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# Speaking up during the COVID-19 pandemic: Nurses' experiences of organizational disregard and silence

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## Abstract

**Aim:** To critically examine nurses' experiences of speaking up during COVID-19 and the consequences of doing so.

**Design:** Longitudinal qualitative study.

**Methods:** Participants were purposively sampled to represent differing geographical locations, specialities, settings and redeployment experiences. They were interviewed (remotely) between July 2020 and April 2022 using a semi-structured interview topic guide.

**Results:** Three key themes were identified inductively from our analysis including: (1) Under threat: The ability to speak up or not; (2) Risk tolerance and avoidance: Consequences of speaking up; and (3) Deafness and hostility: Responses to speaking up. Nurses reported that their attempts to speak up typically focused on PPE, patient safety and redeployment. Findings indicate that when NHS Trusts and community services initiated their pandemic response policies, nurses' opportunities to speak up were frequently thwarted.

**Conclusion:** Accounts presented in this article include nurses' feeling a sense of futility or of suffering in silence in relation to speaking up. Nurses also fear the consequences of speaking up. Those who did speak up encountered a 'deaf' or hostile response, leaving nurses feeling disregarded by their organization. This points to missed opportunities to learn from those on the front line.

**Impact:** Speaking up interventions need to focus on enhancing the skills to both speak up, and respond appropriately, particularly when power, hierarchy, fear and threat might be concerned.

**Patient or Public Contribution:** Nurses working clinically during COVID-19 were involved in the development of this study. Participants were also involved in the development of our interview topic guide and comments obtained from the initial survey helped to shape the study design.

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## 1 | INTRODUCTION

Prior to the COVID-19 pandemic, nurses' ability to speak up was a contentious issue. Speaking up is a term used consistently in health-care as a way of articulating how staff voice concerns about working conditions and/or patient safety (Mannion et al., 2018). These concerns might not only be raised informally, such as to a line manager, but they may also be raised through more formal mechanisms such as incident forms, or via whistle-blowing procedures and the media (Mannion et al., 2018). Some countries, such as the UK, have tried to implement processes to help staff to raise concerns, through for example, the launch of the Freedom to Speak Up initiative and Speak Up Guardians in the English NHS in 2016 (Adams et al., 2020). However, nurses have often reported feeling unsupported, blocked, censored and ultimately unheard, with literature bringing this to the fore in the last decade (Violato, 2022). What has become evident during the COVID-19 pandemic is that even during a time of crisis, conditions about speaking up remain suboptimal; nurses still report being silenced or unheard by their managers and/or organizations in response to raising concerns (Mitchell, 2021). In this article, we critically examine nurses' experiences of speaking up during the COVID-19 pandemic in the United Kingdom, and, importantly, the consequences of doing so. Subsequently, we argue that there is a need to understand more fully the nature of nurses' experiences of speaking up during COVID-19 and beyond.

## 2 | BACKGROUND

Previous research has found that a sense of psychological safety, which is said to stem from a culture of mutual respect and trust among team members (Edmondson, 1999), is an important prerequisite for speaking up. Psychological harm can be encountered when expectations for mutual respect are created and then not followed through; for example, when managers promise to respond to concerns but then fail to do so (Jones et al., 2022). Indeed, research highlights that the ability of staff to speak up has often been related to the workplace culture which encompasses attributes such as an organization's hierarchal forms, the division of labour, organizational locations, departments, units and the variety of roles and technologies used (Myers et al., 2014). Speaking up is thus heavily contingent on pre-existing workplace cultures, norms and hierarchies. The multiple stressors presented during the COVID-19 crisis placed unexpected and unprecedented extra pressures on the nursing workforce and on services already under intense strain (Kinman et al., 2020; West et al., 2020). This has not made speaking up any easier or more productive.

When individuals do not feel able to speak up at work, they become silenced, through fear, or a sense of futility, resignation or disengagement (Brinsfield, 2013; Milliken et al., 2003; Pinder & Harlos, 2001). Silence about concerns can be conceptualized as a multidimensional construct in the workplace (Brinsfield, 2013; Knoll

& van Dick, 2013; Pinder & Harlos, 2001). For example, previous literature describes silences as typified by different influences including quiescent and acquiescent silence (Pinder & Harlos, 2001). Quiescent silence is the active withholding of information for fear of what might happen if one shares, or speaks up. An employee may disagree with custom and practice, or actions taken, but they do not engage with any alternatives and instead chose to suffer silently (Knoll & van Dick, 2013). Acquiescent silence typically occurs when an individual perceives a lack of interest in their opinions. This may occur in organizations when conformity is encouraged and dissent is minimized (Pinder & Harlos, 2001).

Nursing as a profession has a long-standing history and pride in getting on with things and in particular, being resilient despite adversity (Conolly et al., 2022). As such, silence can be seen as socialized acceptance or compliance. However, not feeling able to share one's views or concerns, not having them heard or being complicit can lead to emotional exhaustion, burnout and moral distress which certainly manifested for nurses during the COVID-19 pandemic (Maben et al., 2022). Silence may also be contagious, acting as part of an organization's cultural backdrop and propagated by individuals including line managers (Knoll, 2021). Any hostility or lack of receptiveness to hearing staff concerns makes line managers uniquely placed to either hamper or facilitate speaking up (Edmondson, 1999; Knoll, 2021). Not 'hearing', has the ability to stifle further voices and has been termed the 'deaf ear syndrome' whereby organizational inaction produces failure to respond to staff concerns (Jones & Kelly, 2014). Indeed, those in position to hear and respond are called on both to do so courageously, and subsequently, to act appropriately (Cleary & Doyle, 2016). When an organization is 'deaf' to its staffs' concerns, it signals a dismissal of valuable staff views about their working conditions and/or patient safety, thus exhibiting an overall and pervasive sense of organizational disregard for staff experience and learning. The COVID-19 pandemic has revealed that speaking up remains a stressful choice for the initiator and the recipient, and is fraught with issues about how to communicate concerns effectively, and the extent to which action is taken as a result (Adams et al., 2020; Jones et al., 2022).

## 3 | THE STUDY

### 3.1 | Aims

The overall aim of the study from which our data are derived, was to examine the impact of COVID-19 on nurses' psychological well-being by specifically exploring their working experiences during the pandemic. One key strand to inductively arise from the analysis was the range of experiences relating to speaking up that nurses encountered during COVID-19. This analysis forms the basis of this article which provides complementary findings to the broader study aims more about which can be read in (Couper et al., 2021) and (Maben et al., 2022).

### 3.2 | Design

We adopted a social constructionist approach (Berger & Luckman, 1967), viewing realities as being constructed in a relational context and with multiple insights, and used a longitudinal, qualitative approach to data collection and analysis.

### 3.3 | Sample/participants

Participants were recruited through an opt-in method from a subset of participants who had completed two national nurse and midwife surveys (in April and May 2020; 'Parent study' Couper et al., 2021) and who expressed an interest in being contacted to take part in qualitative interviews about their COVID-19 experiences. Participants were sampled purposively to recruit nurses who worked in a range of settings and specialities, had differing experiences and worked at differing grades. This sampling strategy was deployed with the aim of gathering narratives from nurses across the UK COVID-19 to understand the impacts of working through the COVID-19 pandemic. All participants were emailed with a participant information sheet and consent form and given 14 days to respond. A total of 50 nurses took part in this study as a combination of two different sample groups. Our first sample comprised 27 individuals, including 26 nurses and one midwife (hereafter 'nurses' collectively). Of these, 25 participated in four interviews (we experienced an attrition of two participants after our first interview due to one declining due to availability and the other because their Email address bounced back). To accurately reflect the diverse voices across different healthcare settings, an additional sample was recruited to capture the experiences of, where possible, student nurses, care home nurses and community nurses, as well as other ethnicities. Sample two comprised 23 additional nurses, recruited after the second wave of COVID-19 in the UK. Table 1 below provides further participant details.

### 3.4 | Data collection

The first sample of nurses ( $n = 27$ ) were interviewed in July 2020 and were then invited to a further three interviews with the final interviews conducted in April 2022. The second sample of nurses ( $n = 23$ ) were interviewed in September 2021 and invited to participate in a second interview in April 2022. All interviews were conducted remotely via Zoom, Teams or telephone and lasted between 45–90 min. In all instances, only the researcher and the participant were present. We followed a narrative interviewing process, with participants invited to 'tell us what happened' and were encouraged to speak without interruption (Greenhalgh et al., 2005). An interview topic guide was designed by the research team and used to ensure similar topics were addressed. This guide acted as a steer for the research team, prompting the asking of key topics such as working conditions, psychological well-being and key moments of stress and accomplishment. The questions used were open-ended, allowing

TABLE 1 Participant characteristics

Heading	Sample 1	Sample 2
Ethnicity	3 mixed ethnicity 1 prefer not to say 23 white British	Asian British 1 Black Caribbean 1 Black African 3 White other 4 White British 14
Gender	26 Female 1 Male	22 Female 1 Male
Setting		
Social care	1	0
Community Mental Health (MH)	3	0
Other community nursing	4	7
Private acute hospital	1	0
Care home	1	4
Midwife	1	1
Learning Disabilities setting	1	0
NHS hospital/other acute	13	6
Research	2	1
Student during the first wave of COVID-19	0	4

participants to respond in their own ways while giving the team flexibility (Hollway & Jefferson, 2013). Longitudinal qualitative methods, in the form of repeat interviews, were used to identify and characterize personal trajectories as the pandemic progressed. The timing of each interview was decided by the project team and was undertaken to coincide with the abating of each wave of the pandemic so as to firstly not burden nurses at the height of the pandemic and their working capacity, and secondly to capture reflections and insights after each wave.

The research team are all experienced qualitative researchers with backgrounds in undertaking distressing or sensitive interviews. Additionally, JM, RH, DK and BK are Professors of Nursing of which one (BK) worked clinically during the pandemic in ICU. All are female except one (DK). The research team met frequently to discuss the approach to interviewing and share their process to ensure consistency. This not only helped to ensure rigour with the approach to interviewing but also provided an outlet to debrief after any particularly distressing or emotional interviews.

For sample 1, four researchers (JM, RH, DK and BK) each interviewed the same five participants at all time points to ensure consistency and rapport. RA interviewed seven participants during the first interview wave. The remaining five participants were interviewed by (AC; maternity leave prevented continuity). For sample 2, three researchers (JM, DK and RH) each interviewed two participants. DK interviewed one participant. RA and ER interviewed four participants each and AC interviewed seven participants.

All participants were provided with the opportunity to pause or stop the interview, and with resources in the form of well-being

signposting opportunities as needed. Participants were also offered the opportunity to speak further with a member of the research team if they'd found the interview particularly distressing or emotional. Interviews were audio recorded, transcribed verbatim and participants were given pseudonyms to preserve confidentiality. Transcripts were offered to participants and provided if requested.

### 3.5 | Ethical considerations

Ethics approval was received from the University of Surrey ethical governance committee (FHMS 19-20 078 EGA CVD-19).

### 3.6 | Data analysis

NVivo 12 was used to organize data and develop inductive codes and themes (Elliott, 2018). To avoid fragmentation of the data, pen portraits, or interview summaries, were also produced (Hollway & Jefferson, 2013). The initial coding process was led by one author (AC) with a sub-sample of transcripts and pen portraits selected for additional analysis by ER and RA to interrogate the coding frame by refuting, corroborating and ultimately agreeing and legitimizing the codes. This early stage acted as a form of familiarization and immersion in the data. Themes were generated subsequently, using thematic narrative analysis with a view to exploring both in and between narrative accounts from the inductive codes (Elliott, 2018). The pen portraits, along with the secondary level themes, aided our longitudinal holistic approach to analysis of each participant (Hollway & Jefferson, 2013).

In line with narrative approaches to data analysis, the team avoided the temptation to over-code and instead have depicted broad categories of themes to articulate findings (Riessman, 2008). All data were analysed both in wave and across data sets. Each interview was compared with previous data from the same interviewee so as to determine both the longitudinal and cross-sectional impact, as per longitudinal data analysis (Hermanowicz, 2013).

The findings presented in this article point to the cumulative nature of feeling ignored during the pandemic and indicate how little changed for participants across time. They reflect information power, as opposed to theoretical saturation (Malterud et al., 2016). For further details and analysis relating to the longitudinal aspect of this study, please see (Maben et al., 2022).

### 3.7 | Rigour

We have completed the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist for comprehensive reporting (Tong et al., 2007). This can be found in the [supporting information](#). Participants did not input into the research process aside from acting as interviewees.

## 4 | FINDINGS

We present three key themes that were identified inductively from our analysis: (1) Under threat: The ability to speak up or not; (2) Risk tolerance and avoidance: Consequences of speaking up; and (3) Deafness and hostility: Responses to speaking up. These themes represent accounts where speaking up became problematic. There were a few instances of 'successful' speaking up that yielded action which are also explored below where appropriate.

### 4.1 | Under threat: The ability to speak up or not

Working conditions, for the majority of staff in this study were a key reason for wanting to speak up. This typically occurred in the context of PPE, patient safety and redeployment. Although some participants reported feeling at ease about redeployment, most stated that they did not, instead expressing concerns to their managers about what would happen if they refused to be redeployed. Some participants said that they would have volunteered if asked and in doing so would support others who they felt should not have been redeployed (those with shielding family members, e.g.). Yet many were not asked. Our participants understood that staff redeployment was needed in the pandemic crisis. However, it was *how* it was done that was problematic, with staff feeling they had no agency or choice in the matter. Some who had questioned redeployment were reprimanded for being 'contentious', for making 'a political statement' or 'working against the system':

Oh, we had no choice. We were just told that in the first few weeks there was no choice. There were a few that were really got into a sort of a strong argument against, and we were just told that no (...) don't be contentious, like you're making this into a political statement. You're working against the system. This is the way that we've been told to do it and you have to accept that. (Sue, mental health nurse)

Most nurses reported that managers tended to cite pandemic policies which dictated that nurses had to be redeployed if necessary:

Obviously, I had quite a lot of anxieties about it ... You know, I think we have a pandemic people policy that states that, you know, in a situation like this you have to, you just have to go. (Ellie, redeployed to ICU)

In the example below, Tessa describes how her redeployment was managed and consequently considered herself to have been forced into it, without having any power or voice, to say no:

The Trust sometimes sends out little emails which say, you know, thank you to the staff who volunteered to be redeployed. None of us have ever ... we weren't asked. We were told. And I think that just grates a bit because you think no, I didn't volunteer. I haven't fallen on this sword. I've been told what had been done and when I got upset about it, my boss pointed out the Nursing and Midwifery Council code of conduct to me. (Tessa, redeployed to ICU)

Having the NMC code of conduct cited during a particularly stressful and uncertain time appeared to make nurses feel under threat. This action effectively silenced Tessa through the subtle and implicit reference to disciplinary action, which acted to remove the opportunity of her declining, and therefore, removed any ability to exercise control. Indeed, other nurses had colleagues who had felt that they had been overtly 'bullied' into being redeployed.

Other examples demonstrated the challenges of speaking up or questioning redeployment included Amber, who felt as if her attempts to express concerns about children's nurses being redeployed to adult areas were futile:

So if I had any concerns at all and I tried to voice (them), I think it would have fallen on deaf ears. So I did send an email about the fact that I didn't feel that it would be appropriate that I (as a children's nurse) would be sent out and basically I don't think anybody really cared. I think basically you would be expected to go ... I can't remember what my response was that I got, but I remember thinking that was pointless me even sending that email out, but I did send an email out saying that I really didn't think it was safe if potentially I'd be sent to the adult ward. (Amber, Children's nurse)

Amber's experience of feeling ignored provides another example of how redeployment was handled which in this case was to disregard her concerns, leaving her feeling hopeless even when redeployment was presented as potentially harmful, unsafe or inappropriate.

Some of the nurses we spoke to did say that they volunteered to be redeployed, although their 'choice' to volunteer was made because they perceived it was their moral duty as nurses to do so. Volunteering to be redeployed was more usually referred to in terms of it being the 'right thing to do':

I definitely felt it was the right thing to do [...] I don't know if there was any other way to do it. We had, there were so many patients that needed looking after. (Rachel, redeployed not to ICU)

Rachel highlighted the need for her to opt into be redeployed as she describes no 'other way to' tackle the first wave of COVID-19. Ellie, in the example below decided to volunteer, having previously had some ICU experience before the pandemic, so as to mitigate being ordered:

I did volunteer to go back rather than, you know, being ordered to because I felt like, you know, I have experience. It's going to be horrible for everybody, I may as well use the skills I have to try and help out. (Ellie, redeployed to ICU)

While some of our participants volunteered to be redeployed, as noted above others were left feeling a sense of futility, or in some cases fearful and threatened at how redeployment was managed by their line managers, with little choice or agency. Overall, the citing of pandemic policies, codes of conduct and the degree to which nurses felt heard (or not) led to many nurses feeling like they had to suffer in silence.

## 4.2 | Risk tolerance and avoidance: Consequences of speaking up

Prior to COVID-19, research indicated that speaking up, or in more extreme circumstances, whistle-blowing, can make a difference is a key antecedent to raising concerns (Gagnon & Perron, 2020). Participants from our study indicated that this trust, both in nurses' action of speaking up, and in the NHS system to respond/ change, was largely not present during the pandemic. Nurses in our study indicated that while they wanted to speak up, they felt professionally at risk if they were to raise issues. While some nurses felt able to do so in spite of this risk, others avoided doing so. In the extract below, Tilly describes the internal conflict she weighed up the impact that speaking up would have on her:

And I think that is my main issue, is that if I had whistleblown, I would have been considered a problem, and it's not that I particularly want to go further in my career, but people are then wary of you. You become the problem, and if I felt it was going to make a difference...I do want the very senior leaders to question behaviours and I don't think the organisation does. I think there's a lack of curiosity (...) (and) in the last 2 years there's a plethora of emails that go - there's lots of evidence, I have got lots of evidence of behaviours which I think are totally unacceptable (...) but without a curiosity from the organisation then where do you go to with it? And I think that's a really uncomfortable place to sit (...) (and) all of my old team (...) (are) all trying to look for new jobs. (Tilly, Clinical Commissioning Group worker)

For Tilly, the professional risk and her continued employment in the NHS outweighed the risks associated with speaking up despite her

desire for change, demonstrating quiescent silence because of the fear of consequences in doing so. Other participants felt a sense of futility, similar to that demonstrated in our first theme, with nurses feeling like their concerns were falling on deaf ears. This also created an internal conflict about doing the right thing, as demonstrated in Sandra's extract below:

I have to look after myself and my team going in there [...] it's a difficult one, isn't it? Because you, kind of, you know, you can see how people that do whistleblowing or whatever are, well, how much do you push and how much do you just say well, you know, you can't change the world? [...] I think it's all very well, you know, that the nurse leaders were often accused of not speaking up or not doing this, but actually, there's a lot of people not hearing what's being said. People are speaking up, and it's falling on deaf ears. And it's something to do with nurses not being listened to and heard, I think. (Sandra, redeployed to ICU)

In the first part of this extract, Sandra appears to suggest that whistle-blowers may not be treated well as a consequence of their speaking up. Sandra also reflects not only on the difficulty in wanting to protect her team, but also not knowing whether change will happen as a result of her speaking up or not.

For some, speaking up was described in terms of a 'moral duty' which would help to ensure the best care for patients. Lara, for instance, spoke about the necessity of speaking up to inform her (largely absent) managers, yet hints at the risks to herself or her career:

Unless people do speak up and say what the problems are, our management aren't going to know because they're not coming near the patients. They're sitting in their little ivory towers, and they've got no idea what it's like. So yeah, I think you've actually got a moral duty ... a professional duty as well to speak out. But it doesn't win you any favours. (Lara, ICU bank nurse)

Some of the participants in this study were students when the pandemic began. One student, Sephy, who had multiple placements during the pandemic raised concerns about different practices in varying locations. On a mental health ward Sephy, with another student, raised concerns about some of the practical things that were happening there, although he was very concerned that he might fail his placement for doing so:

It was challenging at the time, especially because of the main person who we felt was not acting correctly was both of our practice assessors so it made it feel quite unclear whether we'd pass okay through the placement and that sort of thing. (Sephy, student nurse)

The opportunity of not passing their placements and ultimately their degrees, potentially putting at risk their nursing careers, was superseded by the need to speak up about the risk to patients, which in this case was responded to professionally and acted on. However, overall, the consequences demonstrated in this theme such as risk to professional reputations, being stigmatized or failing assessments problematically individualizes speaking up, placing the responsibility and burden of doing so on the individual doing the speaking.

### 4.3 | Deafness and hostility: Responses to speaking up

There was a sentiment repeated by many, but not all, of the nurses we spoke to who complained either about managers and doctors not entering wards, or GPs verifying deaths via video calls, due to contagion fears. Some staff felt that their line managers in particular were absent and hard to get helpful responses from, as discussed by Tessa (who was redeployed to ICU) in the extract below:

I think the thing I found hardest was having no visible line manager for 3 or 4 months. I was literally dismissed. I was called into the office, dismissed. It was like, "Right, go and report now." Any question I asked was met with, "Ask intensive care, ask them." And I didn't even know if my line manager was still my line manager. I asked questions, nobody could answer them. I think there were hundreds of staff redeployed to Critical Care at that time. The senior staff didn't seem to know what the heck to do with people, and so the information was really patchy ... It was like you were a resource moved from one place to the next and nobody was invested in your welfare at all. It was like they were just too overwhelmed to cope with the niceties, but the problem is the niceties seem to be quite essential now. I was struggling with the PPE. They had done mask fit testing for all their staff, and when we got there, I asked on the first day, "Will you be arranging mask fit testing?" "No, we're not bothering anymore." I said, "Well, why?" "Because the masks we get are different every day so there's absolutely no point. And there's no one to then say, "Is this right or wrong?" (Tessa, redeployed to ICU)

Tessa discusses her experience as one of being a resource, one that was directed from pillar to post without niceties or answers. She attributes this to stress and being overwhelmed in the management team, but the knock-on impact of this left her feeling dismissed and uncertain.

When managers were present, other participants also mentioned having their concerns disregarded and ignored, or having their concerns disrespectfully responded to such as being shouted at. For example, Edie, a care home worker, described raising concerns with her

managers about not separating COVID-19-positive residents from negative ones:

[I was trying to be] the best nurse I could be. I still felt I let myself down because, you see, I spoke out, but I didn't speak out enough [...] I feel I should have spoken out more, and I know I said some things, but I'm so scared of people shouting, I'm not really good at that, being shouted at and she was so mouthy and didn't listen. (Edie, care home nurse)

Edie blamed herself for not being able to effectively speak up which may have led to a change in practice and a lessening of contagion risks for patients. She carried this guilt with her, as in her further narrative she went on to explain how she believed infection numbers had risen due to patients not being separated by COVID-positive status in the care home during the first wave. However, being shouted at, presented an uncomfortable professional environment for her, one where she felt unheard and afraid, the opposite of feeling psychologically safe.

In other instances, staff were met with 'deafness' as opposed to active hostility. Sephy, who in the prior theme had experienced a successful response to his speaking up referred to another instance where he had raised concerns, this time alone, in a different setting. These concerns were not acted on:

[on a stroke ward] I spoke to them a bit about why they were keeping the fluid thickener by every patient's bedside within the patient's reach and that's a massive patient safety thing. If the patient consumes it there's a fair chance they'll die. Obviously, people who have strokes are quite cognitively impaired a lot of the time and at one point I found one of my patients trying to thicken her own drink because there was no staff available and hadn't been for a long time. She was very thirsty and she'd poured about half the pot of thickener into her drink and was kind of trying to stir it in with one hand and I was just like what is going on here? I spoke to one of the occupational therapists about it and she just kind of went, "Yeah, but that's what they're like on that ward and there's nothing really you can do about it." I spoke to some of the other nurses and they just ... yeah, didn't really seem to bother them. (Sephy, student nurse)

Sephy's safety concerns here were ignored and, like other participants in our study, he did not know how to escalate his concerns to a satisfactory conclusion. This could have been because of his position as a trainee and therefore not having access or knowledge to other networks intended to facilitate speaking up. Conversely, when Amie, an established and experienced care home manager, felt ignored by her managers, she sought other, more responsive avenues through which to be heard, including the national media. However, Amie then encountered extreme hostility in her organization, being called into

formal meetings with senior leaders, which she rationalized as a stress response from management:

I think she, like everybody, felt under pressure because of COVID and the first wave and none of us knew what we were doing and we were all firefighting and I think that by me being in the media and saying some of the things that I said, all which was true, but I think she found that very difficult to cope with and apparently MPs were phoning her and saying, "Shut this woman up and what do you think she's doing," so I think she found it all very difficult. (Amie, care home manager)

The lack of response to Amie's initial concerns from management led to her speaking up despite being warned (by management) against raising her concerns with the media. The response from management, however, was an attempt to 'shut her up' and silence her. There were other examples of this behaviour, reported by Amanda (a care home nurse) who was also warned about talking to the media during the first wave, and was told to sign a non-disclosure 'waiver':

Right in the beginning when I was saying to you the 11 [deaths from COVID-19] in 9 days, and then it quickly jumped to 22 [deaths from COVID-19], we had TV crew right outside our gates. And we were told, I think we got a letter, or we had to sign something, I can't quite remember but it was definitely something in writing that we are not to speak to anybody at all about this (...) Not on social media, and we were warned that journalists might actually come behind us down the road, might even follow us in our cars to try and get information. So, we were probably effectively bullied from the top down on that because, you never know with this whistleblowing, and taking information out there, you know? I mean, is it wrong? Or is it right? But we had no choice with that because we were just strictly told not to speak to a single sausage about it, and I guess, in effect, that was a bullying thing really. (Amanda, care home nurse)

Amanda shares how, in being asked to sign a non-disclosure waiver, she was effectively silenced which left her feeling bullied, echoing issues in our first theme.

We found however that on rare occasions, nurses found their management teams to be receptive and responsive to staff concerns, as demonstrated by Saffron, a very senior nurse:

I have to say in this Trust and even the experience I had, I think the leadership in the hospital's been such good quality that, even when nurses were redeployed or were working in other areas, I mean, there were



moments, you know, but mostly we managed that really well. I did have one nurse who was redeployed and just said, "I can't," and then came back and said, "I can't," and I was like, "Of course you can't. If you can't, you can't." The Trust heard that and there was no more pressure on her. (Saffron, hospital-based nurse)

When speaking up was responded to appropriately, nurses described instances of being able to affect positive change as a result. Mia, a community nurse, referred to raising issues during the early stages of the COVID-19 pandemic. Below, she reflects on a dispute she and her colleagues encountered with her managers when PPE was first issued and they were directed to don (put on) PPE when inside a patients' house. Here, she explains that using published guidance from the NMC and the RCN helped her to escalate her concerns and feel heard by managers:

If you were on a building site you wouldn't be allowed on without your hard hat and your boots, you wouldn't start putting your protective gear on once you're in the risk, you do it before you go in the risk. So, we had a few issues. The NMC, and I think the RCN, all did publish to say that they were in support of nurses using their own judgements. So, we kind of, we sort of used that to our management and we said, well, you know, 'No!'. You know, we did stand our ground as a night service and then eventually it was changed but that was sort of like that was like a good week of an issue that we didn't need [...] Do you know what I mean? (Mia, community nurse)

Other nurses spoke of raising issues that had particularly angered them, even though they were not directly affected by these issues. For example, Sandra recounted how she spoke out on behalf of her colleagues about free parking to shorten their long working days, and to ensure that they felt valued again:

It took a few weeks, but they did say staff can park at the hospital, and now they've said, "Only if you have got staff parking again", even though all the public car parks are empty. And I think that just shows how short-lived that gratitude is, now that everyone that can work from home has come back into work, suddenly the clinicians that have had to be there throughout have to walk again. If you're doing a 12 and 1/2h day, now it's light probably at 9 o'clock, but otherwise you're walking home in the dark and you're having to come home next morning [...] I've got a parking permit, but I feel really incensed for my colleagues that we're the heroes and now they have to walk to work [...] So I've written on behalf of my colleagues to the RCN and to the Chief Exec and stuff. (Sandra, redeployed ICU)

In her second interview, Sandra was able to confirm that her action had been successful, and the issue of parking for all staff had been resolved. She was celebratory about this, although she downplayed the extent to which she personally had been responsible for the change. Mia and Sandra's positive experiences of being able to effect change on issues during the pandemic were, however, in the minority. Despite this, it appears they were heard perhaps because of the scale of the issue, that is, affecting more than one person, transforming a concern into something not only voiceable but also capable of being heard and acted on.

## 5 | DISCUSSION

Findings from our study demonstrate that many staff reported feeling a sense of futility in raising concerns (acquiescent silence) or fearful of the consequences of doing so (quiescent silence). Some concerns, such as those affecting larger numbers of staff or patients, may feel easier to speak up about. However, this does not necessarily lead to them being heard. There were a few examples of concerns being heard and acted on, but far more data reported the difficulties, lack of voice and agency and a 'deaf' response.

Findings from our study indicate that even during a pandemic, both speaking up and being heard remain problematic. This reflects a key finding from our study indicating how nursing staff typically speak up about working conditions such as redeployment in this instance, rather than speaking up explicitly about patient safety. That working conditions are considered a 'voiceable concern' (Dixon-Woods et al., 2022, p. 2) concurs with previous literature on speaking up, whereby nurses have focused on the nature of their roles in relation to structural and workplace culture issues such as workplace bullying rather than patient safety concerns per se (Jones et al., 2022). This could be because working conditions are easily recognized and agreed on as concerns, and also that they are systems-based, and affecting more than one person. As Dixon-Woods et al. (2022) indicate, having a concern that can be defined, with shared language and understanding, may make it easier to communicate. By their very nature, patient safety concerns may involve more uncertainty and so may not be so easily identifiable or their solutions agreed on (Bosk, 2003).

Participants in our study appeared to demonstrate different forms of silence. For example, those threatened with job loss or other negative consequences may more likely to exhibit quiescent silence whereby, despite disagreeing with, for example, how redeployment was handled in some cases, they did not speak up for fear of what might happen to them (i.e. suffering in silence). Other participants felt a sense of resignation, reflecting acquiescent silence. Individuals are much more likely to demonstrate acquiescent silence when they do not feel their opinions will be valued by line managers or supervisors, which was frequently expressed by our participants. In some cases, the invoking of codes of conduct, disciplinary measures and the threat of job loss, seemed to be enacted by those in authority to force compliance, causing staff to feel bullied

and effectively minimize, withdraw or withhold their views. While silence may reflect a difficulty among some staff in transmitting their concerns, it also points to the intended audience's response (Mannion et al., 2018). For example, those who did speak up often encountered forms of hostile leadership, for example, shouting at staff or bullying which, as evidence indicates, is ineffective and counterproductive (Limb, 2021).

Extant research suggests that silence, in the form of not raising views, questions and/or concerns can greatly inhibit psychological safety and thus the detection of errors (Edmondson, 1999), marginalize minorities (Newheiser & Barreto, 2014) and impact staff well-being negatively, including staff mental health (Knoll, 2021). Feeling ignored by managers and their organization can reduce nurses' feelings of commitment to the organization and increase the risk of stress, burnout and intention to leave (Kinman et al., 2020). Thus silence, whether by choice or not, can cause feelings of anger, stress and resentment (Knoll, 2021). While our data cannot depict causation, many staff have since left the NHS with workplace culture being cited as one of the top four reasons for leaving the NHS (Palmer & Rolewicz, 2022).

The fact that staff experienced hostility, bullying and an overall feelings of being ignored also indicates that speaking up and being heard does not occur on a level playing field. Those wanting to speak up may be faced with navigating specific power dynamics in their workplace, amplified by the very nature of a hierarchical environment in healthcare settings (Umoren et al., 2022) or the unpredictability of the hearer's response (Niederhauser & Schwappach, 2022). Indeed, Mannion et al. (2018) highlight the courage required not only for those speaking up but also by those hearing concerns to accept and act on concerns. Actions derived from the active hearing of concerns may involve challenging colleagues, changing routines, redirecting resources and speaking up to higher authorities, all of which bring risk and exposure.

We argue that we now need to turn our attention towards interventions that may support the multifaceted nature of not only speaking up but also hearing and acting on that which is heard, effectively and appropriately, in the NHS as a way of retaining staff. While some interventions already exist (see, e.g. Jones et al., 2022), none of our participants talked about using the Freedom to Speak Up Guardians, or any other mechanisms of available support for raising concerns, including among those expected to hear and respond to them. This needs to include consideration of how all levels of an organization need to be prepared to both speak up and respond to concerns (Violato, 2022). Timing, tone of voice and power dynamics, as well as organization culture and evidence are likely to affect the way in which space is held for communicating and hearing concerns (Dixon-Woods et al., 2022; Mannion et al., 2018). Educational interventions or training programmes that seek to upskill staff with effective communication strategies including both in terms of speaking up and listening, particularly during times of crisis or stress, are important to consider. Co-designing interventions across different grades, levels of seniority and workplace hierarchies may help to reduce instances of the deaf-ear syndrome and enhance organizational

responses to concerns, especially nurses' safety and workplace experiences during a global pandemic.

## 5.1 | Limitations

While we sampled for a range of voices and experiences in our participant quota, this was an opt in study and ethnic minorities numbers remain underrepresented. Future research would benefit from exploring whether experiences of speaking out and the associated actions required to respond appropriately differ, depending on who is doing the speaking.

## 6 | CONCLUSION

The COVID-19 pandemic has had a significant impact on the working lives of all healthcare staff, particularly those working on the front line such as nurses. During COVID-19, nurses have frequently encountered working environments that have given cause for significant concern including PPE, patient safety and being redeployed at short notice. The range of accounts presented in this article demonstrate that, while some nurses felt able to speak up, many encountered a 'deaf' or hostile response, leaving them feeling disregarded by their place of work. Nurses also felt fearful about consequences, such as being threatened with the NMC code of conduct and tended to engage in quiescent silence (i.e. suffering in silence). Others felt silenced through feelings of futility and resignation, reflecting acquiescent silence. Both instances demonstrate organizational missed opportunities to learn from the nursing workforce about how to improve their response to current and future pandemics. Exploring the demands placed on those hearing concerns, including the resources required to respond, both at the psychological and organizational level, such as having the courage to act (or not) is now necessary. Both effective communication skills and appropriate responses are needed to construct successful speaking up interventions that address power dynamics at play in the workplace, especially in times of a global pandemic when the need for openness and transparency in health systems may be at its greatest.

## AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE): (1) substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content.

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## CONFLICT OF INTEREST

No conflict of interest has been declared by the author(s).

## PEER REVIEW

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## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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## SUPPORTING INFORMATION

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