014)	7
phase 2 (2005–2009)	6
phase 1 (2000–2004)	4
phase 5 (2020–2021)	1
Country/research center	
UK	17
Australia	8
USA	4
Ireland	2
Israel	1
Canada	1
Finland	1
Italy	1
Hong Kong	1
Ghana	1
Egypt	1

Tab. 2. Characteristics of the included studies. Source: Author's elaboration.

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It also appears that the majority of papers (16) are commentary and theoretical. Among the British papers, those by Mannion and Davies (2015; 2016), and Blenkinsopp and Snowden (2016) deserve special attention, because their works on whistleblowing in health care are very often cited in the other identified works (Sarfo-Annin, 2015; Jones, 2016; Waring, 2015; Cleary & Doyle, 2015; MacDougall, 2015; Hyde, 2016; Alford, 2016; Waring, 2015; Ciasullo, Cosimato, & Palumbo, 2017; Rauwolf & Jones, 2019), including an article by Schein (2016), a well-known researcher of organizational culture. As already indicated, some of these articles are reflective comments and thoughts in relation to these works. In the set of articles, the papers devoted to the area of nursing are also very inspiring (15 papers), and in this case, the works written by Australian authors deserve special attention (e.g. McDonald & Ahern, 2000; Ahern & McDonald, 2002; Firtko & Jackson, 2005; Jackson et al., 2010, 2014). However, there are relatively few quantitative publications based on a randomized and on a convenience sample (8 papers). Among the pioneers in this regard are, for example: McDonald and Ahern (2000), and Ahern and McDonald (2002), who, respectively, examine the professional effects of whistleblowing and nonwhistleblowing in nursing, and explore the beliefs of nurses who wrestled with an ethical dilemma when reporting; Moore and McAuliffe (2010), who examine experiences of those nurses who have observed poor care and reported it; or Lawton and Parker (2002), who investigate the willingness of health care professionals (doctors, nurses, and midwives) to report an adverse incident or near miss. In the set of works, there are three articles based on the literature review (Jackson et al., 2014; Nacioglu, 2016; Blenkinsopp et al., 2019). They are mentioned later in this article. It should be noted, however, that among the analyzed works, neither research nor considerations concerning the administrative staff in health care were found. There were also no studies on whistleblowing in such institutions as medical laboratories, research laboratories, hospital pharmacies or medical wholesalers. As evidenced in different studies (Yousef & Yousef, 2017; Milinković, Jovičić, & Ignjatović, 2020; Silva & Costa, 2020), any deviation from patient safety rules in these areas, and above all the lack of knowledge about its occurrence, may contribute to serious harm to the patient and other stakeholders cooperating with the organization.

3.2. How Do Researchers Define Whistleblowing in Health Care?

Based on the analysis, one can note that in the UK and in some cases in Australia, whistleblowing is synonymous with ‘raising concerns’ or ‘speaking up’, which better reflects the essence of this phenomenon. The above terms are used, inter alia, by: Mannion and Davies (2015, 2016), Hilton (2016), Jones, Lankshear, and Kelly (2016), Alford (2016), Blenkinsoop and Snowden (2016), Blenkinsoop et al. (2019), Kusu-Orkar, Symonds, Bickerstaffe, Allorto, and Oultram (2019), Ahern and McDonald (2002), Firtko and Jackson (2005)

or by Jackson et al. (2014), but not only. The literature studies made it possible to explore the definitions of whistleblowing in health care. As Bolsin, Faunce, and Oakley, (2005) show, it can be recognized as 'a voice against the lack of quality and safety in health care'. According to White (2006), Mansbach, Melzer, and Bachner (2012) or Asiamah and Mensah (2019), whistleblowing is described more generally as 'the disclosure by organization members (former or current) of illegal, immoral or illegitimate practices under the control of their employers, to persons or organizations that may be able to effect action'. A similar definition can be found in the article by Jackson et al. (2014) where 'whistleblowing is a process whereby a current or former member of an organization discloses practices believe to be illegal, immoral or illegitimate, to those who may be able to effect change'. Jackson (2008) defines whistleblowing as 'an honest behaviour of telling the truth about what is right and what is wrong'. She describes it as a method of ensuring justice and making amends. The same author adds that disclosing irregularities is the 'voice of conscience'. Mannion and Davies (2015) show that 'whistleblowing is one type of ethical activity for raising concerns about wrongdoing and intentional harming of patients', and according to Blenkinsopp and Snowden (2016), 'whistleblowing is considered an act of courageous people who are able to "convey the truth to those in power"'. To sum up, one can conclude that the reporting of incidents or whistleblowing occurs when a member of staff within an organization discloses that an employee has acted in a way that is a cause for concern, and the person it is reported to has the ability to do something about it (Moore & McAuliffe, 2010). There are also some papers where *whistleblowers* and *nonwhistleblowers* are definied. From the perspective of nursing, a *whistleblower* is described as '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', and a *nonwhistleblower* as 'a nurse who identifies an incompetent, unethical, or illegal situation in the workplace, but does not openly report it' (McDonald & Ahern, 2000; Ahern & McDonald, 2002). Based on that, Moore and McAuliffe (2010) propose a more general definition by substituting the word 'nurse' for the word 'someone'. With the above suggestions in mind, the author of this article defines whistleblowing as creating a culture of voice within the organization and supporting it to ensure patient safety and quality of care, and a whistleblower as a person who is not indifferent to the violations of the principles of quality and patient safety, and reports them to protect the patient.

3.3. What Are the Main Problems (Limitations) of Whistleblowing in Health Care Organizations?

As Rauwolf and Jones (2019) emphasize, few disagree that care is improved when employees are able, willing and supported within their organization to speak up about poor care. They add that, in the long term,

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internal whistleblowing may even prove cost-effective to the institution. As already indicated in the theoretical section, it can also have positive effects on the entire care system (Waring, 2015). According to Mannion and Davies (2015) and Waring (2015), whistleblowing in health care has gained importance due to scandals in medical organizations in many countries. They revealed how serious the consequences of various deficiencies and ineffective practices carried out in individual medical institutions can be for the health and life of patients, as well as for the organizations themselves. They not only concern the 'first victims' (patients and their families) and 'second victims' (employees), but also the 'third victim', which is the medical organization itself. This is due to fact that in the event of a scandal, the health care organization loses the patient's trust and credibility with its owners (e.g. local government units) and suffers financial and image losses, as confirmed by Waring (2015). However, the literature draws attention to the difficulties and controversies related to whistleblowing, because it causes great emotions, not only in countries with extensive experience in this field (e.g. the United States, Australia, the UK), but above all it causes real difficulties and numerous controversies in post-totalitarian countries. The history of those countries (e.g. Poland, Czech Republic or Slovakia), mainly the Nazi occupation during World War II, and then the decades of communism, has had a key influence on the perception of 'ethical denunciations'. Informants were perceived negatively as 'narks' (Kobroń, 2015). The analysis of the collected sources made it possible to confirm similar concerns in health care. According to Rauolf and Jones (2019), in general, the term whistleblowing is often regarded as having negative connotations related to 'grassing' or 'snitching' on colleagues. The negative consequences of whistleblowing are confirmed, i.a., by McDonald and Ahern (2000), Ahern and McDonald (2002). The authors show that blowing the whistle on misconduct is a devastating experience for the nurses and those who have the courage to report misconduct suffer profound professional effects. Little support and understanding from other nurses is also observed. According to Cruise (2002) and Sarfo-Annin (2015), during the process of disclosure the individual whistleblower is placed at extreme personal and professional risk. People who report abuses tend to claim to be motivated by conscience and professional virtue, citing medical ethics and even human rights. However, the disclosure of problems with quality and safety of the patient takes place at a great personal cost and with surprisingly little positive recognition among colleagues (Firtko & Jackson, 2005; Bolsin et al., 2005). As Moore and McAuliffe (2010) identify, whistleblowing is hampered by a lack of faith in the organization's ability to take corrective action. These are often traumatic experiences for the employee associated with a prior moral burden regarding the awareness of having information that, if not communicated, may affect the patient's health (Faunce & Oakley, 2005; Sarfo-Annin, 2015; Moore & McAuliffe, 2010). Moreover, the authors

observe: 'a fear of repercussions, retribution, labelling and blame for raising concerns' (Attree, 2007), 'an inadequate response to whistleblowing' (Moore & McAuliffe, 2012), or 'a climate of fear' (Jackson et al., 2010). Therefore, reporting shortcomings and abuses can cause conflicting emotions. On the one hand, there is a fear of harming another person, including the patient, and on the other hand – a fear of losing relationships in the workplace, of ostracism and accusations of disloyalty. This leads to a great deal of stress and fosters alienation, a feeling of bitterness, and a loss of trust – especially if the report is ignored (Blenkinsopp & Snowden, 2016). Thus, the 'deaf effect' seems to be critical. It occurs when the management fails to hear, ignores, or overrules reported misconduct. The superiors often do so because of a fear of losing power or to gain status in the hierarchy, e.g. of a hospital (Cleary & Doyle, 2015). The result of such behavior is a sense of futility and helplessness among the staff (Sarfo-Annin, 2015). The lack of reports or the fear of reporting errors or adverse effects may also have a cultural (Ciasullo et al., 2017) and political basis (Sharkawi & Ali 2020), but not only. According to Lawton and Parker (2002), the position of the informer and the informed person is also critical. Health care professionals appear reluctant to report adverse incidents to a senior member of staff, and doctors are more unwilling than nurses or midwives in this regard.

3.4. What Factors Affect Whistleblowing in Health Care Organizations?

As shown in Table 3, the literature studies made it possible to indicate and to classify the most important factors affecting whistleblowing. For this purpose, McKinsey's 7S model was used. The classification presented in the table can be regarded as subjective and quite arbitrary in nature. However, to reduce this limitation, after the classification, the author of this article consulted and verified the results with five experts representing four different health care organizations: two clinical nurses, including one in a managerial position, two doctors (pediatric specialist and occupational medicine specialist) and the director of a small dental clinic. The final results give an interesting picture of the factors that determine the implementation of whistleblowing. Where appropriate, quotations from individual statements or opinions were used. As can be seen, there are some cases where one factor belongs to two or three 'S' categories of the 7S model. This is due to fact that many problems and issues are closely interrelated (Waterman et al., 1980). For example, 'whistleblower's support' goes hand in hand with both the management 'style' (Firtko & Jackson, 2005) and the attitude of each individual employee ('staff') (Ciasullo et al., 2017). 'Responsiveness' depends on how and how quickly the manager responds to the notification ('style') (Cleary & Doyle, 2015), on the personal commitment of lower level managers ('staff') (Mannion & Davies, 2016; Blenkinsopp et al., 2019), as well as on the internal responsibilities and roles of the employees ('structure')

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(Firtko & Jackson, 2005). Taking into account the number and types of factors assigned to the individual indications (see Table 3), it appeared that 'staff', 'style' and 'shared values' are the factors most often pointed out by the authors of the studied publications, and these are factors considered 'soft' in McKinsey's model. The growing importance of 'soft' factors is evidenced by different scientific publications worldwide (e.g. Štrukelj et al., 2020; Bagni et al., 2021), including those related to health care organizations during the pandemic (Kravchenko & Yusupova, 2020).

No	Author(s), year, & journal	Country of authors' origin	Type of paper, studied area & purpose	Factors
1.	McDonald and Ahern (2000) *Journal of Professional Nursing*	Australia	Questionnaire survey/ random sample 95 nurses from Western Australia (general and mental health nurses) Purpose: To examine the professional consequences of whistleblowing in nursing	• 'Being formally reprimanded' (Style) (Staff) • Education (Skills) • Support from others and from leaders (Staff) (Style) • 'Autonomous decision-making power' (Structure) • 'Positive platform toward reporting misconduct' (System) • 'Guidance and commendations' (System)
2.	Ahern and McDonald (2002) *Journal of Advanced Nursing*	Australia	Questionnaire survey/ random sample 95 nurses from Western Australia (general and mental health nurses) Purpose: To explore the beliefs of nurses who wrestled with an ethical dilemma when reporting	• Support and understanding from other nurses (Staff) • Nursing codes of conduct (System)
3.	Lawton and Parker (2002) *Quality and Safety in Health Care*	UK	Questionnaire survey/ convenience sample 260 nurses of all grades in three specialties (surgery, anesthetics, and obstetrics) from three hospitals Purpose: To investigate the willingness of health care professionals (doctors, nurses, and midwives) to report an adverse incident or near misses	• Best practice defined in the form of a written protocol (System) • Professional/organizational status (Structure)

Table cont.

No	Author(s), year, & journal	Country of authors' origin	Type of paper, studied area & purpose	Factors
4.	Cruise (2002) *Public Administration Quarterly*	USA	Theoretical Health care in general Purpose: To examine the effects of whistleblowing	• 'Whistle-blowers' protection procedures' (System) • 'Resources to deal with ethical issues arising out of patient care' (System) • Ethical climate (Shared values) • 'Firm foundation in virtue ethics' (Shared values) • 'Understanding of what is essentially right and what is wrong' (Shared values) (Staff)
5.	Bolsin et al. (2005) *Journal of Medical Ethics*	Australia	Theoretical Health care in general Purpose: To examine whether health care whistleblowing should be considered central to any medical ethics emphasizing professional virtues and conscience	• Responsiveness (Staff) (Style) (Structure) (System) • 'Firm foundation in virtue ethics' (Shared values) • Role models of good ethical behavior (Shared Values) (Style) (Staff) • Professional, performance monitoring program (System) • Digital technology (System)
6.	Firtko and Jackson (2005) *The Australian Journal of Advanced Nursing: A Quarterly Publication of the Royal Australian Nursing Federation*	Australia	Theoretical Nursing in general Purpose: To explore current knowledge about whistleblowing in nursing	• Platform to discuss issues around whistleblowing (System) • Whistle-blowers' support (Style) (Staff) • Internal platform in place to ensure employees' concerns are addressed (System) • Whistleblowing culture (Shared values)
7.	White, S.M. (2006) *Best Practice* & Research: *Clinical Anaesthesiology*	UK	Theoretical Health care in general from the perspective of nurses Purpose: To explore the evolution of law and ethics regarding whistleblowing	• 'No-blame culture' (Shared values) • 'Blame-free error reporting system' (System)

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Table cont.

No	Author(s), year, & journal	Country of authors' origin	Type of paper, studied area & purpose	Factors
8.	Attree, M. (2007) *Journal of Nursing Management*	UK	Semi-structured interviews 142 nurses Purpose: To explore factors that influence nurses' decisions to raise concerns about standards of practice	• Open culture (Shared values) • Quality, safety and learning promotion (Strategy) (Shared values) (Style) • Organizational and professional guidelines (System) • Organizational reporting systems (System)
9.	Goldberg, R. (2007) *Journal of Advanced Nursing*	Canada	Theoretical Health care in general Purpose: To present the role of the whistle-blower	• Good communication (Structure) (Staff) (Style) (System) • Empowerment of front-line health professionals (Style) (Staff) • Culture of empowerment (Shared values) • Continuous education (Staff) (Shared values) • 'Processes in place to investigate the act' (System) • 'Internal procedures for identifying and reporting unsafe behaviors and practices' (System) • 'Encouraging doctors, nurses and technologists to admit mistakes and monitor themselves' (Style) (Staff)
10.	Jackson (2008) *Journal of Clinical Nursing*	Australia	Theoretical Health care in general, nursing in particular Purpose: To answer the question about what becomes of whistle-blowers	• Whistleblowing culture (Shared values) • Ethical culture (Shared values) • Vigilance – being in a position to become aware of violations (Staff) (Skills) • Engagement – a state of genuine connection with the organization (Style) (Staff) (Shared values) • Credibility – belief in organizational integrity (Shared values)

Table cont.

No	Author(s), year, & journal	Country of authors' origin	Type of paper, studied area & purpose	Factors
				• Accountability – sense of duty or moral responsibility to report violations (Staff) (Shared values) • Empowerment – a belief in the power to affect positive change (Shared values) • Courage – to face possible retaliatory actions (Staff) • Options – the existence of clear and proper procedure and channels within which concerns can be raised (System)
11.	Jackson et al. (2010) *Journal of Advanced Nursing*	Australia	In-depth semi-structured interviews 11 nurses from several Australian states Purpose: To explore the reasons behind the decision to blow the whistle and provide insights into nurses' experiences of being whistleblowers	• 'Greater clarity about the role nurses have as patient advocates' (Structure) • Clear guidelines (System) • 'Internal health care system response' (System) • 'Safe environment to raise issues of concern' (Style) (Staff) (System)
12.	Moore and McAuliffe (2010) *Clinical Governance. An International Journal*	Ireland	Questionnaire survey/ random sample 152 nurses form eight acute hospitals in the Health Services Executive (HSE) regions in Ireland. Purpose: To examine experiences of those who have observed poor care and reported it	• 'No blame' approach and culture (Shared values) (Style) (Staff) • Support (Style) (Staff) • 'Complaints taken seriously' (Style) (Staff) • Positive response (Style) (Staff) • 'A sense of relief' (Staff) • Feedback (Style) (Staff)

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Table cont.

No	Author(s), year, & journal	Country of authors' origin	Type of paper, studied area & purpose	Factors
13.	Mansbach et al. (2012) *Physiotherapy*	Israel	Questionnaire survey/ convenience sample 126 undergraduate students and 101 certified physiotherapists Purpose: To answer three questions: about the willingness to take action to prevent misconduct; about the willingness to report the misconduct to authorities within an organization and/or outside of it; and about willingness to report a colleague's wrongdoing as well as that of a manager	• Professional experience (Staff)
14.	Moore and McAuliffe (2012) *Clinical Governance. An International Journal*	Ireland	Questionnaire survey/ random sample 152 nurses from eight acute hospitals Purpose: To advance understanding of reporting behavior by exploring differences between those who report incidents and those who choose not to report	• Professional and organizational status (nurse/ doctor) (Structure) (Staff) • Best interest of the patient (Shared values) (Strategy) • Ethical duty (Shared values) (Staff) • 'Being convinced that the line manager will believe' (Shared values) (Staff) (Style) • Risk management structure (System) (Strategy) (Structure) • Policies and procedures (Strategy) (System) • Support from ethics committee (Staff) (Style)

Table cont.

No	Author(s), year, & journal	Country of authors' origin	Type of paper, studied area & purpose	Factors
15.	Jones and Kelly (2014) *Sociology of Health and Illness*	UK	Semi-structured interviews and focus group method Nurses, nurse managers, care assistants, student nurses and regulators/ police (38 persons in total) Purpose: To explore perception of whistleblowing	• Learning from events (Staff) (Skills) • Open culture in the workplace (Shared values) • Role-modeling desired behavior (Style) (Staff) • Team meetings (Staff) (Style) • Whistleblowing procedures (System) • Response to whistleblowing (Staff) (Style) • Codes of ethics and workplace norms (Shared values) (System) • Whistleblowing culture (Shared values)
16.	Monrouxe et al. (2014) *Medical Education*	UK	A qualitative cross-sectional study/group/ individual narrative interviews 69 dental, nursing, pharmacy and physiotherapy students Purpose: To examine narratives of professionalism dilemmas: the types of events they encounter ('whats') and the ways in which they narrate those events ('hows')	• Health care students' education (Skills) (Staff) • Safety culture (Shared values)
17.	Jackson et al. (2014) *Contemporary Nursing*	Australia	Literature review Health care in general, nursing in particular Purpose: To summarize and critique the research literature about whistleblowing	• 'To engage more maturely' (Style) (Staff) • 'To respond appropriately' (Style) (Staff) • Concern for patient safety (Shared values) (Strategy) • 'Professional ethics' (Shared values) • 'Lack of fear and blame' (Staff) (Style) • Professional/organizational status (Staff) (Structure)

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Table cont.

No	Author(s), year, & journal	Country of authors' origin	Type of paper, studied area & purpose	Factors
18.	Mannion and Davies (2015) *International Journal of Health Policy and Management*	UK	Theoretical Health care in general Purpose: To present and discuss the role of whistleblowing	• Culture of voice (Shared values) • Effective voicing of concerns (Staff) (Style) (System) • Creating the right organizational environments (System) (Style) (Staff) • Personal traits and characteristics (Staff)
19.	Cleary and Doyle (2015) *International Journal of Health Policy and Management*	Australia	Commentary Health care in general Purpose: To comment on the role of whistleblowing	• 'Focusing on the message, not the messenger' (Style) (Staff) • Health care managers' behaviors (Style) (Staff)
20.	MacDougall (2015) *International Journal of Health Policy and Management*	USA	Commentary Health care in general Purpose: To comment on the role of whistleblowing	• Procedure to protect or encourage whistle-blowers (System) • Internal reporting policies (System) • Rewarding employees (Style) • Management support (Style) (Staff)
21.	Sarfo-Annin (2015) *Future Hospital Journal*	UK	Theoretical Health care in general Purpose: To discuss the importance of whistleblowing and whistleblowing education	• Leadership (Style) • Education and training (Skills) • Health care culture (Shared values) • Assuring support from national health care system (Strategy)
22.	Waring (2015) *International Journal of Health Policy and Management*	UK	Commentary Health care in general Purpose: To comment on the role of whistleblowing	• Culture of voice (Shared values) • Workplace culture (Shared values) • Safety culture (Shared values) • Ethical culture (Shared values) • Communication channels (Structure) (System)

Table cont.

No	Author(s), year, & journal	Country of authors' origin	Type of paper, studied area & purpose	Factors
23.	Jones (2016) *International Journal of Health Policy and Management*	UK	Commentary Health care in general Purpose: To comment on the role of whistleblowing	• Culture of voice (Shared values) • Workplace culture (Shared values) • Safety culture (Shared values)
24.	Mannion and Davies (2016) *International Journal of Health Policy and Management*	UK	Commentary Health care in general Purpose: To comment on the role of whistleblowing	• 'Need for a new socially situated research agenda on whistleblowing in the context of communication, sense-making and judgement-forming' (Strategy) (System)
25.	Blenkinsopp and Snowden (2016) *International Journal of Health Policy and Management*	UK	Commentary Health care in general Purpose: To comment on the role of whistleblowing	• Leadership and leaders' behavior (Style) (Staff) • Open communication (Style) (Staff) (System) (Structure)
26.	Alford (2016) *International Journal of Health Policy and Management*	USA	Commentary Health care in general Purpose: To comment on the role of whistleblowing	• Responsiveness (Style) (Staff) (System) (Structure)
27.	Hyde (2016) *International Journal of Health Policy and Management*	UK	Commentary Health care in general Purpose: To comment on the role of whistleblowing	• Safety culture (Shared values) • Whistle-blowers' protection procedures (System)
28.	Nacioglu (2016) *Safety in Health*	Hong-Kong	Literature review Purpose: To determine the evidence of the role of 'speaking up' as a safety behavior in health care	• Hospital policy (Strategy) • Interdisciplinary policy making (Strategy) • Team relationships (Style) (Staff) • Attitudes of leaders (Style) (Staff) • Satisfaction with the job (Style) (Staff) • Responsibility towards patients (Shared values) (Style) (Staff) • Roles as professionals (Staff) (Skills) (Style)

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Table cont.

No	Author(s), year, & journal	Country of authors' origin	Type of paper, studied area & purpose	Factors
				• Confidence (Shared values) • Previous experience (Style) (Skills) • Communication skills (Skills) • Educational background (Skills) (Staff)
29.	Schein (2016) *International Journal of Health Policy and Management*	USA	Commentary Health care in general Purpose: To comment on the role of whistleblowing	• Communication within organization (Style) (Staff) (Structure) • Professional responsibility (Strategy) (Style) (Staff) • Senior management engagement (Style) (Staff) • Personalizing internal relationships (Style) (Staff) • Mutual trust and openness (Shared values) • 'To deal with a problem rather than blame and punish' (Shared values) (Style) (Staff)
30.	Hilton (2016) *The Journal of the Royal Society of Medicine*	UK	Case study Two official reference documents Purpose: On the basis of two documents to explore the theme of the duty of candor and whistleblowing, with the view to informing about it within a current debate	• 'People factors' (Staff)
31.	Jones et al. (2016) *International Journal of Nursing Studies*	UK	Semi-structured interview 40 nurses (invitation sent to the whole population of executive level nurses working within NHS England or Wales) Purpose: To generate empirical evidence on the experiences of executive nurses working at board level	• 'The experiences of executive nurses' (Staff) (Style) • 'Supportive, engaged boards' (Style) (Staff) • 'Building relationships' (Staff) (Style) • 'Groupthink' (Staff) (Style) • 'Supportive attitude towards matters of safety and quality' (Shared values) (Style) (Staff)

Table cont.

No	Author(s), year, & journal	Country of authors' origin	Type of paper, studied area & purpose	Factors
32.	Ciasullo et al. (2017) *The TQM Journal*	Italy	Case studies Three health care organizations – Alfa, Beta, Gamma (details not given) Purpose: To contribute to a better understanding of whistleblowing procedures and their influence on overall organizational quality	• Deep-rooted ethical culture (Shared values) • Preventing the likelihood of malpractices in the health care environment (Strategy) (Style) (System) • Improving the quality of services (Strategy) • A web-based system to collect and manage whistleblowing initiatives (System) • Feedback about how the alerts contribute to improving patient safety and service quality within organization (Structure) (Style) (Staff) • Supportive organizational environment (Style) (Staff) • Strong ethical climate (Shared values) • Deep-rooted sense of organizational citizenship among employees (Shared values) • Whistleblowing procedures (System) • The absence of blame for not whistleblowing (Shared values) (Style)
33.	Asiamah and Mensah (2019) *International Journal of Healthcare Management*	Ghana	Questionnaire/survey random sample 630 health care workers Purpose: To explain the influence of leadership status and demographic variables on whistleblowing intention	• Whistle-blowers' status/rank (Structure) • Whistle-blowers' gender (Staff) • Job tenure (Staff) • Religious affiliation (Staff)

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Table cont.

No	Author(s), year, & journal	Country of authors' origin	Type of paper, studied area & purpose	Factors
34.	Blenkinsopp et al. (2019) *Journal of Health Organization and Management*	UK	Literature review Literature (health care and not health care) Purpose: To review existing research on whistleblowing in health care to develop an evidence base for policy and research	• Training (Skills) • Positive response to whistleblowing (Style) (Staff) • Educating managers (Skills) • 'Safety first' approach (Shared values) • Debates on whistleblowing (Style) (Staff) • Feedback (Style) (Staff) (Structure)
35.	Kusu-Orkar et al. (2019) *Indian Journal of Medical Ethics*	UK	Questionnaire/survey convenience sample Surgical staff and medical students in a public hospital Purpose: (i) To elicit the views of medical personnel regarding whistleblowing; (ii) to add to the current discussion and an evidence base on whistleblowing in the South African health care system, (iii) to contribute to the current research base on whistleblowing in developing countries	• Consequence (Style) (Staff) • Understanding the whistleblowing (Staff) (Skills) • Education (Skills) • Reporting systems in place (System)
36.	Pohjanoksa et al. (2019) *Journal of Advanced Nursing*	Finland	Cross sectional studies open questions 226 health care professionals Purpose: To describe health care professionals' experiences of observed wrongdoing and potential whistleblowing acts regarding it. The main goal was to strengthen the whistleblowing process described based on the existing literature and to make it more visible for future research.	• Individual characteristics (Staff) • Moral courage (Shared values) (Staff) • 'Know what to do or how or where to address the act' (Staff) (Structure) • Ethics (Shared values)

Table cont.

No	Author(s), year, & journal	Country of authors' origin	Type of paper, studied area & purpose	Factors
37.	Rauwolf and Jones (2019) *BMJ Open*	UK	Conceptual Using computational models Purpose: To answer the question: How the efficacy of formal inquiries within organizations in response to employees' speaking up about their concerns affects the utility of internal whistleblowing.	• Promoting an environment where staff speak up informally (Style) (Staff)
38.	Sharkawi and Ali (2020) *Interface: A Journal on Social Movements*	Egypt	Case study Two cases of whistleblowing at two university hospitals Purpose: To examine acts of whistleblowing performed by Egypt's health care workers during a public health crisis	• Assure supportive political environment (Strategy)

Tab. 3. Factors affecting whistleblowing classified according to McKinsey's 7S model. Source: Author's elaboration.

7S factor	Number of indications
Staff	77
Style	59
Shared values	49
System	38
Structure	16
Strategy	13
Skills	13

Tab. 4. 7S factors affecting whistleblowing in health care. Source: Author's elaboration.

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3.4.1. Staff

The workforce is the heart of every organization and there are employees who have the daily obligation to achieve the adopted goals. Their role in the organization is confirmed on an ongoing basis in numerous publications (e.g. Roskams & Hayness, 2019; Soriano et al., 2020; Moynan et al., 2020; Ng et al., 2021). Importantly, it is not only the individual effort of a given employee that counts, but also team effort and mutual help to achieve goals. The study confirms that whistleblowing depends on the individual and group attitude towards reporting errors (Nacioglu, 2016); on leadership and leaders' behavior (Blenkinsopp & Snowden, 2016); and on open communication and internal relations between employees (Blenkinsopp & Snowden, 2016; Schein, 2016; Nacioglu, 2016). Very important is 'to deal with a problem rather than blame and punish' in a situation when irregularities are reported (Schein, 2016), and this is closely related to the supportive environment and attitude of leaders, colleagues and teams (Ciasullo et al., 2017). For people who experience high perceived support, they may feel a stronger obligation to commit themselves to the concerns and objectives of the organization (Klesmeier & Rowold, 2020). In the context of health care, disclosing irregularities is a specific professional responsibility and obligation that serves to reduce the routine security threats faced by patients under the care of a given facility and its staff (Jackson, 2008; Waring, 2015; Nacioglu, 2016; Schein, 2016). Other decisive conditions in this respect are: to be aware of violations (Jackson, 2008); to be engaged (Jackson, 2008; Jackson et al., 2014; Schein, 2016); to 'know what to do or how or where to address the act' (Pohjanoksa, Stolt, Suhonen, & Leino-Kilpi, 2019); and to be able to face possible retaliatory actions, for these are examples of situations that can require courage (Jackson, 2008; Pohjanoksa et al., 2019). The analysis of the publications shows that whistleblowers are treated with coldness or hostility. In parallel, whistleblowers are described as brave workers (Mannion & Davies, 2015); as heroes (Jones & Kelly, 2014; Alford, 2016); as agents fighting fraud and abuse in health care organizations (Cruise, 2002); or as 'disloyal malcontents' who 'snitch' or 'grass' on colleagues (Jones & Kelly, 2014). Of course, being a hero requires an employee to speak out, but it is important that top management hear that voice. Moreover, as other researchers convince, as in general (e.g. Martins de Sant'Anna & Garibaldi de Hilal, 2021; Gan et al., 2020) as during a pandemic, the health care professionals 'are the weakest link in the chain' (Hemapriya et al., 2021). Therefore, there is a need to maintain the well-being of the staff to make them less affected by different stressors connected with raising concerns. Support and understanding from others (McDonald & Ahern, 2000; Ahern & McDonald, 2002; Firtko & Jackson, 2005; Jones et al., 2016); good ethical behavior (Bolsin et al. (2005); to be aware of violations (Cruise, 2002; Jackson, 2008); to be engaged (Jackson, 2008; Schein, 2016), and

being a professional (Jackson et al., 2014; Nacioglu, 2016; Mansbach et al., 2012) appear very important determinants in this process. Ethical duties (Moore & McAuliffe, 2012), personal traits and characteristics (Mannion & Davies, 2015; Pohjanoksa et al., 2019), and various other individual qualities, like whistleblowers' gender, job tenure or religious affiliation (Asiaham & Mensah, 2019), are also taken into account.

3.4.2. Style

The role of leadership styles for staff´s job satisfaction as well as the functioning of the entire organization has long been proven and confirmed by many researchers (e.g. Mehrad & Fallahi, 2014; Xie, 2020; Mukherjee & Mulla, 2021). Leadership style represents management philosophy, worldview, and personality. A wrongly chosen leadership style on the one hand reduces employee performance and on the other hand works as a stressor in managers (Hosseini et al., 2020). As Jackson et al. (2014) argue, leadership is crucial to support the growth of resilient teams that create strong and enabling environments that role model desirable staff behaviors. One of the articles (Cleary & Doyle, 2016) indicated that it is solely up to the management of the health care facility and the conditions they create whether employees take a decisive step to report irregularities. In another publication (Blenkinsopp et al., 2019), it was emphasized that some superiors demonstrate negative, even hostile reactions. According to the authors, such managers lose the right to 'moral leadership' and trust of the staff. Other studies, out of the list, show that a moral and ethical work environment created by management prevents both interpersonal and organizational deviant behavior from the employees (Somro, Kundi, & Kamran, 2020), and that high-quality relationships between supervisors and subordinates increase job satisfaction (Marzec, 2019). The analysis of papers confirms that a sense of safety and supporting environment are the conditions that enable comments about failures to be expressed without fear (Mannion & Davies, 2015; Waring, 2015). According to Nacioglu (2016), it is obviously needed when staff and patients are at risk or vulnerable. However, the visible support, professionalism, personalizing internal relationships, responsiveness, rewarding employees, model behavior and commitment of the management are necessary. The role of leaders in this regard has been confirmed i.a. by Cruise (2002), Bolsin et al. (2005), Firtko and Jackson (2005), Jackson (2008), MacDougall (2015), Sarfo-Annin (2015), Waring (2015), Alford (2016), Hyde (2016), Nacioglu (2016), Schein (2016), Ciasullo et al. (2017), Kusu-Orkar et al. (2019), and Rauwolf and Jones (2019). As Mannion and Davies (2015), Jones (2015), and Blenkinsopp and Snowden (2016) write, if senior management are not perceived as responsive recipients of staff concerns or, worse, are seen to persecute staff, it will lead to a 'culture of silence' in the organization. A willingness to listen to employees, including supporting a 'culture of voice', and an openness to criticism and to admitting mistakes send a clear message to employees

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about what behavior and attitudes are expected of them. Very important seems to be rewarding employees (MacDougall, 2015), because it sends a message to potential whistleblowers that their information is valued and can mitigate the risks of retaliation (https://www.whistleblowers.org...), and is a source of satisfaction with a job (Nacioglu, 2016). The importance of this factor is emphasized by Bolsin et al. (2005), Alford (2016) and Ciasullo et al. (2017).

3.4.3. Shared values and system

Shared values are the key elements and the basis of the organizational culture. For this reason, the obtained results seem very interesting, because one of the factors identified during the study is a supportive organizational culture, and first of all, safety culture, which together play a key role in whistleblowing (Blenkinsopp et al., 2019). The identified works mention: 'ethical culture' (Cruise, 2002; Jackson, 2008); 'ethical climate' (Cruise, 2002; Waring, 2015; Ciasullo et al., 2017); 'whistleblowing culture' (Jackson, 2008; Jones & Kelly, 2014); 'open culture' (Jones & Kelly, 2014); 'workplace culture' (Waring, 2015; Jones, 2016); 'culture of raising concerns'; 'a culture free from bullying'; 'a culture of visible leadership'; 'a culture of valuing staff'; or 'a culture of reflexive practice' (Waring, 2015).

As confirmed by Cruise (2002), Jackson (2008), Jones and Kelly (2014), Hyde (2016) and Ciasullo et al. (2017), system, including workplace policies and programs, is especially important when implementing a whistleblowing mechanism. It is not only about 'when, to whom, and how' to report errors or other irregularities (Pohjanoksa et al., 2019), but also how to protect and support the medical staff who speaks up about them. Therefore, when it comes to the systemic context, the authors of the articles pay attention to the importance of such factors as: positive and blame-free error reporting system (McDonald & Ahern, 2000; Cruise, 2002) to ensure employees concerns are addressed (Firtko & Jackson, 2005; White,2006); a web-based infrastructure to collect and manage whistleblowing initiatives (Ciasullo et al., 2017); whistleblowing/reporting procedures and guidelines (Attree, 2007; Goldberg, 2007; Jackson et al., 2010; Jones & Kelly, 2014; MacDougall, 2015; Hyde, 2016; Ciasullo et al., 2017; Kusu-Orkar et al., 2019); codes of conduct (Ahern & McDonald, 2002), and best practices in place (Lawton & Parker, 2002).

3.4.4. Structure, strategy, and skills

In order for the system described above to work properly and effectively, a specific and supporting internal structure is required. As the analysis of the publications shows, the authors emphasize the importance of such issues as: individual responsibilities and duties (Jackson, 2008), personal or individual status (Lawton & Parker, 2002), as well as the clarity about the roles within the organization (Jackson et al., 2010; Nacioglu, 2016; Schein, 2016). Next, there is a need for communication channels within

which concerns can be raised (Jackson, 2008; Waring, 2015; Manionn & Davies, 2016; Schein, 2016; Blenkinsopp & Snowden, 2016) and for effective feedback (Ciasullo et al., 2017). Strategy and skills appear to be the least visible factors influencing speaking, but they are essential in improving the quality of medical services (Ciasullo et al., 2017) and maintaining patient safety. Therefore, as Jackson et al. (2014) show, to maintain health care safety and quality, strategies need to be implemented to ensure employees are supported to raise issues of concern. Moore and McAuliffe (2012) argue that a good whistleblowing policy is connected with confidentiality and respecting promises. It is evident that an appropriate strategy allows for the development of beneficial relations with the environment, both political (Sharkawi & Ali, 2020) and within the national health care system (Sarfo-Annin, 2015). It also sets the goals to prevent the likelihood of malpractices (Ciasullo et al., 2017) and to invest in necessary resources (Wang et al., 2020). Researchers confirm that whistleblowing should be treated as an element of professionalism (e.g. Bolsin, 2005; Jackson, et al., 2014; Nacioglu, 2016). Therefore, appropriate qualifications, both professional and moral, are essential. The analysis of the publications seems to confirm this postulate. The authors point out to: the necessity of education (McDonald & Ahern; 2000; Goldberg, 2007; Sarfo-Annin, 2015; Nacioglu, 2016; Kusu-Orkar et al., 2019); learning from errors (e.g. Jones & Kelly, 2014) and from previous experience (Nacioglu, 2016); the need to educate managers and staff (Blenkinsopp et al., 2019; Kusu-Orkar et al., 2019); the need to understand the idea of whistleblowing (Cruise, 2002; Kusu-Orkar et al., 2019); and the necessity to improve communication skills in this regard (Nacioglu, 2016; Mannion & Davies, 2016). The authors above also confirm a relationship between the competence of the management board and the willingness of employees to submit reports on errors and incidents, as well as the impact of management on the attitudes of first-line employees reporting shortcomings. The attitudes towards reporting errors and other irregularities should be formed at the stage of medical education while exploring the basics of professional ethics (Bolsin et al., 2005; Monrouxe, Rees, Endacott, & Ternan, 2014; Nacioglu, 2016; Kusu-Orkar et al., 2019; Pohjanoksa et al., 2019). Medical school studies are the best time to conduct appropriate research among students in order to identify their opinions on reporting shortcomings and, on this basis, to educate young people about the ways and possibilities of joining such a process.

4. Whistleblowing Verification Matrix

To check the correctness of wistleblowing, the author proposes to use the WVM as a discussion tool to help organizations identify where there is a need to verify speaking up to achieve the maximum benefit for patient safety. The matrix takes into account four possible scenarios, explained in Figure 2.

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I. People report a lot, and what is relevant for patient safety;
II. People report a lot, but not what is relevant to patient safety;
III. People report a little, and what is relevant for patient safety;
IV. People report a little, and not what is relevant for patient safety.

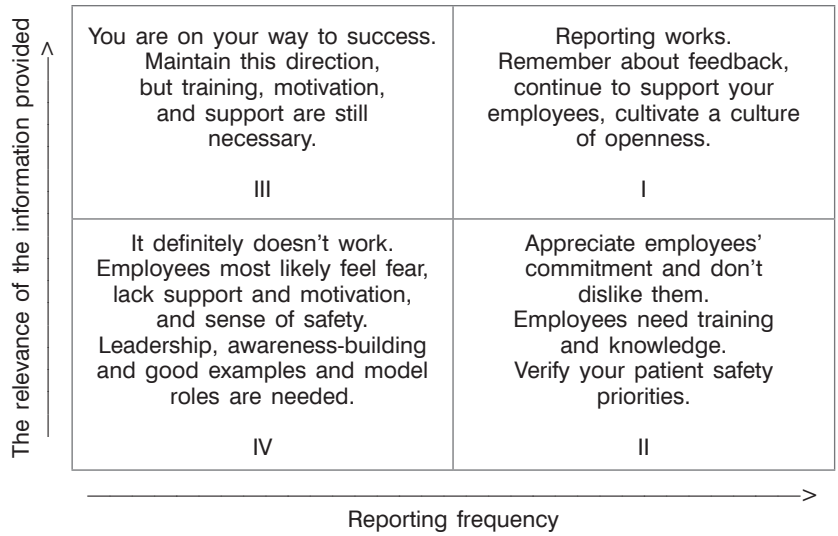

Fig. 2. Whistleblowing Verification Matrix and its explanation. Source: Author's elaboration.

5. Conclusions

The analysis of sources conducted for this study allowed for the collection of valuable material on the basis of which important cognitive conclusions can be drawn. It should be emphasized that whistleblowing as a phenomenon is relatively well known in various areas of application; however, more research is needed in the area of health care. Due to the lack of studies from Central European research centers, including Polish ones, the recommendation must be to consider the solutions of more experienced countries in order to identify the essence of this phenomenon and the conditions for its implementation. All of the authors pointed out that whistleblowing serves the good and safety of the patient, as well as the health care organization itself. Nonetheless, it raises numerous controversies and barriers due to the connotations with malicious denunciation during the war and under communism and due to staff concerns about the consequences they may face, such as job loss, ostracism, fear, or helplessness. In order to reduce these barriers and fears, it is necessary to develop a patient safety culture and a culture of voice which are dependent on parallel support, positive

response, and the real commitment of top management. It is also important to educate people in order to show the differences between denouncing and reporting in good faith. It was possible to identify and classify the factors affecting whistleblowing in health care. In this regard, 'style', 'staff' and 'shared values' seem to be crucial, and these are factors considered 'soft'. To better understand their essence, it is also necessary to emphasize that they are closely related to other factors, and depend on the organizational context, like external, internal and personal (Mannion et al., 2018). The external context includes i.a. the political situation and academic education. The internal context includes i.a. a supportive organizational culture and, first of all, safety culture, 'a culture of voice', 'just culture'; training and education; as well as protecting and supporting whistleblowers. The personal context includes individual traits and characteristics (e.g. courage, morality); the would-be whistleblower's position and role in the organization; and an openness and willingness to cooperate and to share experiences. Due to the lack of works, there is a need to continue research not only on the behavior of typically medical personnel, but also administrative staff, for the roles of administrative staff in health care encompass an indirect impact on patient care and on the overall quality of medical services. The influence of such cooperating units as medical and research laboratories, hospital pharmacies or pharmaceutical wholesalers is also important. It is decidedly worth noting that all European Union (EU) member countries are obliged to implement by 17 December 2021 Directive (EU) 2019/1937 of the European Parliament and of the Council of 23 October 2019 on the protection of persons reporting cases of violations of EU law (the whistleblower protection directive). This regulation requires the EU countries to implement systemic protection of whistleblowers, i.e. people who report abuses. The regulation also applies to the organization of the health care sector. The author of the paper is aware of some limitations related to the research. First, the study was qualitative in nature, and the qualification of the factors, however supported by medical experts, including managers, was subjective and arbitrary. The next reason results from the access to databases managed by the home University. Therefore, in future studies there is a need to take into account other databases, including additional sources of knowledge which would contribute to a better understanding of the phenomenon and its popularization.

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