How Perceptions and Emotions Shaped Employee Silence
in the Case of “Dr. Death” at Bundaberg Hospital

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Abstract

Purpose
For over three decades, researchers have sought to identify factors influencing employees’ responses to wrongdoing in work settings, including organizational, contextual and individual factors. In focusing predominantly on understanding whistle-blowing responses, however, researchers have tended to neglect inquiry into employees’ decisions to withhold concerns. The major purpose of this study was to explore the factors that influenced how staff members responded to a series of adverse events in a healthcare setting in Australia, with a particular focus on the role of perceptions and emotions.

Design/Methodology/Approach
Based on publicly accessible transcripts taken from a government inquiry that followed the event, we employed a modified grounded theory approach to explore the nature of the adverse events and how employees responded emotionally and behaviorally; we focused in particular on how organizational and contextual factors shaped key employee perceptions and emotions encouraging silence.

Findings
Our results revealed that staff members became aware of a range of adverse events over time and responded in a variety of ways, including disclosure to trusted others, confrontation, informal reporting, formal reporting, and external whistle-blowing. Based on this analysis, we developed a model of how organizational and contextual factors shape employee perceptions and emotions leading to employee silence in the face of wrongdoing.

Research Limitations/Implications
Although limited to publicly available transcripts only, our findings provide support for the idea that perceptions and emotions play important roles in shaping employees’ responses to adverse events at work, and that decisions about whether to voice concerns about wrongdoing is an ongoing process, influenced by emotions, sensemaking, and critical events.

Keywords: employee voice, wrongdoing, culture of silence, emotions, healthcare organization
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Workplace wrongdoing, such as bullying, negligence, abusive supervision, fraud and theft, is common in the contemporary workplace (see Kidwell & Martin, 2005). In addition to its immediate and tangible costs, intentional wrongdoing can have serious consequences for organizations over time, particularly if the behaviors are allowed to continue unchecked, and employee complaints are not addressed appropriately (Edwards & Greenberg, 2010). For example, in a 2009 poll of 2852 non-government employees in the United States, the Ethics Resource Center found that almost half of all respondents (49%) had observed some form of misconduct, and 63% reported the wrongdoing to another party, most often to an immediate superior or senior management. Yet, 15% per cent reported that they experienced some form of retaliation after speaking up, including ostracism and verbal abuse from colleagues, indicating that retaliation against whistle-blowers remains a problem in certain settings.

Moreover, while research over the past three decades has focused primarily on explaining the predictors of whistle-blowing as a response to adverse events involving apparent intentional wrongdoing (see Miceli & Near, 2005; Miceli, Near, Rehg & Van Scotter, 2012), it is only over the past fifteen years that researchers have begun to explore the phenomenon of employee silence. In this line of study, researchers sought to understand why and under what circumstances some individuals choose to withhold their opinions, information, and concerns in response to adverse events in organizational settings, especially from those who are capable of correcting the situation (see Henriksen & Dayton, 2006; Morrison & Milliken, 2000; Pinder & Harlos, 2001).

In an early review article for example, Pinder and Harlos (2001) suggested that there was a “silence surrounding silence” in the management and organizational psychology literatures owing to the inherent complexity of the phenomenon. Specifically, Pinder and Harlos argued
that silence is a multilevel phenomenon, and can occur within and between individuals, teams, and organizations (cf, Morrison & Milliken, 2000; Tangirala & Ramanujam, 2008). Employees may be motivated to remain silent for many reasons – not all of them prosocial or altruistic; and these motivations can be difficult to detect. Silence can have both positive and negative consequences depending on the circumstances in question, and multiple stakeholders can be affected, including subordinates, managers, organizations, customers, and the general public. Furthermore, silence is a highly contextual phenomenon, such that the situation in which silence arises is critical for interpreting and understanding its meaning and significance (Brinsfield, Edwards & Greenberg, 2009).

In this chapter, we adopt Pinder and Harlos’ (2001) definition of silence, such that it constitutes “the withholding of any form of genuine expression about the individual’s behavioral, cognitive and/or affective evaluations of his or her organizational circumstance to persons who are perceived to be capable of effecting change or redress” (p. 334). More specifically, we focus on why employees were reluctant to report their concerns formally, both inside (to senior management) and outside of the organization.

Over the last decade, researchers have explored several key avenues of study, including the motives underlying employees’ decisions to keep silent (Brinsfield, 2013; Milliken et al., 2003), the effects of procedural justice climate on silence in workgroups (Tangirala & Ramanujam, 2008), and the relationship between ethical climates and silence dimensions (Wang & Hsieh, 2013). Rather than focusing on silence in the context of apparent severe wrongdoing, however, most authors to date have conceptualized silence as a response to general organizational issues, problems, and concerns. Furthermore, researchers have tended to investigate employees’ behavior using quantitative approaches, and detailed case studies of employee silence are rare. In this chapter therefore, we offer an alternative to traditional studies of employee silence: specifically, using a modified version of grounded theory, we provide a systematic and detailed analysis of the adverse events that transpired between April 2003 and
March 2005 at Bundaberg Base Hospital\textsuperscript{ii}, a regional health center in the state of Queensland, Australia.

The central figure in our case is Dr. Jayant Patel, who worked at the Bundaberg Hospital as its Director of Surgery during this period. Dr. Patel, who came to Australia from the United States at a time when there was a shortage of medical professionals in Queensland, was subject to allegations of professional misconduct that came to be known in the press as the “Dr. Death” case (e.g., see Mancuso, 2005). It is known from the proceedings of the subsequent inquiry (discussed later in this chapter) that hospital staff already had concerns about Dr. Patel soon after his arrival, and that their disquiet increased following a range of adverse events (e.g., surgical complications, high rates of post-surgical infections, patients who passed away following surgery, etc.). After numerous attempts to deal with the situation internally, including notifying senior doctors and hospital administrators of their concerns, a senior ward nurse at the hospital approached a member of the Queensland Government Legislative Assembly (Parliament) with her allegations about Dr. Patel’s conduct. The politician raised the matter publicly, which attracted the attention of the media and generated public outrage. Following intense and highly critical media coverage of the scandal in Australia and internationally, the Government commissioned a public independent inquiry to determine how and why the events in Bundaberg occurred.

The Bundaberg Hospital case offers a rare opportunity to contribute to the literature on governance failures and emotions, insofar as it generated access to a rich and detailed source of information about how employees responded to apparent wrongdoing in a healthcare work setting. The case study approach has been used in the past to study employee responses to organizational crises (e.g., Ulmer & Sellnow, 2000), and it is not an exaggeration for us to view the adverse events that occurred at Bundaberg Hospital during Dr. Patel’s tenure as a crisis (Sandall, 2005).
The structure of our chapter is as follows: First, and prior to introducing the case in detail, we discuss previous research into whistle-blowing in healthcare settings and particularly findings relating to the “Dr. Death” case. Next, based on a brief review of the employee silence and whistle-blowing literature, we derive three research questions to guide our case analysis. We then outline our methods and present the results of our analysis, culminating in development of a model of the organizational and contextual factors that shaped perceptions encouraging employee silence in this case. We conclude with a discussion of the theoretical and practical implications of our findings, consider some of the limitations of our research, and offer suggestions for future research.

Organizational context

The setting for our study is a regional hospital in Queensland, Australia. Similar to their American counterparts (see Blatt, Christianson, Sutcliffe & Rosenthal, 2006; Ramanujam & Rousseau, 2006), studies of whistle-blowing in hospitals suggest that this particular context involves unique challenges and implications for employees. As we will discuss, many parallels exist between the findings of previous studies and the current case. Faunce and Bolsin (2004), for example, detailed three cases of whistle-blowing in Australian hospitals and identified six key characteristics: (1) the problems were not detected by existing formal reporting systems; (2) leading clinicians considered administrative structures as appropriate when the complaints were made; (3) whistle-blowers faced institutional criticism; (4) whistle-blowers had to approach politicians directly to initiate action; (5) a negative organizational culture existed; and (6) more than one inquiry was held to investigate the complaints.

Mannion and Davies (2015) recently reviewed the role of whistle-blowing in healthcare settings, and noted several important findings. For example, survey results suggest that many health professionals remain reluctant to report concerns about unsafe, illegal or illegitimate practices to their employers, despite policies in place to encourage such reporting behavior.
Here, the authors observe that organizational culture plays a key role in determining how health professionals respond when faced with ethical challenges, alongside power and status differences between different occupational groups. The authors also point out that individuals do not simply engage in either “silence” or “whistle-blowing”; rather, employees may raise concerns informally in a variety of ways (e.g., through querying what is happening, using sarcasm or humor to highlight their discomfort, or engaging in “off-the-record” conversations) before progressing to formal reporting behavior. Finally, the authors note that effective speaking up behavior is only one part of the process of safer healthcare practices; those in positions of authority must be willing to listen and act on employees’ concerns.

In another study, Kingston, Evans, Smith, and Berry (2004) found important differences in the way doctors and nurses viewed the act of whistle-blowing. Doctors generally viewed whistle-blowing as unethical and disloyal to colleagues, and expressed a preference to keep adverse events “in house;” nurses were more accepting of the need for a reporting system. Further, while nurses often reported events as a matter of habit, doctors were less likely to regard adverse incidents as “reportable”, and instead regarded them as “known complications.” More recent research suggests that nurses most frequently report issues of concern because of a perceived duty to protect their patients from harm, although some nurses experience a tension between their roles as patient advocate and whistle-blower (Jackson et al., 2010). As Hooper (2011) observed, whistle-blowing remains an act of moral courage for nurses and is often undertaken despite significant fear of retribution.

Perhaps unsurprisingly, the events at Bundaberg Base Hospital involving Dr. Patel have attracted attention from researchers already. In one of the earliest discussions of the “Dr. Death” case, Morton (2005) argued that a highly bureaucratic approach to healthcare focused on “corporate structures [that] devalue clinical involvement, alienate hospital communities, diminish humanity… and [concentrate] on business plans and targets” (p. 328) has contributed significantly to problems in the Australian healthcare system today. In a subsequent analysis of
the culture and decision-making processes in place at Bundaberg Base Hospital during Dr. Patel’s employment, Casali and Day (2010) noted that managers failed to exercise their duty of care to protect their staff and patients from harm. In particular, they noted that a disconnect existed between the organizational values held by staff and promoted to the wider public (e.g., integrity, honesty, open discussion of concerns) and those advocated by management. In a more recent study, Wilkinson, Townsend, Graham and Muurlink (2015) analyzed why the voice systems in place in the hospital failed, and argued that both individual and organizational factors played a role. For example, some individuals were given more credence than others when reporting concerns; in many cases, staff members were uncertain of the correct channels to use; staff perceived that formal reporting of concerns was unwelcome; and management was reluctant to pursue complaints about Dr. Patel because of financial constraints and potential adverse publicity. Overall, previous research suggests that multiple factors contributed to the development of the crisis, and that systematic exploration of the factors underpinning employees’ decisions about how to respond to the adverse events is necessary. Furthermore, our model extends previous work to delineate how organizational and contextual factors likely contributed to the key beliefs that reinforced silence in this context.

**Research questions**

Three research questions guided the data collection and analysis that underpin our study. First, it was critical to gain a comprehensive understanding of the nature of the adverse events in question. In particular, and as Edwards and Greenberg (2010) note, researchers have found that different forms of wrongdoing exist in organizations that range in their subjective severity, intensity, frequency and consequences, which in turn affect how people respond. In their model of the factors that influence observer intervention in episodes of sexual harassment, for example, Bowes-Sperry and O’Leary-Kelly (2005) argue that the moral intensity and the ambiguity of the behavior help people to determine whether the situation requires action. Miceli
and Near (2005) have observed similarly that researchers have generally found a positive relationship between wrongdoing severity and whistle-blowing. As such, before we could explain and analyze how organizational members responded to the adverse events that took place at the Bundaberg Hospital, we needed to identify clearly the events that transpired during this crisis. Thus our first research question was:

*RQ1. What were the adverse events that occurred at Bundaberg Hospital?*

Second, and as we outlined in the introduction to the Chapter, we wanted to explore how people respond when they become aware of episodes of adverse events in their organizations. Thus, while we have a good understanding of some of the ways in which they can respond, very few researchers have explored how employees’ emotions and behaviors change over time. An exception can be found in the work of Pinder and Harlos (2001), who proposed that employees confronted by an adverse event initially evaluate whether the event is unjust using a two-stage appraisal process (Lazarus & Folkman, 1984). In Pinder and Harlos’s model, if an employee perceives that an injustice has occurred, a secondary appraisal process follows that involves an assessment as to whether voicing her or his concerns will help to resolve the situation.

Pinder and Harlos (2001) noted further that the employees may respond in different ways, including agreement with the status quo, quitting, raising their concerns through official channels (i.e., voice), or engaging in quiescent silence (i.e., recognizing that they have the means and opportunity to speak up about their concerns, but remaining silent out of fear of the adverse consequences of voice). Following an extended period of quiescence (a state characterized by anger, cynicism and fear of speaking up), some employees may move to a state of acquiescence (characterized by resignation, despondency and a reduced propensity to speak up), while others may choose to exit the organization and then voice their concerns. Van Dyne et al. (2003) later argued for a further alternative: the possibility that employees may remain silent out of loyalty (see also Tangirala & Ramanujam, 2009).
In the present study, we were interested in how employees responded emotionally and behaviorally to the adverse events involving Dr. Patel, whether any patterns of behavior could be identified, and whether they engaged in different responses as time passed. This therefore leads to our second research question:

*RQ2. How did the members of the organization respond emotionally and behaviorally to the adverse events that occurred?*

In our third research question, we sought to explore the organizational and contextual factors that helped to shape employees’ perceptions in this particular context. In this respect, Miceli, Near, and Dworkin (2008) identified a list of factors that affect how people respond to wrongdoing in organizational settings, and particularly whether employees will engage in whistle-blowing. In particular, national, organizational, contextual and individual-level factors appear to play a role, highlighting the complexity of the decision-making process. At an organizational level, Miceli and Near (2005) reported that whistle-blowing seems to occur more frequently in high performing, less bureaucratic organizations; yet appears to be more common in the public sector rather than private or non-government not-for-profit settings. Although this finding may seem counter-intuitive, Miceli, Near and Dworkin (2008) note that individuals who work in the public sector may be driven to engage in more reporting behavior for the greater good, such that “whistle-blowing may be seen as consistent with serving the public or society-at-large” (p. 86). Moreover, given the dearth of research into the psychological processes underlying decisions about how to respond to wrongdoing in organizations, we sought to identify in particular those individual perceptions and emotions that encouraged employees to withhold their concerns from management. Although many researchers have proposed theoretical models of potential factors and individual perceptions (including appraisals) influencing employee-level silence (Pinder & Harlos, 2001) and organizational-level silence (e.g., Henriksen & Dayton, 2006; Morrison & Milliken, 2000), our study is one of the first to
investigate empirically the factors and perceptions that shape employee silence about problems in healthcare settings. Thus our third research question was twofold:

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\text{RQ3a. What were the organizational-level and contextual-level factors that affected employees’ behavior?}
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\text{RQ3b. What were employees’ perceptions, appraisals, and emotions arising from the factors that shaped their decisions to remain silent?}
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**Case summary**

This case study we report focuses on the events that occurred at Bundaberg Hospital during the tenure of the Director of Surgery, Dr. Jayant Patel, who graduated from an Indian medical school in 1973 and then moved to the United States to train as a surgeon (Sandall, 2005). Dr. Patel’s employment history reveals that medical authorities saw cause to invoke disciplinary action on more than one occasion. In 1984, when practicing in New York, health officials disciplined Dr. Patel for negligence, incompetence, and unprofessional conduct, and placed him on probation. Five years later, in Portland, Oregon, Dr. Patel’s performance as a general surgeon continued to elicit concern. In 1998, the hospital banned him from performing certain surgeries and ordered him to seek a second opinion on complicated cases. Following further restrictions on his permit to practice, he surrendered his medical license in April, 2001 (Sandall, 2005).

Two referees were contacted prior to the appointment of Dr. Patel and both provided positive reports about his performance. The Hospital therefore chose not to conduct any further background checks, so Dr. Patel was quickly appointed Director of Surgery upon his arrival at Bundaberg Hospital in April, 2003. The two senior administrators at the time, Dr. Darren Keating, Director of Medicine, and Mr. Peter Leck, Director of Medical Services, were unaware of his U.S. history because Dr. Patel failed to disclose his disciplinary record on his curriculum vitae. As time passed, however, serious problems began to surface, including an abnormally
high rate of post-operative complications among patients, an apparent lack of basic knowledge about surgical techniques and anatomy, and a tendency to describe critically ill patients as “stable.” Despite employees reporting to senior management (i.e., Keating and Leck) regarding Dr. Patel’s apparent surgical ineptitude on numerous occasions, and allegations of harassment and bullying, hospital administrators did not initiate any internal investigatory reaction until late 2004.

In March 2005, frustrated that no action was being taken, Ms. Toni Hoffman, the Intensive Care Unit (ICU) nurse unit manager, provided a detailed letter to her local Member of the Legislative Assembly (MLA), Mr. Rob Messenger, who then named Dr. Patel publicly during a Legislative Assembly sitting. A few days later, a journalist discovered Dr. Patel’s history of alleged negligence and incompetence on the Internet and the press began to refer to him as “Dr. Death” (Mancuso, 2005), sparking public uproar and Dr. Patel’s hasty return to the USA.

Bundaberg is a public hospital funded by the Queensland State Government, so the Government assumed responsibility for investigating the circumstances surrounding Dr. Patel’s employment and professional conduct. To this end, The Queensland Public Hospitals Commission of Inquiry was initiated to look into the case. The Inquiry recommended prosecuting both hospital administrators for misconduct, and that Queensland Police investigate Dr. Patel with respect to laying charges including fraud, grievous bodily harm, assault, negligence, and manslaughter. Furthermore, on the basis of expert testimony, the Inquiry concluded that 13 patients likely died as a result of Dr. Patel’s negligence and multiple others suffered adverse consequences (Davies, 2005).

Following a series of legal proceedings, Dr. Patel was found guilty of three counts of manslaughter and one count of grievous bodily harm in the Queensland Supreme Court in June 2010. Dr. Patel subsequently appealed the verdict however and the High Court of Australia unanimously quashed his conviction, ruling that prejudicial evidence may have influenced the
jury’s decision. Upon retrial, Dr. Patel was acquitted of manslaughter and pleaded guilty to fraud in relation to dishonestly obtaining registration and employment in Queensland, in exchange for all other charges being dropped. He was sentenced to two years imprisonment, suspended immediately. In May 2015, the Queensland Civil and Administrative Tribunal found that Dr. Patel had “engaged in unsatisfactory professional conduct of a serious nature. This included misconduct in a professional sense, improper and unethical conduct. The tribunal found that his practice was incompetent, showed lack of adequate knowledge, skill, judgment and care and fell well below acceptable standards.” Furthermore, the Board ordered that he never be allowed to practice medicine in Australia again (Queensland Civil and Administrative Tribunal, 2015).

**Method**

The method we employed in this case was an analysis of transcripts from the Queensland Government Inquiry, which ran from May to October, 2005. The Inquiry elicited testimony from over 100 sworn witnesses. In the current case, the final analysis consisted of 29 separate transcripts (some witnesses testified more than once) totaling 1660 pages. The readings of the transcripts were supplemented by the publicly-available documentation submitted to the Inquiry and available online, including witness statements, numerous e-mails, meeting notes, patient notes, and copies of organizational policies and procedures.

**Participants**

Owing to the volume of data, we identified a subset of witnesses whose testimony provided us sufficiently rich and detailed information to understand the phenomenon and inform emerging theory (Patton, 2002). In the end, we selected the testimony of 22 employees (7 female, 15 male) who spoke of their direct experience with Dr. Patel, recounted critical events, and described the factors and perceptions that affected their behavior at certain time points. Participants were not required to provide age, marital status, or similar demographic
information as part of their testimony; therefore only limited information is available, but we nonetheless identified three distinct groups: (1) experienced nurses, (2) experienced doctors, (3) recent medical graduates who worked under Dr. Patel (see Table 1).

Procedure and analysis

We based our analysis in principles of grounded theory (Glaser & Strauss, 1967; Ng & Hase, 2008; Suddaby, 2006). In this method, researchers adhere to five basic principles: (1) allow the theory to emerge from the data; (2) avoid preconceptions about the phenomena under investigation; (3) be theoretically sensitized (i.e., to identify patterns of behavior in the data); (4) engage in the constant comparison method of data analysis; and (5) follow an iterative research progression. Although we were limited to the use of secondary data and thus could not conduct a “pure” grounded theory study, we followed the approach of Hollensbe, Khazanchi, and Masterson (2008), who drew on the literature to ensure analytic rigor and alignment with recommended practices. As such, our method should be regarded as an example of “modified grounded theory” (Cutcliffe, Stevenson, Jackson, & Smith, 2006, p. 791).

We used an “open coding” method, which was undertaken by the first author and two research assistants who were trained in the coding scheme but were otherwise blind to the purpose and objectives of the study. Because of the large volume of data involved, not all of which were relevant to the research questions, we used open coding to identify sections of the text (either sentences or paragraphs that captured a single idea) in which participants spoke about the adverse events, how they responded, or the factors that affected their perceptions, emotions, and behavioral responses. As a result of the coding, a large number of codes and 1020 references (individual sections of coded text) were generated.

In line with Pratt, Rockman, and Kaufman (2006), the data were also continuously reviewed to ensure that previously-coded sections of text fitted into newly-developed
categories; in some cases, categories were revised to reflect new understandings. Prior to finalizing the categories, we calculated interrater reliability (cf. Hollensbe, Khazanchi, & Masterson, 2008). The resulting reliability (.89) was deemed acceptable, and any outstanding disagreements were resolved through discussion.

Results

Results are presented here in three parts (pertaining in turn to each of our three research questions). First, we address findings from RQ1 to gain an understanding of the nature of the adverse events that occurred. In answering RQ2, we determined how employees responded to these events and also explored the process of responding over time. To answer RQ3, we adopted a theory-building approach in order to understand how and why employees elected to withhold their concerns from management, and the potential role of their perceptions and emotions in this process.

Research Question 1

What were the adverse events that occurred at Bundaberg Hospital?

Employees had concerns about Dr. Patel in four identifiable respects, namely: (1) his interpersonal interactions with staff; (2) his decisions to undertake complicated and risky surgical procedures; (3) his clinical skills and decision-making; and (4) his alleged failure to record patients’ charts, notes and discharge summaries accurately.

Bullying and intimidation of staff members. One of the first problems to emerge concerned Dr. Patel’s interpersonal interactions with other employees, including alleged disparaging comments (i.e., referring to the conditions of the hospital as “Third World”), belittling and insulting staff members, and being argumentative and aggressive, and at times engaging in shouting matches with colleagues following disagreement. Dr. Patel’s intimidating and threatening behavior meant that many staff members were fearful of confronting him about adverse events and unwilling to formally report their concerns to senior management.
Patel undertook complex and risky surgical procedures. A successful surgical outcome depends on many factors, but the degree of risk involved and the capacity of the hospital to provide post-operative care are critical. According to witnesses, although Dr. Patel appeared ostensibly to be a competent general surgeon, his willingness to undertake complicated, risky procedures requiring a high degree of post-operative care was a source of staff concern. In addition, staff members’ testimony suggests that Dr. Patel’s patients experienced a range of adverse outcomes following surgery, including complications, wound dehiscence (sutures and wounds coming apart after surgery), and infections. One of the challenges for employees was to determine how many of these adverse outcomes were unlikely or preventable, and could be attributed directly to Dr. Patel.

Patel’s questionable clinical skills and behavior. Staff members also held concerns about Dr. Patel’s skills as a clinician. Testimony revealed a range of concerns about Dr. Patel’s judgment and decision-making, including an incident involving a failure to use appropriate anesthesia when undertaking minor surgery, difficulty diagnosing conditions, and his unwillingness to follow hospital hygiene practices. Although some incidents were matters of clinical judgment, staff members’ testimony suggests a pattern of potentially negligent behavior (and, incidentally, the same charge that he faced in the U.S. in 2001).

Alleged falsification of patient records. Among the most serious accusations to emerge during the Inquiry came from witnesses alleging that Dr. Patel failed to record patients’ charts and surgical notes accurately. As the Ms. Hoffman explained, staff members had to rely on their own recordings to determine patients’ actual status:

Where Dr Patel was saying the patient was stable, for instance, where if you looked at the nurses’ notes in ICU, the patients weren’t stable at all…. It went through everything, you know, that the documentation was not accurate.

The evidence presented in the Inquiry further suggested that Dr. Patel may have used misleading terminology in patients’ charts and discharge summaries. A junior doctor who
worked under Dr. Patel’s supervision testified that he became concerned that Dr. Patel was deliberately attempting to minimize the incidence of wound dehiscence in his patients. As later discussed, the alleged falsification of records meant less evidence to support staff members’ concerns about Dr. Patel, which in turn affected staff member responses to the situation.

Taken together, it is unsurprising that many employees felt fearful and were therefore reluctant to voice their concerns. We suggest two reasons why this may have been so. First, consistent with studies of interpersonal mistreatment (e.g., Cortina & Magley, 2003; Lutgen-Sandvik, 2008), Patel’s aggressive and intimidating interpersonal behavior engendered fear in his subordinates and co-workers, which discouraged staff from confronting him about issues of concern. Second, rather than a single act of unambiguous wrongdoing, employees were confronted with multiple incidents over an extended period of time, many of which could be attributed to benign causes and varied with respect to severity. Patel was known as a competent general surgeon and completed many routine operations successfully and within a short time frame; as time passed, however, it became apparent that when he attempted to undertake complex surgery, adverse outcomes were often likely.

Research Question 2

*RQ2: How did employees respond emotionally and behaviorally to the adverse events that occurred?*

Based on our analysis, we concluded that the adverse events—and in turn, employees’ behavioral responses—can be categorized into four stages. *Stage 1* was comprised a series of relatively minor incidents; *Stage 2* involved both major and minor incidents; *Stage 3* involved several critical incidents; and *Stage 4* included the major event triggering external whistle-blowing and public disclosure.

*Stage 1: Informal reporting of unsubstantiated concerns.* Consistent with their understanding of the situation at that time, staff members did not respond immediately with
trepidation and alarm when adverse events began to occur. As problems emerged following Dr. Patel’s appointment, employees discussed their concerns amongst themselves and speculated about potential causes. Although a small number of employees attempted to deal with Dr. Patel directly, others informally communicated their concerns to management. In the middle of 2003, Nurse Manager Hoffman e-mailed the Director of Medicine outlining her concerns about Dr. Patel’s interpersonal behavior, his undertaking demanding and complex surgeries, and inaccurate surgical notes and patient records. When asked how the manager responded, Hoffman stated,

I just remember that we were told that Dr Patel was a very experienced surgeon, very used to doing these sorts of surgery and that no, it was important that we keep him in the hospital so it was important that we worked with him and did what he wanted, basically.

At this stage, neither management nor employees had reason to believe that Dr. Patel’s behavior was a really serious problem, and staff members tried to find ways to encourage him to comply with accepted standards. Overall, employees’ testimony indicates that, during the initial months of Dr. Patel’s tenure, he was regarded as difficult, abrasive, and arrogant; yet staff still did not perceive that he represented a major risk to patients.

**Stage 2: Increasing concern, confrontation, and informal reporting to management.**

According to testimony, as the number of adverse events increased, employees started to make informal reports to management. Throughout 2003, a number of employees had approached administrators both verbally and in writing, or raised concerns at formal meetings. Yet senior management allegedly responded to those reports by failing to provide feedback at all, or attributing the problem to benign causes, and appeared unwilling to investigate staff concerns further.

In early 2004, Nurse Hoffman documented a series of incidents in writing to the Director of Medical Services, and arranged an informal meeting to explain her concerns about Dr. Patel conducting highly complex surgery; his interpersonal behavior, which was creating
“an atmosphere of fear and intimidation” in the ICU; and his reluctance to transfer patients to other hospitals. Hoffman testified that, despite holding serious concerns, at this point she did not want direct management intervention with Dr. Patel:

And I - I just want to make it clear that I did ask [manager] not to officially do anything with this knowledge at this point in time because I was going back to the ICU and I wanted to try - I was going back after my period of relieving and I wanted to try again through Dr - with Dr Carter's help and that to try and work out some sort of working relationship with Dr Patel.

Following this meeting, however, adverse events linked to Dr. Patel increased, including a number of episodes of wound dehiscence, serious post-surgical complications, and several patient deaths following surgery.

Stage 3: Critical incident and approaches to outside organizations. A turning point in responses to Dr. Patel’s behavior occurred in the ICU in July 2004 after Dr. Patel’s refusal to transfer a patient with extensive injuries to another hospital with more advanced equipment and facilities. The patient died overnight, and the incident was a source of extreme distress for staff. Nurse Manager Hoffman recounted incidents involving Dr. Patel to another doctor, who told her that he would discuss the matter with colleagues. He returned a few days later, allegedly telling her that there was considerable concern among staff but no one was willing to “stick their neck out” yet.

In the following weeks, Hoffman completed a sentinel event form, summarizing the incidents occurring since the middle of 2003 and stating her belief that Dr. Patel’s intervention directly contributed to a patient’s death. After e-mailing the Director of Nursing, she was invited to a meeting with the Director of Nursing and the Director of Medical Services. In this meeting, Hoffman told them that while she was aware that she could take her concerns to an outside party, she would prefer that they address the matter from within the organization. A written complaint was submitted along with the statements from ICU nurses on October 22,
2004. These were followed by several more formal internal complaints although, after being informed it was illegal for employees to disclose confidential patient information to outside parties, staff were afraid to take their complaints outside the organization.

*Stage 4: Desperation, external whistle-blowing.* After almost 24 distressing and chaotic months, the situation reached crisis point. In February 2005, staff members became aware that Dr. Patel’s contract had been extended for another three months. In fact, management was seeking to extend his contract for another four years. In her testimony, Nurse Manager Hoffman expressed her frustration and stated that management’s contract extension decision felt like “a huge slap in the face” after staff members had voiced their concerns on so many occasions, and decided then that she would have to do something “drastic” to stop Dr. Patel from operating and treating patients. This was the point that she contacted Rob Messenger, Member of Parliament, who had raised concerns about the quality of healthcare services in Queensland previously, initiating public awareness, Patel’s resignation and return to the USA, and the subsequent inquiry.

**Major themes**

Based on above analysis, we identified three major themes: (1) employees used different strategies over time, (2) certain key events played a pivotal role, triggering strong negative emotional responses; and (3) employees differed in their behavioral and emotional responses to events.

*Employees used different strategies over time.* Employees used many different behavioral strategies in response to the adverse events that occurred at the hospital, initially responding by confrontation and expressing their concerns to management. Several nurses noted that upon confrontation, Dr. Patel was dismissive, condescending or verbally abusive, and refused future interactions with anyone who challenged his behavior. Employees’ testimony indicates also that Dr. Patel’s behavior was a frequent conversation topic between colleagues.
with staff members initially expressing their frustrations to each other; however, as time progressed, employees sought to problem-solve actively and discussed strategies about how best to deal with Dr. Patel. Among a small group of employees, reporting behavior was used most consistently. Importantly, however, not all employees continued to speak up as time passed. As we discuss later, the response of managers was crucial here; after voicing their concerns on numerous occasions and receiving no effective redress, several employees simply stopped reporting events and entered a state of “extended quiescence” (Pinder & Harlos, 2001, p. 354).

Importance of key emotion-triggering events. Another important theme to emerge from the data analysis is the importance of critical events and associated sensemaking in shaping employees’ perceptions, emotional reactions, and eventually their behavior. Associated with this finding is the observation that, as Blatt et al. (2006) emphasized, the decision about whether to voice concerns about workplace problems and issues is a dynamic process (see also Bisel & Arterburn, 2012). It is apparent that, although staff members held concerns about Dr. Patel from at least the middle of the 2003, most were unwilling make a formal complaint to management; indeed, no major complaint was filed until October 2004. As we noted earlier, Nurse Manager Hoffman told the Inquiry that even as late as the beginning of 2004, she did not want management to take any direct action against Dr. Patel because she wanted to try to maintain a working relationship with him. In July 2004, following the traumatic death of the patient whom Dr. Patel had refused to transfer, her perception of the situation changed and she began to campaign for an external review of his clinical cases. Furthermore, it was the decision by management to extend Dr. Patel’s contract that ultimately triggered her decision to go outside of the organisation for assistance.

In her study of observers of workplace bullying, Lutgen-Sandvik (2006) noted that observers’ responses to workplace bullying can take many forms, including a form she defined as “mutual advocacy.” Specifically, Lutgen-Sandvik suggests that this category of response involves a variety of behaviors, often emotion-driven, including agreeing with others’
perceptions of the situation, offering collegial reassurance, providing consolation and support, talking with co-workers about what to do, and defending others when bullying occurred. In the current case study, employees’ testimony suggests that discussions between coworkers facilitated the sharing of information as part of a process Weick, Sutcliffe and Obstfeld (2005) define as “sensemaking” (see also Weick, 1969). These authors observe that sensemaking involves “the ongoing, retrospective development of plausible images that rationalize what people are doing” (p. 409). When unexpected incidents occur, people seek to explain what is happening using cues from the situation, preexisting views and beliefs about the world, communication with others, and previous interactions with social actors.

In addition to understanding the events that occur, sensemaking also involves determining whether some form of corrective action is required, and then how to respond to the event. Weick and colleagues (2005) observe that this is particularly important in healthcare settings, where professionals must “simultaneously interpret their knowledge with trusted frameworks, yet mistrust those very same frameworks by testing new frameworks and new interpretations” (p. 412). As further adverse events occurred, these challenged employees’ beliefs that the surgical complications and patient deaths were simply the result of rare mistakes and errors which are a potential risk associated with surgical procedures. In other words, they attributed new meaning to the situation and labelled it as one of concern, facilitating the progression from silence (a previously appropriate response) to voice. Similarly, Weick et al. argue that situations are constantly evolving and behaviors must be adjusted accordingly, stating that, “There are truths of the moment that change, develop, and take shape through time. It is these changes through time that progressively reveal that a seemingly correct action ‘back then’ is becoming an incorrect action ‘now’. These changes may also signal a progression from worse to better” (p. 413). Although not stated explicitly in employees’ testimony, it is possible that, when Dr. Patel announced that his contract was being extended and management failed to stop him from operating, some employees interpreted this as a sign that they had been wrong
about his behavior – leading them to question their beliefs and reframe the situation accordingly. For others, however, this act served to confirm their belief that administrators were not interested in addressing the concerns of employees, despite the potential risk to patients.

In addition to significant changes in employees’ interpretations of the situation, these events also served to trigger strong emotional responses, which in turn played a major role in employees’ decision-making and behavior. Although employees were not asked direct questions about their emotional responses to the events involving Dr. Patel, their testimony to the Inquiry included nonetheless included descriptions of their discrete emotions at key points in time, which appeared to arise from three specific sources. Firstly, our analysis suggests that simply witnessing and experiencing (e.g., in the case of bullying) the adverse incidents involving Dr. Patel elicited negative emotions including anger, annoyance, frustration, and distress. Here, employees spoke specifically of the traumatic effect of watching patients suffer serious complications or die following surgery, with one nurse stating that:

I still get upset [when I think about the patients that died]. It is just going to be a matter of time, I think. You know, it was pretty traumatic. You feel like you are involved in this case, and these nice people die and that, and it did really upset me. It still upsets me.

Second, after attempting to raise their concerns with senior management over a significant period of time, nurses in particular described a range of strong emotional reactions, including feeling upset, shocked, frustrated, concerned, and disappointed when their complaints about Dr. Patel were minimized and dismissed. Additionally, their emotional responses appeared to escalate in intensity and accumulate as further adverse events occurred. Nurse Manager Hoffman, indeed, described herself and her colleagues as “absolutely desperate” when they chose to file a formal complaint with management in October 2004. Third, employees’ testimony revealed that many individuals were fearful of the potential negative outcomes associated with formally reporting the adverse events. As we discuss later, evidence suggests
that whistle-blowing was explicitly discouraged in the organisation, and those who reported concerns were seen as “trouble-makers”; Furthermore, evidence from several witnesses suggests that this perception was widely shared among staff.

**Differences in employees’ emotional and behavioral responses to the adverse events.**

As we previously observed, the three participant groups responded differently to the unfolding of events. Firstly, it is apparent that the nurses were the most concerned and persistent in reporting their concerns to senior management. Although their reports varied with respect to formality and form of expression, nurses from various sectors of the hospital were generally determined to make management aware of their increasing concerns about Dr. Patel. It is important to note, however, that those nurses who reported their concerns were the exception rather than the norm; generally speaking, testimony suggests that reporting behavior by the hospital staff, particularly over time, was not common. Though one reason for the silence may have been unawareness of the situation, employees’ testimony indicates that many people held concerns about Dr. Patel but were afraid of the consequences of speaking up. As noted previously, nurses expressed strong negative emotional reactions to the adverse events, particularly when patients were harmed, which likely played a critical role in encouraging reporting behavior.

There are interesting variations in how the doctors responded to the adverse events associated with Dr. Patel. For example, the Director of the Renal Unit discussed his concerns about Dr. Patel’s conduct with fellow doctors and nursing staff in informal discussions and also spoke with the Director of Medical Services. After no action was taken, and after observing Dr. Patel’s clinical skills and decision-making on a number of occasions and becoming sufficiently alarmed, he made the decision that he would not refer his patients to him any longer, and informed all relevant medical and nursing staff of his decision. He also asked that nurses in the Renal Unit audit Dr. Patel’s patients to assess for complications following surgery, and passed the results of the audit on to management. In contrast to the nurses, the Director of the Renal
Unit did not actively continue reporting his concerns to management, particularly as he had attempted to do this in the past and had received no feedback. Although this doctor revealed that he experienced considerable anger and frustration when patients were harmed and his complaints were ignored, he felt that he was able to initiate his own measures to protect his patients and indeed did so.

In contrast, some of the employees who worked most closely with Dr. Patel were junior doctors under his supervision, most having obtained their medical degrees within the last four to five years, and relatively inexperienced with limited exposure to complex surgical procedures. The testimony of these employees reveals that, although they knew that Dr. Patel could be rude and abrupt, particularly to the nursing staff, they felt that he was, in general, very supportive of junior medical staff and provided effective supervision. While some stated in their testimony that they felt somewhat apprehensive about the complexity of surgery that Dr. Patel was willing to undertake, his surgical skills and his unwillingness to transfer patients, they felt they were not in a position to directly question his decisions.

**Research Questions 3**

(a) *What were the organizational-level and contextual-level factors that affected employees’ emotions and behavior?*

(b) *What were employees’ perceptions, appraisals and emotions arising from these factors that shaped their decisions to remain silent?*

These two questions focus on how organizational and contextual factors shaped key perceptions amongst employees that encouraged them to withhold their concerns from management. We present an overarching model of these factors and perceptions in Figure 1, and discuss the results in the following paragraphs.

________________________________________

Take in Figure 1 about here
Organizational factors

In line with previous research (e.g., Morrison and Milliken, 2000), employee testimony indicates that organizational factors influenced decisions to withhold concerns from management. Here, we review five organizational characteristics contributing to decisions to remain silent: (1) a bureaucratic culture focused on cost minimization; (2) attitude and behavior of senior managers; (3) difficulty communicating with key staff; (4) failure to follow adverse events reporting policies effectively; and (5) a retaliatory and unsupportive climate for whistle-blowing. We emphasize that these factors were not independent of each other and rather worked together to reinforce key perceptions about the safety and utility of reporting adverse events to management.

Bureaucratic culture focused on cost minimization. One of the most prominent findings from the analysis was that the hospital culture was highly bureaucratic and senior management was under extreme pressure to maximize profits and minimize financial losses. This led senior management to emphasize financial performance over clinical performance; an emphasis at odds with typical healthcare practice. Participants spoke of attending numerous meetings to discuss administrative issues rather than focusing on critical concerns such as patient care and chronic staff and bed shortages, and of having to present a “business case” before implementing new initiatives or changes. One doctor summarized the apparent goal of hospital administrators as:

To make money, to come in on budget… Patients are a secondary consideration. And most physicians, most nurses, most people who work in fact would see it 100 per cent differently.

Furthermore (in a now discontinued practice) hospitals at that time were required to meet targets for elective surgery each year which were linked to funding allocations. In such a culture, a surgeon willing to perform operations in minimum time was an asset to the organization. According to employees’ testimony, Dr. Patel used this fact to intimidate staff members. As a consequence, employees were reluctant to complain about an individual who
was highly valued by hospital administrators and, in turn, unlikely to face serious consequences for his misbehavior. Ashkanasy and Nicholson (2001) referred to this as a “climate of fear.”

**Attitude and behavior of senior managers.** Another salient finding was that employees perceived that the managers responsible for Dr. Patel were not interested in listening to or adequately addressing employees’ concerns about his interpersonal behavior and surgical performance. Although it is not surprising that managers gave Dr. Patel the benefit of the doubt when allegations emerged initially, hospital administrators did not begin to initiate an independent, external review until December 2004—almost eighteen months after concerns first surfaced. Even when managers began interviewing employees, staff perceived that they were not highly motivated to find the truth. As one doctor told the Inquiry, “I remember... they didn’t really ask my opinion about him and they didn’t really explore other areas of knowledge that I had about them.” He further noted that although he felt that he had been given adequate opportunity to voice his experiences with Dr. Patel, the questions he responded to were highly specific, and “the situation didn’t lend itself” to expressing his concerns further.

**Difficulty communicating with key staff.** A further prominent finding to emerge was that employees across the organization had difficulty accessing key staff members to report their concerns directly. Although many employees used e-mail to document their incidents to their immediate supervisors, there was a consensus among witnesses that members of the Executive were inaccessible and unwilling to have face-to-face contact with staff members to discuss concerns. Even if employees brought up an issue of concern in a regular, scheduled meeting, they were told on at least one occasion that “this was not the place to discuss it” and they had to make a formal appointment to take the matter further. In particular, two nurses told of their difficulties arranging meetings with the Director of Nursing, their line manager and the person responsible for receiving nurses’ complaints and concerns. The nurses told the Inquiry that this person “was just not available to talk to” and that all appointments had to be made through administrative personnel. As one nurse described in her testimony,
I found that she was non-accessible. You couldn't ring her. You had to go through - you always had to go through the clerical support people to actually speak to her, and they would drill you about what did you want to see her for.

An additional observation (made independently by several employees) is that members of the Hospital Executive were rarely seen on the wards and thus had minimal access to staff members outside of formal meetings. This lack of contact with both employees and patients had two consequences. Firstly, as one nurse testified, the fact that administrators were not present on a daily basis meant that staff members were unable to draw attention to issues when they first arose. In turn, staff members were unwilling to go through the process of making an appointment, meaning that many of the minor issues arising during Dr. Patel’s initial tenure were not raised. A second consequence was that managers had to rely on the evidence of employees and Dr. Patel rather than their own observations. Overall, managers’ reluctance to avail themselves to employees’ concerns helped to shape perceptions that hospital administrators were not interested in hearing about adverse incidents.

*Failure to follow adverse event reporting and complaint management policies effectively.* Interestingly, these events occurred despite multiple policies designed to detect and ostensibly to address any adverse incidents and complaints in the organization, especially the *Bundaberg Adverse Events Management Policy*, implemented in February 2004. Under this policy, staff members were required to document all adverse incidents and to forward the completed form to management. In turn, these reports would be reviewed and collated on an *Adverse Events Register* to allow for the identification of patterns and trends in the data, and forwarded to relevant authorities depending on the degree of assessed risks.

According to employees’ testimony, however, a major reason that many staff members did not report adverse events in accordance with policy was because the organization failed to provide feedback about the outcomes of previous reports. Indeed, the manager of the unit responsible for monitoring staff reports and complaints told the Inquiry that the practice of
giving feedback to all complainants was discontinued. One senior doctor summarized the
process of completing adverse events forms as follows:

    They were filled in, they went somewhere and who knows where they went, it's sort of
    some big black hole I think. I mean, I never received any feedback on adverse events.

Coupled with employees’ reluctance to document incidents, the organization’s failure to
provide feedback reinforced perceptions that there was no point voicing concerns. It is worth
noting that other factors also reinforced employees’ reluctance to adhere to the policies in place
and report incidents of concern, including the degree of administrative work involved, and the
culture in the organisation, which we discuss next.

    Unsupportive and retaliatory climate for whistle-blowing. Another finding to emerge
from our analysis was that many employees perceived that people who reported adverse events
or made complaints were unlikely to receive support from management, or even from other
colleagues. Many felt that management did not want to know about adverse incidents,
particularly those that might place the hospital’s reputation at risk. Indeed, four nurses who
observed adverse incidents involving Dr. Patel testified that they did not feel supported by their
immediate superiors, and that even though one senior doctor was well aware of their concerns
he refused to join them in making a complaint.

    In addition to a perceived lack of support for employees who voiced their concerns, our
results reveal that employees felt that it was likely that they would face negative consequences
if they reported adverse events. This perception was not without merit. Several employees told
the Inquiry that the Queensland Health Code of Conduct meant that they felt that they could
only raise their concerns within the organization, and that management’s failure to address their
complaints appropriately left them with the perception that they had nowhere else to go. Nurse
Hoffman stated that she believed that whistle-blowing externally would limit her opportunities
to progress further in her position, and could mean the end of her career in Queensland Health.
While approaching an outside party was strongly discouraged under the Code of Conduct, our findings reveal that employees perceived that complaining internally to management was itself a risky and unattractive option. Indeed, the evidence indicates that many employees felt that making a complaint about organizational problems could lead to negative outcomes, such as being transferred from one’s work unit, or being labeled a “trouble-maker.” Several nurses told the Inquiry that Dr. Patel would loudly criticize and bully members of staff if they challenged his decisions, and boast of his close relationship with management.

A related issue of concern was that many of the doctors who worked with Dr. Patel had trained overseas and were in Australia on work visas. These individuals were particularly vulnerable as they were dependent on Dr. Patel for favorable performance evaluations to remain employed by Queensland Health. One senior doctor told the Inquiry that he specifically instructed these doctors to “stay out of [the situation]” because they were reliant on their positions in the organization to remain in the country.

**Contextual Factors**

Although organizational factors helped influence employees’ decisions to remain silent, our results suggest that other contextual factors also played an important role. This finding is consistent with previous studies of silence (e.g., Milliken et al., 2003) and reviews of the whistle-blowing literature (e.g., Miceli et al., 2008) indicating that employees’ responses are shaped by multiple variables, including those specific to the situation in question. We next review four additional contextual factors that contributed to perceptions that motivated employees to withhold concerns.

**Perpetrator characteristics.** Employees’ testimony about Dr. Patel offers a complex picture. According to witnesses, he was verbally abusive and threatening when challenged, and unwilling to listen to the advice and opinions of others. At the same time, he maintained cordial relationships with certain senior colleagues and administrators, and employees were aware that
management held him in high regard. These factors shaped three critical perceptions central to employees’ decisions to remain silent.

First, Dr. Patel’s position power and alleged abusive treatment of employees contributed to the perception that staff members could face negative consequences for reporting concerns. Here, six employees testified about Dr. Patel’s intimidating and argumentative behavior, which allegedly included threats to have nursing staff transferred from the OR if they criticized his skills. Second, Dr. Patel’s adequate surgical skills and extensive surgical experience suggested that the adverse events were not intentional, and initially colleagues gave him the benefit of the doubt. As part of their testimony, several employees noted his constant emphasis on his experience and achievements, with one doctor noting that he had “a very, very highly inflated view of his own ability.” One nurse explained that after approaching the Director of Medicine with concerns about Dr. Patel’s failure to comply with hygiene regulations, Dr. Patel confronted her and emphasized his decades of medical experience. She felt that she was unable to challenge his opinion, saying, “It was quite intimidating … I was well out of my depth and I knew I couldn't debate these things with him.” Third, given Dr. Patel’s close relationship with administrators, staff members felt that they were unlikely to be believed if they took their concerns to management, which in turn discouraged reporting behavior.

**Characteristics of the adverse events.** Another contextual factor that affected employees’ responses to the adverse events concerned the precise nature of the events. As several employees acknowledged, variations exist in what are considered “acceptable” practices in a hospital and what constitutes an appropriate technique when performing surgery. Furthermore, most of the junior doctors who worked with Dr. Patel were relatively inexperienced and had little exposure to certain kinds of surgery, and thus they were unable to assess whether his actions were appropriate or not. As such, because deviations from practice had become normalized and the degree of subjectivity involved in judging behavior, employees found it difficult to determine what episodes should be reported. With respect to adverse
surgical outcomes, both doctors and nurses noted the difficulty in establishing the extent of the problem because all types of surgery involve a degree of risk. Additionally, two particular complications that arose in his patients—wound dehiscence and infections—can arise from different sources, making it difficult to attribute these directly to the surgeon. As one doctor testified, Dr. Patel had a considerable patient load and frequently undertook surgeries with a greater than usual risk of infection, so he believed that it would not be unusual to see a high infection rate.

Finally, employees were not aware initially of the extent of the problems relating to Dr. Patel because they emerged and escalated over time. For example, concerns initially centered on Dr. Patel’s interpersonal behavior and his willingness to undertake complex operations. As he continued to perform advanced procedures despite adverse consequences, staff members became fearful that he represented a risk to patients. Although some nurses testified that they had concerns about Dr. Patel almost from the very beginning of his tenure, the majority acknowledged that it took time for a pattern of behavior to emerge and their doubts to be confirmed.

*General failure to maintain an accurate record of the adverse events.* Employee testimony indicates an unwillingness to approach management with about certain issues, especially some surgical complications, owing to a lack of accurate records. According to staff members, a key reason for the lack of adverse outcomes records was alleged falsification on the part of Dr. Patel, through either failure to record surgical complications or the use of evasive or incorrect terminology. With respect to the issue of wound dehiscence (where a wound ruptures along the surgical structure), nurses testified that they became increasingly worried that incidences of wound dehiscence were not being recorded in patients’ notes, even though they were seeing the complication in ICU patients. When they approached Dr. Patel, he challenged their interpretation of “wound dehiscence” and the issue was never completely resolved. Since there was no accurate recording of adverse outcomes, staff members had little evidence to
support their concerns about Dr. Patel’s surgical performance, contributing to employees’ decisions to withhold their concerns.

Reduced personal responsibility to report wrongdoing among employees. A final factor that emerged from our analysis is that many staff members felt that it was not their personal responsibility to report adverse incidents. Three reasons may explain why this perception existed.

First, when questioned directly about why they did not challenge or question Dr. Patel or report adverse incidents, many employees stated firmly that they did not believe that it was their role to monitor or assess a surgeon’s performance. Several employees stated that they felt that they were not in a position to evaluate a surgeon’s competence or investigate the allegations, that this kind of assessment was not part of their role, and that they feared the consequences were they to be found wrong. When questioned about withholding concerns from management, one nurse explained, “It is not my job to say whether a surgeon is competent or not. I was - you know, that’s the job of whoever registers him and management, I would assume.” Similarly, a senior doctor summarized the attitude of many of his colleagues, saying, “I’m a physician. I run a general medical unit. I’m not an ombudsman in a surgical ward. I don’t *de facto* become sort of a policeman for the surgical unit.”

A second reason for employee perceptions that they felt it was not their responsibility to report adverse events was because, in many cases, it was not clear who actually was required to document an incident in the first place. This diffusion of responsibility was especially problematic when complications or adverse outcomes arose during an OR surgical procedure, with many individuals present. ICU nurses explained that they experienced considerable frustration when patients would arrive in the unit after suffering a complication during surgery yet surgical staff had not completed an adverse event form. Finally, testimony revealed that peer expectations also reduced personal responsibility to report concerns to management, especially among nurses. As one nurse explained: “Nurses in general do not criticize medical
staff and do not report perhaps incidents that they see to medical staff... It’s a general
effect of a nurse that you respect what the surgeon’s doing and they respect what you are
doing.” Similarly, doctors testified that it was not their place to criticize Dr. Patel’s surgical
performance, particularly given his senior position and experience, and that they feared the
consequences if they were to do so, especially were they to be labelled a “whistleblower.”

Discussion

As we noted earlier in this chapter, in our case study we aimed to answer three major
research questions. Firstly, we sought to identify the nature of the adverse events that occurred
at the hospital. Second, we wanted to understand how employees responded both emotionally
and behaviorally to the events. Finally, we sought to identify some of the organizational-level
and contextual-level factors that shaped employees’ decisions to withhold their concerns; and in
particular to identify some of the associated perceptions, appraisals, and emotions that
couraged silence.

Our results indicate that employees were faced with a series of adverse episodes
involving different types of wrongdoing that generally escalated in severity, and often
employees were confronted with different forms of wrongdoing, some of which were difficult
to identify and prove, and at times a matter of subjective judgment. As a result, employees
responded in a variety of ways over time, and we argue that employees’ responses can be
classified into four stages: (1) informal reporting; (2) increasing concern, confrontation and
reporting to management; (3) critical incident and approaches to outside organizations; and
(4) desperation and/or external whistle-blowing. Overall, our results highlight the fact that
individuals can vary greatly in their responses to adverse events, and typically use a range of
behavioral strategies over time. While some individuals were comfortable disclosing their
concerns to immediate colleagues only, others progressed to informal then formal reporting. In
the case of the nurse unit manager, who was ultimately responsible for bringing the matter to
the attention of the media, her decision to engage in external whistle-blowing was only made after multiple attempts to raise the matter within the organization.

We also identified that organizational and contextual factors that seem to have played an important role in the development of perceptions that encouraged silence: A bureaucratic culture emphasizing financial performance, administrator attitudes, and a retaliatory and unsupportive climate for whistle-blowing helped to shape employees’ beliefs that management was not interested in listening to employees’ concerns, that there was no point speaking up about problems because no action would be taken, and that whistle-blowing could be personally damaging and result in negative individual consequences. Perpetrator characteristics led employees to believe that they could face negative consequences for speaking up, the ambiguous nature of the wrongdoing created uncertainty about the intentionality of the behavior and whether events should be reported, and the failure to accurately record adverse events meant that employees felt that they were unlikely to be believed by management. Additionally, role rigidity and diffusion of responsibility reduced employees’ personal responsibility for reporting.

The case study suggests in particular that employees’ emotional responses arising from these perceptions and appraisals influenced how they responded behaviorally to the unfolding situation. Furthermore, employees’ recollections of the adverse events frequently contained strong emotional content and emotions appeared to arise from at least three sources. First, in line with considerable theoretical and empirical research (e.g., Bunk & Magley, 2013; Judge, Scott & Ilies, 2006; Kiefer, 2005; Rodell & Judge, 2009; Weiss & Cropanzano, 1996), key events in the workplace appear to trigger employees’ emotional responses. Here, employees explained that observing the adverse incidents involving Dr. Patel incited considerable anger and distress, particularly when patients were harmed. Second, managers’ failure to listen to and adequately address employees’ complaints about Dr. Patel emerged also as a source of intense negative emotions. Consistent also with evidence from the whistle-blowing literature (e.g.,
McDonald & Ahern, 2002), staff members spoke of their anger, frustration and despair after they approached hospital administrators with their concerns only to be ignored, dismissed or have their concerns minimized. Third, employees’ testimony reveals that many were fearful of the potential negative outcomes associated with making a formal report to management, particularly given the punitive Code of Conduct in the organisation.

Theoretical implications

The results of this case have implications for our theoretical understanding of how employees respond to wrongdoing in organizations and the factors influencing decision-making. As we noted earlier, employee silence may be generally defined as the conscious decision to withhold genuine concerns from those able to initiate effective change (Pinder and Harlos, 2001). Consistent with Morrison and Milliken’s (2000) model, our results suggest that administrator attitudes and behaviors contribute to a perception that reporting an adverse events is not worth the effort. Further, we extend previous work by explicating the relationship between specific organizational and contextual factors and key perceptions to explain employee silence. Dr. Patel’s perceived power, bullying behavior, and surgical ability claims led to perceptions that employees could face negative consequences for reporting concerns, that employees would not be believed if they approached management, and uncertainty about intentionality of the wrongdoing. In relation to silence about wrongdoing in healthcare settings, we make it clear in our model that characteristics of adverse events need to be considered, as well as the social dynamics between doctors and nurses.

More broadly, our results extend theoretical concepts proposed in the management sciences literature thus far, including a climate of silence (Morrison & Milliken, 2000) and quiescent and acquiescent silence (Pinder & Harlos, 2001). While some employees may remain silent because they are fearful of the personal consequences of speaking up (quiescent silence), others may fail to speak up because they feel that voicing one’s concerns is unlikely to make a
difference to the situation (acquiescent silence). Employees’ testimony revealed that both of these perceptions contributed to employees’ decisions to withhold their concerns about Dr. Patel. We also found that the ambiguity of the adverse events and corresponding uncertainty about intentionality, which has received little attention to date in the literature, played an important role.

Our results further suggest that, consistent with previous theoretical (Morrison & Milliken, 2000) and field studies (e.g., Bisel & Arterburn, 2012; Blenkinsopp & Edwards, 2008), the decision about whether to voice concerns about wrongdoing is an ongoing process, influenced by emotions, sensemaking, and critical events. In some cases, the incidents reassured individuals of Dr. Patel’s competence; in others, a critical incident played a crucial role in shifting employees’ interpretations of the situation from one of uncertainty to one of considerable concern and a perceived need for action. Managers’ responses to employees’ complaints also represented critical incidents. Rather than simply considering employee silence as the final point of a decision-making process, our analysis demonstrates how employees’ perceptions, emotions and behaviors shifted over time in response to changing circumstances, and suggests a need to study employee silence using a longitudinal approach.

Furthermore, our results revealed that few of the employees in our sample elected to withhold their concerns from management entirely (i.e., they remained completely silent). Over time, employees typically progressed from low-risk behaviors (e.g., disclosing their concerns to one another) to informal reporting, then formal reporting and then—in the case of Nurse Manager Hoffman—external whistle-blowing. For other employees, voicing their concerns formally or even informally served to establish or confirm their belief that senior managers were not interested in addressing the issue, leading them to refrain from speaking up in future; instead, they tried to develop alternative measures to protect patients. Rather than viewing silence and voice as a dichotomy, our results indicate that it may be more appropriate for researchers to consider these behaviors on a continuum, and also explore further the factors that
influence employees’ decisions to engage in one behavior versus another (e.g., the decision to confront the perpetrator of wrongdoing directly rather than voice concerns to management).

**Practical implications**

From a practical perspective, our case study analysis contributes to our understanding of employees’ emotional and behavioral responses to adverse organizational events. As noted, employees initially used many different strategies following awareness of adverse incidents, including confrontation and disclosure. When these approaches failed, some employees progressed to informal reporting, formal complaints, and external whistle-blowing. In contrast, other employees stopped speaking up entirely, reflecting the fact that employees respond behaviorally to wrongdoing in a variety of ways. Importantly, evidence suggests that organizations should respond promptly to investigate the validity of employees’ complaints and take appropriate action as required. Our results indicate further that having policies and systems in place to facilitate the reporting of adverse events is not enough; rather, organizations must ensure that employees are willing to use the system(s) in question, feel safe from retaliation and perceive that it is worth doing so. To summarize, our results indicate that, in addition to creating systems to allow employees to report adverse events, organizations need to work to manage and address employees’ perceptions about the safety and utility of reporting behavior (Morrison & Milliken, 2000). We argue that such an approach would minimize the need for public whistleblowing and safeguard organizations’ reputations.

**Limitations**

Our findings should nonetheless be viewed in light of three limitations. First, despite supplementing transcripts with additional data sources to allow triangulation (Creswell & Miller, 2000), we were unable to access participants directly to explore issues in greater depth or clarify their answers. Second, we acknowledge the possibility that employees may have presented themselves and their evidence in a positive light. Although they were testifying to a
formal Inquiry, employees may have selectively recalled incidents, and recollections could have been affected by decay and reinterpretation of events over time (see Brewer, 1994). Finally, we focused on a specific form of silence so, while our findings might be valuable in advancing our understanding of these phenomena in healthcare settings, it is not clear they will extend into other settings.

**Future research**

Results of the case study presented in this chapter suggest two interesting avenues for future research.

First, “adverse events” and episodes of “wrongdoing” in healthcare are often difficult to define and to detect, particularly given the degree of risk carried by all medical procedures and the higher likelihood of an adverse outcome in certain patients. One question for future exploration is how medical (and other) professionals interpret potentially adverse events and decide whether to engage in reporting behavior. In particular, researchers could explore this question with professionals of varying experience and investigate if interpretations change as a function of experience and patient care exposure, and determine the extent of the influence of observers’ relationships with targets of wrongdoing and their perceived power.

Second, and as we already noted, our findings suggest that employees’ perceptions and emotions play a central role in both silence and whistle-blowing, although further research is needed to identify the nature of the cognitive and affective processes involved. This finding is consistent with previous theoretical models and empirical studies into silence and reporting behavior (e.g., Gundlach, Douglas & Martinko, 2003; Gundlach, Martinko & Douglas, 2008; Hollings, 2013; Morrison, Milliken & Hewlin, 2003). For example, the employees’ testimony suggests that a major factor that prompted some employees to speak up was their perceived responsibility to protect patients from harm. Additionally, employees’ perceptions that the events could result in serious outcomes and represented a pattern of behavior generated fear and
apprehension, and also likely influenced their decisions to voice their concerns. All of these beliefs and affective responses appear to have encouraged employees to engage in reporting behavior in this context, but more research into the psychological processes is nonetheless required. As we have argued previously, exploring the role of specific discrete anticipated emotions in encouraging silence and whistle-blowing (e.g., anticipated regret and guilt) may be particularly relevant (Edwards, Ashkanasy & Lawrence, 2013). We also agree with the position of Hollings (2013), who argued that discrete emotions likely play a complex role in the decision-making process following wrongdoing, and emerge to influence employees’ perceptions and appraisals at multiple points in time.

Conclusion

Adverse events in healthcare settings can lead to serious consequences for patients, employees and organizations alike. In this analysis of the events at Bundaberg Hospital in the years 2003 to 2005, the findings reveal that Hospital employees observed multiple adverse incidents over this time period, many of which were ambiguous and difficult to define as genuine issues for concern. In turn, employees’ testimony showed that they responded to the adverse events in a variety of ways, including remaining silent, disclosing their concerns to colleagues, confronting Dr. Patel, informally reporting the adverse events to management, engaging in formal reporting behavior, and finally whistle-blowing to an external party. The results reveal further that “a perfect storm” of organizational and contextual factors helped to create key perceptions that encouraged silence amongst employees, particularly the attitudes and behaviors of hospital administrators who were reluctant to take action to stop Dr. Patel from operating. Furthermore, certain discrete emotions also played a role, including anger, fear, and distress. Overall, the results indicate strongly that employees’ perceptions, appraisals, and emotions shaped their decisions about how to respond to the adverse events, suggesting that further research into the role of psychological processes in this context is warranted.
References


Endnotes

We use the term *adverse events* in this context to describe the episodes of alleged negligence, fraud, and harm to patients

Henceforth referred to as “Bundaberg Hospital”

Bundaberg (population 71,000) is a coastal city located 385 km (240 miles) north of the Queensland State Capital, Brisbane. Its main industry is sugar cane farming.

MLAs are protected from legal consequences under the doctrine of “Parliamentary Privilege.”

The Queensland Health Department provided Dr. Patel with a one-way Business Class airfare to the U.S.
REOM12 Ch13 Table 1. *Properties of groups included in analysis*

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Job description</th>
<th>Average time in profession (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10</td>
<td>Experienced nurses, four of whom were in management roles.</td>
<td>21.5 (Range: 11-31)</td>
</tr>
<tr>
<td>2</td>
<td>8</td>
<td>Experienced senior doctors, many having previously held or currently held leadership positions</td>
<td>25 (Range: 10-40)</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>Doctors who had recently obtained their medical degrees and had worked under Dr. Patel</td>
<td>5 (Range: 3-8)</td>
</tr>
</tbody>
</table>
REOM12 Ch13 Figure 1. How employee perceptions of organizational and contextual factors leads to silence

Organizational factors
- Bureaucratic culture focused on cost minimization
- Attitude and behavior of senior managers
- Difficulty communicating with key staff
- Failure to follow adverse event reporting and complaint management policies effectively
- Unsupportive and retaliatory climate for whistle-blowing

Key perceptions and emotions
- Managers were not interested in hearing employees’ concerns
- There was no point making complaints because nothing would be done
- Frustration and despair
- Climate of fear

Characteristics of the perpetrator
- Position of power as surgeon and Director of Surgery
- Claimed to be highly skilled and experienced
- Bullied and intimidated staff

Key perceptions and emotions
- Employees could face negative consequences for reporting the adverse events
- Perception of threat

Characteristics of the adverse events
- Variations in “acceptable” practice
- Some adverse outcomes were expected
- Difficult to determine Dr. Patel’s role in the adverse outcomes
- Incidents emerged over a period of time

Key perceptions and emotions
- Uncertainty about whether the adverse events should be reported
- Uncertainty about whether the behavior was intentional

General failure to maintain an accurate record of adverse events
- Staff reluctant to document adverse events
- Inaccurate or evasive terminology used in charts and surgical notes

Key perceptions and emotions
- Employees would not be believed if they reported adverse incidents involving Dr. Patel
- Fear of being wrong

Reduced personal responsibility to report wrongdoing among employees
- Rigid role responsibility
- Diffusion of responsibility
- Code of Conduct and cultural expectations (nurses do not report doctors’ mistakes)

Key perceptions and emotions
- It was not employees’ responsibility to report adverse events, particularly involving surgeons
- Fear of consequences of being labelled a whistleblower

Decision to withhold concerns from management

Lack of evidence to support allegations