


Organisational silence among nurses and physicians in public hospitals

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Aims and objectives: To define the underlying reasons that lead physicians and nurses who provide patient care and treatment, to maintain silence in their work and how they perceive the consequences of such silence in public hospitals.

Background: The concept of organisational silence is described as employees' avoidance of stating his/her opinions, thoughts and suggestions, which would improve the organisation and enable it to provide better processes or services. This concept has been examined more frequently in the international literature in the past decade, and it has drawn attention as one of the most important barriers to employees' contributions to their organisation.

Design: Descriptive and cross-sectional study.

Methods: The study sample consisted of 601 physicians and nurses who work in five hospitals with bed capacities of 100 or more. The data were collected using a two-part form: an introductory information form and an organisational silence scale.

Results: Administrative and organisational topics were prominent among the reasons for employees of healthcare organisations to remain silent for both physicians and nurses.

Conclusions: The results of this study should be considered by physicians and nurses to realise and improve themselves. Also, decision makers and managers of public hospitals might evaluate and remove organisational and communicative barriers to employees' contributions to their organisations based on these results.

Relevance to clinical practice: Physicians and nurses are responsible for the fulfilment of highly important tasks for their organisations. Their contributions help their organisations remain competitive, improve the health services, ensure and sustain patient safety. Hence, these results will provide information to facilitate an understanding of the topics, causes and consequences of organisational silence among physicians and nurses, two key healthcare professions, and will be helpful in the development of medical and nursing human resources in clinical settings.

KEYWORDS

nurses, organisational silence, physicians, public hospitals

1 | INTRODUCTION

The concept of organisational silence is defined as the intentional withholding of knowledge and opinions by employees to improve their work and organisation. Van Dyne, Ang, and Botero (2003, p. 1361) defined silence as an employee's "motivation to withhold versus express ideas, information, and opinions about work-related improvements (rather than on the presence or absence of speaking up behaviour)." Although an employee is able to contribute to an organisation and their work as the result of an incomplete process of communication with regard to the organisation, they may prefer not to mention their opinions about such contributions (Tangirala & Ramanujam, 2008).

Organisational silence is expressed as the result of individual, social and organisational factors. Individual factors include being prejudiced and the desire to maintain the present structure. Social factors include a climate of mistrust and obedience to group behaviours. Finally, organisational factors include the coding of certain issues as taboo, not discussing issues that may be defined as taboo and an emphasis on manager–employee relationships (Donaghey, Cullinane, Dundon, & Wilkinson, 2011; Yurdakul, Aydın Beşen, & Erdoğan, 2016).

International studies showed that organisational silence results in rumours, higher turnover intention and organisational cynicism; lower job satisfaction and organisational commitment in different sectors and countries. Therefore, researchers from different countries have been paying attention to the concept of organisational silence in order to improve organisational outputs (Aeen, Zarei, & Matin, 2014; Çaylak & Altuntaş, 2017; Elçi, Karabay Erdilek, Alpkan, & Şener, 2014; Panahi, Veisoh, Divkhar, & Kamari, 2012).

2 | BACKGROUND

In some studies, investigating the conditions under which organisational silence occurs, researchers have tried to reveal organisational conditions that cause and strengthen organisational silence. In these studies, it was found that employees preferred to remain silent for different reasons. For example, employees preferred to keep silent due to conflicts that they had experienced with other employees, not agreeing with decisions that were made about organisational practices in the workplace, not getting along with managers and thinking that they will not be considered or will be judged when expressing an opinion (Beheshtifar, Borhani, & Moghadam, 2012; Nikolaou, Vakola, & Bourantas, 2010). Differently from this study, there are studies which report that employees were whistleblowing—that means informing which entails disclosure, accusation and dissent—on important issues and wrongdoings instead of being silent (Jubb, 1999; Knoll & Van Dick, 2013a, 2013b).

The subject of organisational silence in healthcare organisations has recently begun to receive attention. As is known, when the healthcare staff in an organisation do not express themselves well and information transfers and communication are ineffective, it negatively

What does this paper contribute to the wider global clinical community?

- "Administrative and organisational topics" which are related to organisational policies, procedures, processes and managerial incompetence were prominent reasons that both physicians and nurses of healthcare organisations keep silent.
- The nurses and physicians preferred to keep silent about Administrative problems.
- Unlike physicians, nurses also preferred to keep silent because of "Fear of isolation."

affects the motivation and job satisfaction of healthcare professionals (Çaylak & Altuntaş, 2017; Eroğlu, Adigüzel, & Öztürk, 2011). More importantly, individuals who utilise healthcare services are placed at risk as a result of a healthcare staff that keep silent. Individuals who receive services may be harmed as a result of such practices in healthcare organisations (Henriksen & Dayton, 2006; Tangirala & Ramanujam, 2008). Thus, the importance of the relationship between patient safety and health professionals' speaking up has been highlighted in recent international studies (Maxfield, Grenny, McMillian, Patterson, & Switzler, 2005; Okuyama, Wagner, & Bijnen, 2014; Schwappach & Gehring, 2014). Therefore, it is important to establish an efficient and open feedback system to ensure patient safety in healthcare organisations (Vogus, Sutcliffe, & Weick, 2010).

Physicians and nurses are critical staff members who provide services in the healthcare field. No studies in the literature have examined the subject of organisational silence among physicians. Although studies have investigated organisational silence among nurses, it is notable that these studies have frequently been conducted on a single hospital sample or with a limited number of participants (Deniz, Noyan, & Gülen Ertosun, 2013; Erigüç, Özer, Turaç, & Songur, 2014; Yurdakul et al., 2016). This study is the first to examine organisational silence among physicians and nurses who work in public hospitals in Turkey.

The purpose of this study was to identify the underlying causes of organisational silence among physicians and nurses who provide patient care and treatment; the study also examines the physicians' and nurses' perceptions of the consequences of such silence.

3 | METHODS

3.1 | Design and sample

This was a descriptive and cross-sectional study. The sample of the study consisted of physicians and nurses who work in five general public hospitals with bed capacities of 100 and more, which were located in five districts in the province of Istanbul and were affiliated with the Ministry of Health. Although in total 1,300 nurses and 1,000 physicians were working in these hospitals, only 800 nurses

and 121 physicians were contacted and asked to participate in the study by researchers. Data were collected from 601 physicians and nurses who worked in these five hospitals and agreed by written consent to participate in the study.

3.2 | Instruments

Introductory Information Form: This form determines the socio-demographic characteristics of the participants and involves eight questions (age, gender, job, educational status, organisation, unit, position and total employment period in the organisation).

Organisational Silence Scale: The scale, which was developed by Çakıcı (2010), consists of 13 subscales in three main dimensions (Silence Topics, five subscales and 23 items; Causes of Silence, five subscales and 32 items; and Perceived Consequences of Silence, three subscales and 26 items). Sample items from each domain and subscale are listed in Table 1.

First, the participants were asked the question “How often do you prefer to keep silent instead of declaring your opinions about the topics below?” in the dimension of the organisational Silence Topics. In this five-point Likert-type dimension, the participants ranked their frequency of keeping silent between “never-1 point” and “always-5 points”. A high mean score in this dimension specifies that the participants keep silent more on that topic. There are five subscales those include main threads related to work and organisation such as “Ethics and responsibilities” (seven items), “Administrative problems” (six items), “Performance of employees” (three items), “Amendment efforts” (four items) and “Facilities related to job” (three items). Çakıcı (2010) reported that the internal consistency coefficient of the subscales varied between .80–.88. In this study, the internal consistency coefficients were found to vary between .79–.89 in the subscales, and the total for the dimension was .95 (Table 2).

Second, the participants were asked to “specify the impact levels of the following possible reasons in your choosing to remain silent instead of talking to your administrators” in the dimension of Causes of Silence. The participants ranked the effects of the items in this five-point Likert scale between “has no effect-1 point” and “very effective-5 points”. A high mean score in this dimension specifies that the participants kept silent more for this reason. Five subscales were “Administrative and organisational reasons” (13 items), “Concerns about job” (six items), “Lack of experience” (four items), “Fear of isolation” (four items) and “Fear of damaging relationships” (three items). Çakıcı (2010) reported that the internal consistency coefficients of the subscales varied between .72–.93. In this study, the internal consistency coefficients were found to vary between .76–.96 in the subscales, and the total for the dimension was .97 (Table 2).

Finally, the participants were asked the question “What would you think that the consequences might be, if employees would

prefer staying quiet instead of explaining their opinions and thoughts on issues related to the organization” for the dimension of “Perceived Consequences of Silence”. They scored the items regarding the possible Consequences of Silence between “Strongly disagree-1 point” and “Strongly agree-5 points”. A high mean score in this dimension specifies that the participants considered that silence had a greater impact on that result. In this dimension, three dimensions were “Consequences that prevent performance and synergy” (15 items), “Consequences that limit improvement and development” (seven items) and “Consequences that upset personnel” (four items). Çakıcı (2010) reported that the internal consistency coefficient of the subscales varied between .80–.95. In this study, the internal consistency coefficient was found to range between .88–.97 in the subscales, and the total for the dimension was .98 (Table 2).

3.3 | Statistical analysis

The data were analysed using descriptive analysis (number, percentage, mean and standard deviation), comparative analysis (Mann–Whitney *U*) and a reliability analysis (Cronbach’s alpha internal consistency coefficient) using IBM SPSS statistics version 21 software (Licensed by Istanbul University).

3.4 | Ethical considerations

To conduct this study on physicians and nurses who work in hospitals affiliated with the Ministry of Health in the city centre of Istanbul, ethical approval was received (Decision number: 605.99/4201) from the Education and Research Committee of Istanbul Provincial Directorate of Health. Then, a protocol was signed through a written application to the Istanbul Provincial Directorate of Health, the country’s central organisation. Permission was received from the managers and nursing service managers of each organisation where the data would be collected. Finally, the participants were informed of the aim of the study and the process, and their written consents were obtained.

4 | RESULTS

4.1 | Sample characteristics

The participants’ ages ranged between 17–62 years ($M = 31.44$, $SD = 7.72$); 12.1% were physicians ($n = 73$), and 87.9% were nurses ($n = 528$). Most of the physicians were male (57.5%) and worked as residents (58.9%). However, the nurses were mostly women (91.5%), had bachelor or postgraduate degrees (54.9%) and worked as bedside nurses (92.4%) at inpatient services (62.5%). The participants’ periods of employment at their organisation mostly ranged between 1–5 years (physicians = 45.2%; nurses = 35.4%). According to these results, participants had similar characteristics of participants in other studies, for example Vural, Çiftçi, Fil, Aydın, and Vural (2014).

TABLE 1 The highest scored two items in each subdimension ($N = 601$)

Silence Topics—How often do you prefer to keep silent instead of declaring your opinions about the topics below?	
Ethics and responsibilities	
Personal disputes and conflicts disrupting business (No: 12)	
Waste and losses in your organization (No: 22)	
Administrative problems	
Institution policies or decisions that you do not agree with (No: 9)	
Wrong attitudes and behaviours of managers (No: 23)	
Performances of employees	
Incompetence of your colleagues (knowledge, skills and ability) (No:1)	
Low performance of your colleagues (No: 8)	
Amendment efforts	
Failures and errors in the operations and processes in your institution (No: 2)	
Recommendations to improve your unit/department (No: 4)	
Facilities related to job	
Infrastructural and super structural problems (No: 24)	
Inadequate materials and equipment (No: 25)	
Causes of Silence—Specify the impact level of your reason for choosing to remain silent instead of talking to your administrators	
Administrative and organisational reasons	
Self-righteous attitudes of managers (No: 15)	
The idea that managers will not pay attention (No: 14)	
Concerns about job	
The opinion that those who report problems are mistreated (No: 7)	
Fear of being exposed to retaliation by managers and colleagues (No: 27)	
Lack of experience	
Lack of experience with speaking up (being new on the job, being young, etc.) (No: 8)	
The opinion that the issues and problems regarding the institution and my job do not interest me, that they interest the management (No: 17)	
Fear of isolation	
Negative response of managers to negative feedback (No: 2)	
Fear of being judged as a problematic/complaining person (No: 1)	
Fear of damaging relationships	
The idea that managers will dislike speaking up (No: 11)	
Fear of losing support (No: 13)	
Consequences of Silence—What would you think that the consequences might be if employees would prefer staying quiet instead of explaining their opinions and thoughts on issues related to the organization	
Results preventing performance and synergy	
Problems cannot be solved on time and get worse (No: 25)	
Keeping quiet prevents open communication and constructive dialog in the institution (No: 27)	
Results limiting improvement and development	
Relevant ideas and opinions are kept behind closed doors and cannot be conveyed to the relevant people (No: 12)	
Managers are deprived of important information and data while making a decision (No: 1)	
Results making personnel upset	
The personnel lose trust in their managers (No: 9)	
The personnel are stressed (No: 5)	

4.2 | Topics, reasons and consequences of organisational silence

When the mean scores of the dimensions of scale were examined (Table 2), it was found that the participants obtained a mean score

of 2.39 ± 0.82 on Silence Topics; the physicians obtained a mean score of 2.56 ± 0.84 , and the nurses obtained a mean score of 2.37 ± 0.81 . The mean scores obtained on Causes of Silence were as follows: 2.88 ± 0.90 for all participants, 2.97 ± 0.91 for the physicians and 2.89 ± 0.90 for the nurses. Lastly, the mean scores

TABLE 2 Mean scores of participants got from Organisational Silence Scale and its subdimensions (N = 601)

	α	Total		Physicians		Nurses	
		M	SD	M	SD	M	SD
Silence topics	.95	2.39	0.82	2.56	0.84	2.37	0.81
Ethics and responsibilities	.89	2.18	0.92	2.35	0.88	2.16	0.92
Administrative problems	.89	2.49	0.97	2.66	0.95	2.47	0.97
Performances of employees	.83	2.44	0.96	2.63	1.0	2.41	0.95
Amendment efforts	.82	2.52	0.95	2.67	0.94	2.50	0.95
Facilities related to job	.79	2.47	1.0	2.61	0.93	2.45	1.0
Reasons of silence	.97	2.88	0.90	2.97	0.91	2.86	0.90
Administrative and organisational reasons	.96	3.08	1.0	3.20	1.0	3.06	1.0
Concerns about job	.88	2.56	0.99	2.71	1.1	2.54	0.98
Lack of experience	.76	2.42	0.92	2.49	0.93	2.41	0.92
Fear of isolation	.85	3.10	1.1	3.08	1.0	3.10	1.1
Fear of damaging relationships	.82	2.96	1.1	3.04	1.1	2.95	1.1
Consequences of silence	.98	3.87	0.82	3.64	0.88	3.90	0.81
Consequences preventing performance and synergy	.97	3.90	0.88	3.70	0.94	3.93	0.86
Consequences limiting improvement and development	.91	3.84	0.85	3.68	0.92	3.86	0.84
Consequences making personnel upset	.88	3.84	0.91	3.47	0.96	3.89	0.89

on the Consequences of Silence were as follows: 3.87 ± 0.82 for all participants, 3.64 ± 0.88 for the physicians and 3.90 ± 0.81 for the nurses.

As is shown in the same table, the participants kept silent mostly about "Amendment efforts" due to "Fear of Isolation" and, in this case, "Consequences preventing performance and synergy" appeared. In addition, different from the overall findings, the physicians were observed to mostly keep silent for "Administrative and organisational reasons" (Table 2).

However, the participants expressed that they kept silent the least about "Ethics and responsibilities" due to "Lack of experience". While "Consequences that upset personnel" occurred the least as a result of silence among the physicians, "Consequences limiting improvement and development" occurred the least among the nurses (Table 2).

4.3 | Comparisons of mean scores according to independent variables

The mean scores that were obtained by the physicians and the nurses from the dimension of Topics, and its subscales did not show significant differences in terms of gender or age group ($p > .05$). However, while the position of the physicians (residents–specialist physicians) did not cause a significant difference in the dimension of Topics, the position of the nurses (staff–manager nurse) caused significant differences between the groups in this dimension. Compared to those in a managerial position, participants in the nurse position had a high mean score in the subscales of "Administrative problems" and "Facilities related to job" ($p < .05$) and a high mean score ($p < .01$) in the subscales "Ethics and responsibilities" and

"Amendment efforts" and in the total of the dimension of Topics. The participants' total periods of employment in an organisation caused a significant difference between groups among both the physicians and nurses in some of the Silence Topics. Physicians who worked in an organisation for 5 years or less had a significantly higher mean score in "Ethics and responsibilities" and in the total of dimension of Silence Topics ($p < .05$), and they had a higher mean score ($p < .01$) in the "Administrative problems" and "Performance of employees" subscales than those who worked in an organisation for 6 years or more. This was contrary to the nurses. The nurses who worked in an organisation for 6 years or longer kept silent more in the "Administrative problems" and "Performance of employees" subscales ($p < .01$) and in the total of the dimension ($p < .05$) than those who worked in an organisation for 5 years or less (Table 3).

The mean scores obtained by the physicians and nurses in the dimension of Causes of Silence, and its subscales did not show a significant difference in terms of the total periods of employment in an organisation ($p > .05$). While gender, position and age group did not cause significant differences in the mean scores obtained by the physicians from the dimension of Causes of Silence and its subscales ($p > .05$), it caused significant differences in the nurses for various reasons. The female nurses kept silent more than male nurses due to "Fear of isolation" ($p < .01$) and "Fear of damaging relationships" ($p < .05$). Compared to those who work in a managerial position, those who work in a nurse position had a high score due to "Lack of experience" and "Fear of damaging relationships" ($p < .05$) and "Concerns about job" ($p < .01$). However, managerial nurses had a higher score ($p < .01$) in the subscale of "Administrative and organisational reasons" than those of nonmanagerial nurses. Lastly, nurses who were 30 years of age and younger had a significantly higher mean

TABLE 3 Silence topics of physicians and nurses according to the socio-demographic characteristics (N = 601)

	Gender				Position				Age				Tenure			
	Physicians		Nurses		Physicians		Nurses		Physicians		Nurses		Physicians		Nurses	
	Female (n = 31)	Male (n = 42)	Female (n = 483)	Male (n = 45)	Res. (n = 43)	Spec. (n = 30)	Staff (n = 488)	Manag. (n = 40)	≤30 (n = 35)	≥31 (n = 35)	≤30 (n = 262)	≥31 (n = 256)	≤5 (n = 52)	≥6 (n = 21)	≤5 (n = 364)	≥6 (n = 164)
E&R																
M	2.43	2.29	2.16	2.17	2.42	2.24	2.19	1.77	2.43	2.23	2.21	2.11	2.47	2.05	2.12	2.26
SD	0.87	0.90	0.91	1.0	0.85	0.94	0.93	0.76	0.76	0.97	0.94	0.90	0.83	0.95	0.92	0.90
z	-0.648		-0.259		-1.263		-2.868		-1.453		-1.114		-2.313		1.855	
p	.517		.769		.206		.004**		.146		.265		.021*		.064	
AP																
M	2.69	2.64	2.47	2.40	2.74	2.55	2.49	2.17	2.77	2.53	2.49	2.43	2.84	2.22	2.39	2.64
SD	0.91	0.99	0.96	1.1	0.94	0.97	0.98	0.81	0.86	1.0	0.99	0.95	0.87	1.0	0.98	0.93
z	-0.173		-0.766		-0.927		-1.976		-1.353		-0.705		-2.729		2.908	
p	.862		.444		.354		.048*		.716		.481		.006**		.004**	
PoE																
M	2.83	2.48	2.41	2.39	2.71	2.52	2.42	2.25	2.70	2.46	2.44	2.37	2.84	2.12	2.34	2.58
SD	1.1	1.0	0.93	1.1	0.97	1.1	0.95	0.93	0.93	1.1	1.0	0.89	0.99	0.99	0.98	0.87
z	-1.233		-0.441		-1.063		-1.138		-1.078		-0.546		-2.901		2.780	
p	.218		.660		.288		.255		.281		.585		.004**		.005**	
AE																
M	2.71	2.64	2.51	2.48	2.68	2.66	2.53	2.09	2.73	2.54	2.53	2.45	2.78	2.39	2.46	2.60
SD	0.90	0.98	0.95	0.96	0.89	1.0	0.96	0.74	0.82	1.0	0.97	0.92	0.83	1.1	0.96	0.92
z	-0.359		-0.318		-0.158		-2.945		-0.893		-1.049		-1.668		1.571	
p	.719		.751		.874		.003**		.372		.294		.095		.116	
FJ																
M	2.76	2.50	2.45	2.43	2.60	2.63	2.48	2.08	2.74	2.46	2.45	2.43	2.66	2.51	2.40	2.56
SD	0.89	0.95	1.0	1.1	0.93	0.95	1.0	0.82	0.84	0.99	1.0	0.99	0.89	1.0	1.0	0.97
z	-0.973		-0.294		0.119		-2.261		-1.296		-0.191		-0.817		1.764	
p	.331		.769		.906		.024*		.195		.849		.414		.078	
Total																
M	2.65	2.49	2.37	2.34	2.61	2.48	2.40	2.03	2.65	2.42	2.40	2.33	2.69	2.22	2.31	2.50
SD	0.81	0.86	0.81	0.90	0.82	0.87	0.82	0.68	0.74	0.92	0.84	0.78	0.76	0.94	0.83	0.77
z	-0.653		-0.575		-0.903		-2.678		-1.416		-0.818		-2.572		2.509	
p	.514		.565		.367		.007**		.157		.413		.010*		.012*	

Res, residents; Spec, specialist; Manag, manager; E&R, ethics and responsibilities; AP, administrative problems; PoE, performances of employees; AE, amendment efforts; FJ, facilities related to job.

*p < .05, **p < .01.

Significant values were shown in bold characters.

score ($p < .05$) than those who were 31 years of age and over in the subscales of "Fear of isolation" and "Fear of damaging relationships" (Table 4).

The mean scores obtained by the physicians and nurses from the dimension of Perceived Consequences of Silence, and its subscales did not show a significant difference in terms of gender, position or total periods of employment in an organisation ($p > .05$). However, the age group of the participants caused significant differences in the subscales of "Consequences preventing performance and synergy" and "Consequences limiting improvement and development" and in the total of the dimension. Compared to the physicians who were 30 years old or younger, physicians who were 31 years old or over had a significant mean score ($p < .01$) in the subscale "Consequences limiting improvement and development", and they had a significantly higher mean score ($p < .05$) in the subscale "Consequences preventing performance and synergy" and in the total of the dimension. However, nurses who were 30 years old or younger had a high score ($p < .01$) in the subscales "Consequences preventing performance and synergy" and "Consequences limiting improvement and development" and in the total of the dimension compared with those who were 31 years old or over (Table 5).

5 | DISCUSSION

Because of their function in the care, treatment and recovery of patients, physicians and nurses directly influence the quality of services in healthcare organisations; they affect the satisfaction of healthcare consumers. Hence, members of both occupational groups can contribute to their organisations by expressing their opinions on the organisation's improvement and development and by offering suggestions about both their specific jobs and overall operations (Gkorezis, Panagiotou, & Theodorou, 2016; Kelly & Tazbir, 2013). Organisational silence was chosen as the subject because it is one of the most significant barriers in physicians and nurses improving both their own professional and organisational functions, raising their own satisfaction in their work and also helps promote their organisation itself, in this manner.

This study aimed to reveal the underlying topic physicians and nurses who work in public hospitals keep silent about and to identify their reasons for silence and the perceived consequences of the silence.

5.1 | Topics of organisational silence

Both physicians and the nurses were observed to receive the highest score from the subscales "Amendment efforts" and "Administrative problems" of the dimension "Silence Topics", respectively. The mean scores that were obtained by the participants from the subscales in this dimension ranged between 2.16–2.67. Comparing with others studies, these scores were higher than Yalçın and Baykal's (2012) study and lower than Yurdakul et al.'s (2016) study. Yurdakul et al.'s

(2016) study conducted with 25 midwives and 274 nurses in a public hospital in Mersin using the same scale, it was noted that this ordering was fairly different. The mean scores of the participants were also found to vary between 3.12–3.62 in a study in which the subscales "Ethics and responsibilities" and "Performance of employees" were ranked as the first two (Yurdakul et al., 2016). In Çaylak and Altuntaş's (2017) study, nurses ranked the first two subscales as "Ethics and responsibilities" and "Administrative problems". In another study conducted by Yalçın and Baykal (2012) with 220 nurses who work in private hospitals in Istanbul, the mean score was reported to vary between 1.73–2.49. Similar to the present study, it was determined in that study that the subscale "Administrative problem" was at the forefront as one of the subscales with the highest mean score in the dimension of "Silence Topics". Similarly, in Erigüç and colleagues' study (Erigüç, Özer, Songur, & Turaç, 2014), which was conducted among 137 nurses who work in a single public hospital, the subscale "Administrative problems" was found to be the primary subscale in the dimension of "Silence Topics". Therefore, "Administrative problems" was ranked first in the dimension of Silence Topics in studies that were conducted in metropolises, such as Istanbul and Ankara (Çaylak & Altuntaş, 2017; Erigüç, Özer, Songur, et al., 2014; Yalçın & Baykal, 2012). An evaluation of the above findings shows that employees generally preferred to keep silent about Administrative problems. So, it is important to highlight that healthcare professionals, even the ones as fundamental as nurses and physicians, do not dare speak about administrative problems and do not share their views and opinions those may be critical in their solutions.

The subscale "Amendment efforts" also came to the forefront in this study, which differs from other studies. This result may be associated with the fact that competition between these hospitals with high patient potential in Istanbul has increased because of the health reform applications, hospitals tried to attract more patients and improved services to get better patient satisfaction and quality and improvement activities are addressed regularly (Harmancı Seren & Yıldırım, 2013). Similarly, establishing patient safety standards for public hospitals and expectations for organisations to act in accordance with these standards could be effective for the subscale "Amendment efforts" to become prominent among nurses.

5.2 | Reasons of organisational silence

In the dimension of "Reasons of Silence," it was notable that the physicians and nurses obtained higher scores for different subscales. While the physicians evaluated "Administrative and organisational reasons" first and "Fear of isolation" second, the ranking was different among the nurses. "Fear of isolation" was ranked first, and "Administrative and organisational reasons" was ranked second. Although the rankings of these two subscales are different for the nurses and physicians, they were both first two. "Administrative and organisational reasons" was ranked second by nurses in Çaylak and Altuntaş study (2017). Bayın, Yeşilaydın, and Esatoğlu study (2015) reported "Administrative and organisational reasons" and "Fear of

TABLE 4 Reasons of silence of physicians and nurses according to the socio-demographic characteristics (N = 601)

	Gender				Position				Age				Tenure			
	Physicians		Nurses		Physicians		Nurses		Physicians		Nurses		Physicians		Nurses	
	Female (n = 31)	Male (n = 42)	Female (n = 483)	Male (n = 45)	Res. (n = 43)	Spec. (n = 30)	Staff (n = 488)	Manag. (n = 40)	≤30 (n = 35)	≥31 (n = 35)	≤30 (n = 262)	≥31 (n = 262)	≤5 (n = 52)	≥6 (n = 21)	≤5 (n = 364)	≥6 (n = 164)
A&OR																
M	3.29	3.13	3.08	2.84	3.12	3.31	2.09	2.66	3.10	3.25	3.11	3.00	3.23	3.13	3.00	3.19
SD	0.95	1.1	1.0	1.1	1.0	0.97	1.0	1.0	0.95	1.1	1.0	1.0	0.99	1.1	1.1	0.98
z	-0.514		-1.329		0.607		-2.597		0.764		-1.309		-0.653		1.813	
p	.607		.184		.537		.009**		.445		.191		.514		.070	
CJ																
M	2.71	2.71	2.56	2.30	2.70	2.73	2.58	2.13	2.60	2.76	2.57	2.51	2.73	2.66	3.10	3.19
SD	0.94	1.1	0.97	1.1	1.0	1.1	0.98	0.92	0.97	1.1	0.98	0.99	1.0	1.1	1.1	0.98
z	-0.224		-1.804		0.135		-2.796		0.341		-0.697		-0.360		1.813	
p	.823		.071		.893		.005**		.733		.486		.719		.070	
LoE																
M	2.54	2.45	2.42	2.37	2.56	2.38	2.44	2.04	2.53	2.44	2.45	2.36	2.55	2.33	2.50	2.64
SD	0.82	1.0	0.90	1.1	0.90	0.98	0.92	0.85	0.89	0.97	0.92	0.90	0.88	1.1	0.99	0.96
z	-0.791		-0.464		-0.924		-2.500		-0.591		-1.061		-0.815		1.482	
p	.429		.643		.355		.012*		.555		.289		.415		.138	
FoI																
M	3.17	3.01	3.14	2.61	3.13	3.02	3.12	2.77	3.10	3.01	3.19	2.99	3.15	2.92	2.39	2.46
SD	0.99	1.0	1.1	1.2	0.95	1.1	1.1	1.1	0.87	1.2	1.0	1.1	0.96	1.2	0.95	0.84
z	-0.546		-2.952		-0.554		-1.840		-0.154		-2.074		-0.737		0.871	
p	.585		.003**		.580		.066		.878		.038*		.461		.384	
FoDR																
M	3.10	3.00	2.98	2.57	2.91	3.24	2.97	2.63	2.90	3.15	3.05	2.84	3.05	3.03	3.05	3.21
SD	1.0	1.2	1.1	1.2	1.1	1.1	1.1	1.1	0.96	1.3	1.1	1.1	1.1	1.3	1.1	1.0
z	-0.287		-2.413		1.152		-1.997		0.993		-2.439		-0.221		1.445	
p	.774		.016*		.250		.046*		.321		.015*		.825		.149	
Total																
M	3.04	2.93	2.89	2.61	2.94	3.03	2.90	2.48	2.91	3.00	2.92	2.80	3.01	2.89	2.82	2.97
SD	0.81	0.98	0.88	1.0	0.92	0.89	0.90	0.89	0.82	1.0	0.88	0.92	0.87	1.1	0.92	0.85
z	-0.541		-1.885		0.107		-2.886		0.317		-1.730		-0.756		1.503	
p	.558		.059		.915		.004**		.751		.084		.450		.133	

Res, residents; Spec, specialist; Manag, manager; A&OR, administrative and organisational reasons; CJ, concerns about job; LoE, lack of experience; FoI, fear of isolation; FoDR, fear of damaging relationships. *p < .05; **p < .01.

Significant values were shown in bold characters.

TABLE 5 Consequences of silence of physicians and nurses according to the socio-demographic characteristics (N = 601)

	Gender		Position		Age		Tenure									
	Physicians Female (n = 31)	Physicians Male (n = 42)	Nurses Female (n = 483)	Nurses Male (n = 45)	Physicians Res. (n = 43)	Physicians Spec. (n = 30)	Nurses Staff (n = 488)	Nurses Manag. (n = 40)	Physicians ≤5 (n = 52)	Physicians ≥6 (n = 21)	Nurses ≤5 (n = 364)	Nurses ≥6 (n = 164)				
CPS																
M	3.48	3.81	3.95	3.67	3.62	3.74	3.92	4.02	3.45	3.84	4.07	3.82	3.70	3.60	3.95	3.88
SD	1.0	0.84	0.85	1.0	0.88	1.0	0.87	0.78	0.89	0.97	0.73	0.94	0.92	1.0	0.83	0.93
z	1.248		-1.805		0.967		0.796		2.002		-2.844		-0.354		-0.438	
p	.212		.071		.334		.426		.045*		.004**		.723		.661	
CLI&D																
M	3.51	3.80	3.88	3.69	3.66	3.71	3.86	3.89	3.42	3.89	4.00	3.74	3.68	3.66	3.90	3.77
SD	1.1	0.77	0.81	1.1	0.86	1.0	0.84	0.77	0.84	0.97	0.71	0.92	0.87	1.0	0.81	0.89
z	0.869		-0.653		0.602		0.027		2.648		-2.976		0.343		-1.455	
p	.385		.514		.547		.978		.008**		.003**		.732		.146	
CMPU																
M	3.26	3.62	3.92	3.60	3.49	3.43	3.90	3.80	3.36	3.51	3.97	3.84	3.49	3.40	3.90	3.88
SD	1.1	0.80	0.86	1.1	0.94	1.0	0.90	0.87	0.98	0.96	0.71	0.94	0.93	1.0	0.89	0.91
z	1.075		-1.688		-0.385		-0.867		0.675		-1.397		-0.191		-0.191	
p	.282		.091		.701		.386		.500		.162		.849		.848	
Total																
M	3.45	3.78	3.93	3.67	3.61	3.69	3.90	3.95	3.43	3.80	4.04	3.80	3.66	3.59	3.93	3.85
SD	1.0	0.76	0.78	1.0	0.83	0.97	0.81	0.74	0.83	0.93	0.68	0.88	0.84	1.0	0.78	0.87
z	1.128		-1.515		0.757		0.191		2.340		-2.770		-0.134		-0.705	
p	.259		.130		.449		.848		.019*		.006**		.893		.481	

Res, residents; Spec., specialist; Manag, manager; CPS, consequences preventing performance and synergy; CLI&D, consequences limiting improvement and development; CMPU, consequences making personnel upset.
 *p < .05; **p < .01.
 Significant values were shown in bold characters.

isolation" near the top among reasons of organisational silence. Findings of this study confirm previous research.

In their study conducted in private hospitals, Yalçın and Baykal (2012) reported that "Administrative and organisational reasons" was ranked first. According to Yalçın and Baykal (2012), the reason the subscale "Administrative and organisational reasons" became prominent, because it is associated with repressive attitudes of managers towards their employees, especially in healthcare organisations. Donaghey et al. (2011) took this issue further and considered organisational silence to be a consequence of management policies rather than a behaviour preferred by employees. In fact, in their study, they examined silence based on the argument that "management, through agenda-setting and institutional structures, may well perpetuate silence on a range of issues, which are effectively organised out of the voice process in favour of less threatening items". Therefore, managers of healthcare services should question their management style, their communication with employees and the policies that they pursue (Dabbagh, Esfahani, & Shahin, 2012; Detert & Burris, 2007). Thus, the factors that contributed to the administrative and organisational subscale's becoming prominent among Causes of Silence could be determined, and the administrative and organisational causes in employees' contribution to organisation could be eliminated.

Interestingly, in this study, "Fear of isolation" was important reason for both nurses and physicians to remain silent. This finding is very engrossing because of healthcare professionals' fear of being alone and thus not sharing their ideas or opinions because of this fear.

5.3 | Consequences of organisational silence

In the "Consequences of Silence" category, the third dimension of the scale, both physicians and nurses were observed to obtain the highest mean score from the subscale "Consequences preventing performance and synergy." This was quite notable because it indicates that both occupational groups are aware that their, others' and their organisation's performance is negatively affected as a result of keeping silent and their failure to express their thoughts (Çınar, Karcıoğlu, & Alioğulları, 2013; Dabbagh et al., 2012). Similar to this study, Çakıcı (2010) stated that improvements in performance and the creation of synergy in an organisation could be prevented by organisational silence. Çakıcı (2010) found this result to be very comprehensive in her study and noted that an organisational setting in which the opinions of employees are not utilised, their opinions not considered and the managers hear only what they wish to may be the result of organisational silence, regardless of the cause. Therefore, the emergence of factors that prevent performance and synergy as a result of silence may create an organisational climate in which the expression of new ideas and suggestions of new applications is prevented, and innovative expansion is curtailed (Knoll & Van Dick, 2013a, 2013b). Maintaining silence in these types of working environments can lead to practices that risk patient safety. For this reason, it is important for managers in healthcare

organisations to consider these matters in their evaluation of the risks that are caused by organisational silence (Erigüç, Özer, Songur et al., 2014; Gkorezis et al., 2016).

5.4 | Comparisons of mean scores according to independent variables

When the "Silence Topics" dimension of the physicians and nurses was compared in terms of independent variables in the study, differences occurred between staff and managerial nurses, and the nurses had higher scores than their managers in all subscales except for "Performance of employees". Compared to this study, the managers were shown to keep more silent than their employees in the studies of Tangirala and Ramanujam (2008) and Yalçın and Baykal (2012). This result may be associated with sector differences. While the other studies were conducted in private sector hospitals, the present study was conducted in public hospitals. Because there is also a stricter hierarchical structure from the top down in the organisational structure of contemporary public hospitals, it is understandable that the employees displayed a greater tendency to keep silent than their managers.

The tenure of employees in an organisation is another variable for which differences were found between the participants. However, while the physicians who worked for 5 years or less were remarkably more silent in subscales "Ethics and responsibilities," "Performance of employees" and "Amendment efforts," the nurses who worked for 6 years or longer were observed to keep silent more in the subscales "Performance of employees" and "Amendment efforts." It is possible that the physicians with less experience hesitated and chose silence because they did not yet know the organisation and operations. However, the behaviour may also be associated with the fact that, in time, the nurses reached a point where speaking openly would not change the result, and the expression of their opinions would not be accepted. In their study, Bayın et al. (2015) stated that the reason why especially experienced nurses kept more silent was associated with the fact that they knew the organisational culture and management style well.

When physicians and nurses were examined in terms of "Reasons of Silence," no difference was found for the physicians in terms of independent variables. However, a difference was found among the nurses in all subscales except "Fear of isolation" in terms of position variable. It was notable that the managerial nurses kept silent mainly due to "Administrative and organisational reasons," while the staff nurses kept silent for reasons such as "Concerns about job," "Lack of experience" and "Fear of damaging relationships." Similarly, the female nurses and those who were younger than 30 years also kept silent more due to "Fear of isolation" and "Fear of damaging relationships." When these results were evaluated as a whole, it was found that those who were young, female and staff employees preferred to keep silent on behalf of not damaging their relationships and their concern for risking their tenure in their organisation and unit. Such attitudes are expected to be accepted amongst senior nurses who know an organisation better and hesitate to enter into

conflict with the organisation. Hence, in another study that was conducted with public officers, a correlation was determined between being exposed to mobbing and the dimensions of organisational silence (Gül & Özcan, 2011). Nurses, therefore, can be assumed to be right in their fears that they will be isolated, their relationships will be damaged or they will be alone in cases in which they did not keep silent.

A difference was determined between the groups only according to age in the domain of "Consequences of Silence." Nurses who were 30 years old or younger and physicians who were 31 years old or over thought more than "Consequences preventing performance and synergy" and "Consequences limiting improvement and development" occurred as a result of silence. This result is thought-provoking because it suggests that the senior nurses accepted the current condition. Erigüç, Özer, Turaç, et al. (2014) also emphasised that these nurses adapt to the current conditions that arise from managers and organisational culture as a result of their experience. However, the senior physicians and younger nurses prioritised organisation, improvement and development instead of consequences making personnel upset, and they emphasised that this aspect of silence limited the performance of the organisation and its employees. It is fortunate for organisations to have such employees who place the benefit of the organisation and their performance ahead of relevant results.

5.5 | Limitations

The study was limited to physicians and nurses who work in public hospitals. Therefore, it did not involve physicians and nurses who work in private hospitals, which are growing in size in health sector.

Another limitation was that physicians who work in related organisations showed a low rate of participation in the study. While the numbers of physicians and nurses who work at hospitals are similar, there was a large difference in the number of physicians and nurses who participated in the study.

6 | CONCLUSION

As a whole, this study found that administrative and organisational issues were prominent reasons that physicians and nurses in health-care organisations kept silent. Nurses and physicians engage in extremely important tasks with regard to the performance of the organisations that employ them in terms of competing with other organisations, making a difference in service and ensuring and sustaining patient safety.

7 | RELEVANCE TO CLINICAL PRACTICE

The evaluation of the situation and the elimination of the organisational and communicative barriers that hinder employees' contributions to an organisation is important for the managers of public

hospitals and for the decision makers of the managerial and organisational process in these hospitals. Sublevel and mid-level clinical managers must recognise employees and be aware of their competencies. In this way, they can encourage their employees to contribute to the issues and tasks that are directly related to their competencies. Additionally, hospital and unit managers should consider holding interactive meetings with their employees for each unit and each department on a regular basis to obtain their opinions and recommendations for the clinical process as it relates to patient care, the quality of care and teamwork.

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CONTRIBUTIONS

Study design: AKHS, IT, FEB, NUB, ETE, AY; data collection and analysis: IT, FEB, NUB, ETE; and manuscript preparation: AKHS, IT, FEB, NUB, AY.

CONFLICT OF INTEREST

There is no conflict of interest between the authors.

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