



Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

Understanding Healthcare Professionals' Experiences of Ethical Leadership and
Whistleblowing Decisions

Module: Research Principles and Philosophy (LCDB7007)

Module Lead: Dr Caroline Jawad

Student Name: Mahmuda Aktar Chowdhury

Student Id: 2511849

Table of Contents

1. Background and Context.....	4
2. Research Problem Statement	5
3. Research Questions/Objectives	6
4. Significance of the Research	7
5. Literature Review	8
5.1 Defining Ethical Leadership in Healthcare	8
5.2 Ethical Leadership Models and Frameworks	9
5.3 Whistleblowing in Healthcare.....	10
5.4 Barriers to Whistleblowing	11
5.5 Psychological Safety.....	11
5.6 Psychological Safety as a Mediating Mechanism Between Leadership and Whistleblowing	12
5.7 Healthcare Organisational Culture and the Speaking-Up Climate.....	13
5.8 Synthesis and Research Gap	13
6. Theoretical Framework.....	14
6.1 Ethical Leadership Theory	14
6.2 Psychological Safety Theory.....	15
6.3 Social Learning Theory	15
6.4 Moral Identity Theory	16
6.5 Theoretical Integration	16
7. Conceptual Framework.....	17
7.1 Ethical Leadership	17
7.2 Psychological Safety as a Mediating Construct.....	17
7.3 Whistleblowing Intentions and Behaviour	17
7.4 Healthcare Organisational Culture as a Contextual Layer	18
7.5 Relationships Within the Conceptual Framework	18
7.6 Justification for a Qualitative Conceptual Framework	18
7.7 Contribution of the Conceptual Framework.....	19
8. Research Methodology	19
8.1 Paradigmatic Foundations	19
8.1.1 Interpretivism as the Guiding Paradigm	20
8.1.2 Ontological Position: Relativist Ontology	20
8.1.3 Epistemological Position: Subjectivist Epistemology	21
8.1.4 Axiological Position: Value-Laden Inquiry.....	21

8.1.5 Implications of the Paradigmatic Position for Methodological Choices	22
8.1.6 Alternative Paradigmatic Positions Considered.....	22
8.2 Creswell’s Five Approaches: Comparative Analysis	23
8.3 Research Design and Methods	23
8.4 Trustworthiness Criteria	24
9. Ethical Considerations.....	24
10. Limitations	25
References	28

1. Background and Context

Ethical leadership as a fundamental organizational phenomenon has recently become an urgent priority, especially given the consequences of failed leadership in healthcare settings where good and bad practices affect not only patient outcomes, but also professional reputation and public confidence (Keselman & Saxe-Braithwaite, 2020). While the importance of ethical leadership has been established in shaping organizational culture and creating an environment conducive to professional behavior elsewhere in contemporary organizational studies, its relevance within healthcare deserves special attention, given the high-stakes factors involved and the emotionally charged environments in which medical decisions are made. Ethical leadership in healthcare organizations entails more than compliance with such structures; it serves as a basic process through which leaders structure moral agency, show that they can be trusted to be fair and open, and contrive institutional conditions under which clinicians can emphasize patient safety or professional values over competing interests or organizational convenience (Elhihi et al., 2025).

Whistleblowing (the disclosure by an organization member of wrongdoing in the organization) has a long tradition and has been reported in numerous public inquiries into healthcare and regulatory reviews as playing a key role in uncovering patient harm and failure within organizations. Further cases, such as the Bristol heart scandal, Shipman murders, and Mid-Staffordshire NHS Trust scandals, confirm that excessive harm is caused by normal organizational procedures failing to deal with serious risk, which whistleblowers try to expose (Fox, 2001; O'Neill, 2000; Holmes, 2013). However, despite this acknowledged requirement, the healthcare industry has never managed to fully overcome what researchers describe as “cultures of silence,” which are defined by hierarchical and autocratic systems that stifle discussion due to fear of reprisals or institutional unwillingness to maintain an open dialogue on safety issues (Mannion & Davies, 2015).

The association between ethical leadership and whistle-blowing intentions has only recently become a focus of empirical investigation. This mirrors recent research showing that ethical leaders who demonstrate trustworthiness, integrity, and accessibility foster environments where there is psychological safety, a belief that you can express concerns without retribution or embarrassment. This ‘psychological safety’ functions as a key mediating factor that allows health workers to turn ethical duties into acts. Healthcare workers who perceive ethical leadership have increased moral agency and are more likely to voice concerns surrounding unsafe/unethical

behaviour. Alternatively, in hierarchy-bound settings where access to leaders is limited and candid responses are punished, and despite professional responsibilities to do so, healthcare workers remain silent.

It remains less clear, however, how healthcare professionals personally experience ethical leadership in a subjective sense or how such ‘lived experiences’ may be shaping their reasoning on whether to whistle-blow. This lacuna between established empirical relationships and human understanding of moral phenomena constitutes a critical gap for organizational ethics research, especially the interpretive complexity of ethical decision-making in healthcare.

2. Research Problem Statement

While there is widespread agreement on the need for whistleblowing in order to ensure patient safety and organisational accountability, paradox lies at the heart of healthcare practice. Trained healthcare professionals find themselves repeatedly observing unsafe or unethical conditions, and yet they often choose to remain silent. This institutional silence is not indicative of incompetence or indifference among healthcare workers; rather, it is a rational response to systemic obstacles that are woven into the fabric of hierarchical health systems and organisational cultures where openness is discouraged. The reluctance to report is found to involve several inhibitory factors, including fear of reprisal against one's professional reputation and career opportunities; perception of a lack of organizational support for reporting internally; uncertainty about the appropriate means through which to make reports, especially in cases of interprofessional misconduct or incompetence; and the existence of considerable power imbalances among health professionals generating personal risk when subordinates attempt bringing attention to superiors' conduct.

Although empirical research has documented that ethical leadership is related to higher levels of whistleblowing intentions and behaviors of nurses and healthcare employees, there remain significant voids with respect to the underlying psychological and attitudinal processes through which ethical leadership shapes reporting decisions among these individuals. Existing literature has largely relied on quantitative correlational designs that observe variables, including mediating pathways such as psychological safety; however, the qualitative construction of how healthcare workers make sense of ethical leadership and enact this through whistleblowing intentions is still

underdeveloped. In addition, the focus of research in this domain has been disproportionately on nursing staff above those of doctors, allied healthcare professionals, and managers.

Importantly, we have little understanding from the literature as to how specific contextualized meanings (that is, interpretations of leader fairness, moral mandate, approachability, and trustworthiness) professionals attribute to ‘ethical leadership’ impact on their subjective evaluations of organizational safety and therefore their decisions to speak up. At the same time, relatively few studies have considered how organizational and hierarchical obstacles interact with, or even trump, individual leader ethical behaviors in curbing healthcare whistleblowing behavior.

This research challenge arises from the basic realization that any improvement in patient safety is unlikely to proceed if it does not consider the phenomenological groundings and constraints surrounding the ethical experiences and judgment of health care professionals. The current failure to understand how ethical leadership experiences relate to whistleblowing intentions is a core opportunity to research aimed at advancing ethically robust organizational cultures that authentically support healthcare professionals in meeting professional obligations to patients and the public.

3. Research Questions/Objectives

Aligned with the interpretivist paradigm, this research aims to understand the contextual meanings of ethical leadership and whistleblowing intention in healthcare scenarios. The central research questions are:

1. How do healthcare professionals interpret and experience ethical leadership in their workplace?
2. What meanings do healthcare workers attach to whistleblowing decisions?
3. How do healthcare professionals describe the relationship between their leadership experiences and their willingness to report concerns?

The objectives of the study are:

1. To explore healthcare professionals’ perceptions regarding ethical leadership in their workplaces.

2. To understand the meanings the healthcare workers associate with whistleblowing decisions.
3. To examine how healthcare professionals experience the interplay between leadership, psychological safety, and decisions to report concerns.

4. Significance of the Research

This study fills several gaps across academic, analytical, and practical domains that are underserved in the existing organizational ethics, patient safety science, and healthcare leadership research. First, the academic contribution is significant. Academic literature on ethical leadership and whistleblowing has reached maturity, but interpretationist epistemology to these constructs represents a departure from the objective measurement methodologies typically applied to this evidence. Specifically, most quantitative investigations treat ethical leadership either as a measurable, objective, factual variable with clearly identifiable organizational outcomes or as a personal trait that individual leaders have or lack. Rather, this study treats ethical leadership as a socially constructed variable whose definition and implications are context-dependent, with a meaning constructed and assigned by healthcare professionals based on their organizational history, professional socialization, and personal sensemaking processes. This approach thus adds much-needed theoretical depth to the understanding of how abstract concepts like “ethical leadership” or “psychological safety” are actually experienced by heterogeneous groups of healthcare workers in complex, dynamic organizational systems and is firmly grounded in prior theoretical and empirical work. Secondly, the analytical contribution is unique and allows testing of how the constructs linked to ethical leadership are experienced by those who are exposed to it. As explained, the principal-agent problem is not a useful theory for this analysis, as it is one-size-fits-all about leader behavior’s intentions, is applied to many scenarios, and does not suggest any passive mechanisms through which it unfolds. By gaining insights into how healthcare professionals make meaning of their ethical leadership experiences before deciding to report wrongdoing or not, this study expands organization theory’s reach into how leader behavior can either inhibit or enable followers’ ethical agency in professional contexts. This study has implications for organizational administration and associated fields that study the significance of sound leader behavior and an ethical workplace context on employees’ ethical agency, conduct, and purposive work attitudes.

5. Literature Review

5.1 Defining Ethical Leadership in Healthcare

Ethical leadership has begun to develop as a separate and multidimensional construct in organizational settings, especially in healthcare, where medical decisions such as these have significant consequences for patient care and the integrity of the institution. The influential definition of Brown et al. (2005) articulates ethical leadership as "the demonstration of normatively appropriate conduct through personal actions and interpersonal relationships, and the promotion of such conduct to followers through two-way communication, reinforcement, and decision-making". This notion contrasts starkly with previous concepts of leadership as charismatic or visionary in nature and locates the practices of ethical comportment and moral exemplarity at the centre of how leadership is conducted.

In healthcare institutional settings, this definition structure serves as a framework for understanding how leaders develop credibility, trustworthiness, and the institution's integrity. According to Treviño et al. (2000), ethical leaders are exemplary role models who are, at minimum, (a) altruistic and caring; (b) honest and trustworthy; and (c) advocates for the needs of the group. This perspective highlights that both intrapsychic attributes of the leader (honesty, integrity, moral reasoning) and interpersonal behaviors that express values and build relational trust with organizational members are at play in ethical leadership (Din & Zhang, 2023; Sosik et al., 2018; Gerpott et al., 2017; Zheng et al., 2021).

At an operational level, ethical leadership in health care takes the form of specific behavioural dimensions that health care workers see and assess as a function of their day-to-day interactions with leaders (Barkhordari-Sharifabad et al., 2017; Alo et al., 2022; Varga et al., 2023). These aspects are related to the demonstration of transparency in decision-making, adherence to professional code(s) of ethics, fair treatment across levels within organizations, true interest in the well-being of patients and staff. The healthcare environment, in particular, calls for ethical leaders to place patient well-being over administrative expediency and grounded decisions in evidence-based practice while being accountable to a variety of vested parties, clinicians, patients and family members, and regulators (Denier et al., 2019; Engle et al., 2021).

Importantly, ethical leadership ought to be considered separately from other related constructs in the leadership literature. Whereas transformational leadership highlights visionary inspiration and intellectual stimulation to motivate followers towards challenging organizational objectives, ethical leadership serves as a lens for examining the moral content of leadership behavior itself, particularly in terms of how leaders exemplify and encourage normative conduct. Similarly, although authentic leadership (focus on leader self-awareness, relational transparency, and balanced decision-making) shares the ethical dimension of ethical leadership, it puts in the forefront to lead via a sense of integrity of the person himself or herself rather than his or her effects on others. Servant leadership, however, which has service to followers' growth and well-being as its central focus, prioritizes follower-centered outcomes. Ethical leadership, although perhaps compatible with these practices, is distinct insofar as it emphasises the leader's active responsibility for helping to shape organisational ethical norms and defining expectations of behavior.

5.2 Ethical Leadership Models and Frameworks

Modern considerations of ethical leadership more and more refer to social learning theory and moral identity theory as the underlying psychological processes through which leaders can shape followers' ethical attitudes and actions. According to social learning theory, people learn behavior patterns and values through observational learning that leads to the modeling and imitation of credible role models. If translated to ethical leadership, this perspective posits that when leaders repeatedly exhibit moral virtues, i.e., trustworthiness, caring, fairness, honesty, openness, and social interest, employees learn the virtue of being moral through their direct perceptions and impersonation of the leader as a morally virtuous role model. Social learning theory suggests that organizational commitment to ethical behavior must be seen as having consequences (i.e., rewards and punishments) so that followers can understand this and anticipate the consequences. In health care settings, this means leaders must praise ethical behavior in public; punish unethical behavior at all levels of the organization; and articulate frequent compelling messages about ethical behaviors/values.

Moral identity theory extends social learning models of moral development to explain how ethical leadership helps shape followers' self-views as they relate to moral values. The moral identity

relates to "the degree being a moral person is an aspect of the self". Upon repeated exposure to ethical leadership, followers' moral identity becomes more deeply internalized and highly accessible, impacting the manner in which they make decisions or interpret situations from an ethical perspective. This is particularly salient in healthcare, where it has been argued that the internalization of such consideration takes them out of the realm of externally applied mechanisms to one of professionally held identities.

5.3 Whistleblowing in Healthcare

Whistleblowing within the healthcare domain refers to the actions taken by healthcare practitioners to disclose unsafe, unethical, or unlawful practices that compromise patient safety, professional integrity, or public trust (Elsehrawy et al., 2025). Unlike whistleblowing in diverse corporate environments, healthcare whistleblowing is substantially intertwined with professional ethics, clinical accountability, and a moral duty towards patients. Regulatory frameworks governing healthcare typically mandate the reporting of hazardous practices (Kassim, 2017).

The existing body of literature delineates a distinction between internal and external whistleblowing. Internal whistleblowing issues are addressed within the organizational context. On the other hand, external whistleblowing entails contacting regulatory bodies, professional associations, or the media (Yeoh, 2014; Kampourakis, 2020). Within the healthcare sector, policymakers fervently promote internal whistleblowing. However, numerous high-profile inquiries, such as the investigation into the Mid Staffordshire NHS Foundation Trust, have illustrated that internal mechanisms frequently fail to protect individuals who express concerns, culminating in retaliation, detrimental career impacts, and psychological distress (Lampard, 2024).

Recent empirical studies suggest that healthcare professionals often opt for silence, even in the face of identifiable threats to patient safety. Research conducted in the UK, Europe, and Australia demonstrates that apprehensions regarding retaliation, reputational damage, and professional isolation substantially inhibit intentions to engage in whistleblowing (Khan et al., 2022; Oyewunmi & Oyewunmi, 2022). This tendency toward silence is particularly pronounced among junior staff, nursing personnel, and temporary or internationally recruited workers. This highlights the influence of power disparities and precarious employment conditions within healthcare systems (Ismail & Harvey, 2025).

5.4 Barriers to Whistleblowing

Studies of whistleblowing in health care consistently find that the main obstacle to reporting concerns is the fear of retaliation (Vian et al., 2022). Retaliation can manifest itself subtly through social exclusion, negative performance evaluations, and discrimination in career evolution, but also more directly as punishment and loss of employment (Hennequin, 2021). But, importantly for their impact in preventing voice behaviour from occurring altogether, such retaliation need not actually occur; rather, the perceived risk of it suffices to disable those who would otherwise engage in voice. However, most studies frame barriers individualistically (fear, moral courage) rather than examining how organisational systems actively produce silence through inadequate Freedom to Speak Up policy implementation (Mannion & Davies, 2015).

Organisational studies have elucidated the phenomenon of ‘normalisation of deviance’ at work, which sees risky practices as routinised and ethically neutralised (Entwistle & Doering, 2023; p.353). In these conditions, whistleblowing is recast not as the act of courage that it is, but rather as behaviour akin to subversion or disloyalty. This cultural transformation has been particularly apparent in the high-stress healthcare milieu, characterized by staff shortages, performance indicators, and persistent resource constraints (Zimmermann, 2025).

Notably, a large part of the early literature on whistleblowing took an individualist perspective and engaged with traits such as personal bravery or moral fortitude (Olesen, 2021). Current work is questioning this perspective, arguing that whistleblowing should be seen as an organisational and relational phenomenon, influenced by leadership interaction, team culture, and the perceived ‘psychological safety’ (Filiz & Blenkinsopp, 2025).

5.5 Psychological Safety

Psychological safety is conceptualized as a collective belief that the professional environment fosters interpersonal risk engagement, encompassing the expression of concerns, admission of errors, or confrontation of ethical dilemmas (Edmondson, 1999). Within the context of healthcare, psychological safety has emerged as a critical construct connecting leadership behaviors to patient safety outcomes, the reporting of errors, and the cultivation of learning practices (Wawersik et al., 2023).

Healthcare settings are particularly vulnerable to a decline in psychological safety due to entrenched professional hierarchies, significant authority differentials, and entrenched cultures of blame (Siad & Rabi, 2021). Empirical evidence suggests that when healthcare practitioners perceive a deficiency in psychological safety, they exhibit a marked reluctance to report errors, challenge unsafe practices, or articulate ethical concerns, even in circumstances where patient harm is probable (Grailey et al., 2021).

Recent systematic reviews have demonstrated that psychological safety is positively associated with voice behavior, team learning, and patient safety indicators across diverse clinical environments (O'donovan & McAuliffe, 2020). However, the existing literature cautions against interpreting psychological safety solely as an individual perception; instead, it is increasingly recognized as a socially constructed climate that is contingent upon leadership dynamics, varying across distinct teams and organizations.

5.6 Psychological Safety as a Mediating Mechanism Between Leadership and Whistleblowing

An increased volume of academic research emphasizes that psychological safety is a crucial mediating variable for the effect of leadership behavior on speaking up and whistleblowing. Leadership that demonstrates ethical values, such as fairness, transparency, integrity, concern for others' well-being, has proved to foster psychological safety by communicating the importance of contribution to discussions and also non-retaliation (Liu et al., 2023).

These beliefs have been subject to increasing empirical scrutiny in health-related contexts. For example, Frazier et al. (2017) explain that leadership inclusiveness significantly predicts employee voice through its effects on psychological safety. New studies in the healthcare sector suggest that ethical and inclusive leadership styles indirectly affect whistleblowing intentions by affecting perceptions of safety and trust (El-Gazar et al., 2024).

Although we have made progress in understanding the dynamics of whistle-blower retaliation, many current studies employ quantitative, cross-sectional methods, which are unable to capture the lived emotions or richness of psychological safety within a whistle-blowing context. Psychological safety is usually measured as a score. This is unhelpful in communicating how

health professionals understand safety, fear, and moral risk on the ground (O'Donovan & McAuliffe, 2020). This points to a major gap that exists in the literature, given evidence of people rating moderate levels of psychological safety yet remaining voiceless in ethically problematic situations.

5.7 Healthcare Organisational Culture and the Speaking-Up Climate

Healthcare organizational culture exerts a profound influence on the propensity for whistleblowing behavior. This culture encompasses collective norms, values, and assumptions that specify which behaviors are deemed commendable, acceptable, or subject to sanction (Steers & Sánchez-Runde, 2017). Empirical studies consistently reveal that cultures that emphasize performance metrics, reputation management, and professional loyalty are likely to suppress whistleblowing, whereas those that prioritize learning promote open communication and transparency (Rustiarini et al., 2021).

Contemporary healthcare scholarship critiques the persistent existence of “toxic resilience” cultures, in which employees are compelled to endure systemic failures without vocalizing their concerns (Towey, 2023). Within these environments, individuals who engage in whistleblowing are often perceived as disruptors rather than as advocates for patient welfare, thereby perpetuating a culture of silence even in the context of ethical leadership rhetoric.

Importantly, organizational culture interacts with leadership and psychological safety in intricate, non-linear manners. Ethical leaders operating within punitive or blame-oriented contexts may encounter significant obstacles in translating their personal values into environments conducive to safe expression, suggesting that the phenomenon of whistleblowing cannot be fully elucidated solely through the dyadic lens of leader–follower dynamics.

5.8 Synthesis and Research Gap

The literature reviewed thus far arguably suggests that healthcare whistleblowing is complicated by multilevel considerations from the leadership's action to psychological safety, and the organization's culture. Despite such quantitative studies, there still remains a lack of understanding concerning the subjective experiences of healthcare workers surrounding psychological safety in situations where they must speak out against wrongdoing among their

superiors, particularly when embedded within contextually ethically-laden and hierarchical frameworks.

In addition, existing theoretical frameworks often fail to adequately capture the emotional, moral, and relational dimensions of whistleblowing, tending instead to reduce this complex experience to a rational process. This study aims to address these theoretical gaps by using a qualitative interpretative phenomenological methodology with which we explore how health care professionals make sense of the construct of ethical leadership and psychological safety as they reflect on the action of speaking up.

6. Theoretical Framework

6.1 Ethical Leadership Theory

Ethical leadership theory conceptualizes leaders as individuals who internalize moral values and serve as moral stewards, demonstrating appropriate conduct through their personal behavior, interpersonal relationships, and decision-making (Brown & Treviño, 2006). Ethical leaders embody principles of integrity and justice, and are committed to the welfare of others, while simultaneously promoting ethical norms through effective communication and reinforcement mechanisms. In healthcare, the significance of ethical leadership is particularly pronounced, as leaders' decisions directly affect patient safety, professional ethics, and public trust (Keselman & Saxe-Braithwaite, 2020).

While ethical leadership theory emphasizes leader behaviors, it is also not without criticism that such emphasis threatens to ignore systemic controls in hierarchical structures where individual leader ethics are unlikely to be sufficient to challenge deeply embedded cultures (Kaundinya, 2023). In the NHS, where there are budgetary pressures and understaffing, and targets create competing demands, it may not be sufficient to have ethical leadership in place to encourage speaking up.

Empirical evidence suggests that ethical leadership is positively associated with an increased employee voice, reduced apprehension regarding retaliation, and improved perceptions of organizational justice (Rai & Koodamara, 2025). However, critics argue that ethical leadership

theory often assumes a simplistic and universally beneficial trajectory, disregarding contextual constraints such as bureaucratic exigencies, resource limitations, and entrenched hierarchies that are commonplace in healthcare organizations (Kaundinya, 2023). As a result, this investigation treats ethical leadership as a multifaceted and contextually sensitive construct, variably experienced by healthcare practitioners depending on their specific roles and positions of authority.

6.2 Psychological Safety Theory

Based on Edmondson's (1999) original conceptualisation of the concept, psychological safety theory argues that when individuals believe they will not be punished, embarrassed, or rejected for speaking up, risky interpersonal behaviours are more likely to occur. In healthcare, PS is associated with error reporting, learning behaviors, and the outcomes related to patient safety (O'Donovan & McAuliffe, 2020).

It has particular applicability within the context of whistleblowing, where raising concerns about unsafe or unethical behavior is regarded as a high-risk activity. The reputation, emotional, career related risks that health care professionals face in expressing their concerns, especially in cultures of blame and strong hierarchical authority (Radhakrishna, 2015). The theory of psychological safety may help to explain how ethically conscientious professionals might nonetheless decide not to speak out should they perceive their context as threatening.

Current research depicts psychological safety as a contextual, collectively constructed environment influenced by leadership behaviors, peer relationships, and organizational standards, rather than an individualistic attitude alone (Edmondson & Bransby, 2023). Such a theoretical basis supports the current study on psychological safety as an intermediate variable between ethical leadership and intention to whistleblow.

6.3 Social Learning Theory

Social learning theory (Bandura, 1977) provides an additional lens through which to understand the mechanisms by which individuals assimilate appropriate behaviors via observation, modeling, and reinforcement. Whilst social learning theory illuminates observational learning, critics argue it underestimates NHS systemic constraints where staffing shortages and performance targets override individual leader modelling (Schaub et al., 2021). Ethical leaders influence their followers

not solely through established policies, but also through their quotidian actions that signal which behaviors are considered acceptable or perilous.

In healthcare settings, where ambiguity and ethical quandaries frequently arise, professionals meticulously observe the manner in which leaders address error reporting and dissent. When leaders exhibit affirmative responses to concerns, they cultivate psychological safety and nurture an environment conducive to open communication. Conversely, punitive or dismissive responses impart a sense of peril, further entrenching silence even within organizations that possess formal whistleblowing protocols (Tiitinen, 2018).

As a result, social learning theory elucidates the process by which ethical leadership fosters shared perceptions of safety and collective norms concerning whistleblowing. It also illuminates the reasons for the persistence of silence in organizations where unethical behaviors are tacitly endorsed through inaction.

6.4 Moral Identity Theory

Moral identity theory suggests that one's likelihood of behaving ethically may be connected to the degree that moral traits are prominent in the self-concept (Blasi, 1983). Professional identity often has a substantial moral dimension in the context of health care, based on caring, responsibility and being an advocate for patients. Nevertheless, moral identity alone is not as good in predicting the blowing of the whistle; organizational situations may inhibit audio morality (Khan et al., 2020). Drawing on moral identity theory, the article aims to explore the trade-offs between individual moral adherence and organizational psychological safety, to provide a subtler account of why morally oriented professionals may choose silence.

6.5 Theoretical Integration

These theoretical frameworks collectively suggest that ethical leadership exerts an indirect influence on whistleblowing by cultivating an environment of psychological safety through mechanisms of social learning, while an individual's moral identity interacts with organizational variables. This all-encompassing framework surpasses reductionist interpretations of whistleblowing and underscores the significance of leadership, relational dynamics, and contextual factors specific to the healthcare sector. It provides a robust theoretical foundation for

comprehending the lived experiences of healthcare professionals as they navigate the decision to either voice their concerns or maintain silence.

7. Conceptual Framework

The conceptual framework centres on four interrelated constructs: ethical leadership, psychological safety, whistleblowing intentions, and healthcare organisational culture.

7.1 Ethical Leadership

In this scholarly discourse, ethical leadership is conceptualized as the observable commitment of healthcare administrators to the tenets of integrity, fairness, transparency, and ethical decision-making, as recognized by healthcare practitioners. Importantly, ethical leadership is perceived as an experiential phenomenon rather than a mere assumption, recognizing that the mere possession of formal leadership roles does not automatically bestow ethical authority.

7.2 Psychological Safety as a Mediating Construct

Psychological safety serves a crucial mediating function within the proposed theoretical framework. It embodies the perception among healthcare professionals that they are able to articulate concerns without the fear of retaliation, humiliation, or detrimental career consequences. The comprehension of psychological safety as a mediating variable is bolstered by empirical evidence suggesting that leadership influences whistleblowing predominantly through shaping perceptions of safety as opposed to exerting direct control over behaviors (Frazier et al., 2017; Liang et al., 2022).

In healthcare environments, psychological safety is influenced not solely by leaders but also by the responses of colleagues, professional norms, and prior experiences related to expressing opinions. Hence, the framework characterizes psychological safety as a relational and contextual construct, rather than solely an individual trait.

7.3 Whistleblowing Intentions and Behaviour

Whistleblowing is comprehensively defined to include both internal and external disclosures of unethical or unsafe practices. The framework recognizes that intentions and actions may not

consistently correspond; professionals may intend to voice concerns yet refrain from doing so due to perceived risks. This distinction is particularly salient in healthcare, wherein ethical obligations frequently conflict with self-preservation (Miceli et al., 2021).

7.4 Healthcare Organisational Culture as a Contextual Layer

Healthcare organisational culture functions as an overarching contextual framework that shapes all interactions within the model. Drawing on Schein's (2017) cultural theory, the framework acknowledges that collective beliefs regarding hierarchy, blame, and professional allegiance influence perceptions of ethical leadership and psychological safety.

Cultures characterized by blame avoidance, performance pressures, or defensive reputational strategies may undermine the positive effects of ethical leadership on psychological safety. Conversely, cultures that prioritize learning may amplify these beneficial effects.

7.5 Relationships Within the Conceptual Framework

The proposed model suggests that ethical leadership positively influence psychological safety by modeling that ethics is action as related to a vision, promoting open communication, and constructive addressing of issues. As such, psychological safety increases the likelihood individuals will blow the whistle by reducing perceived social and work-based uncertainties.

But it's not an ironclad one. The organization's culture highly mediates the interpretation of leadership behavior, and the individual's moral identity is a primary driver in how the professional responds to voice process encountered when faced with an ethical choice. Such details could not be accounted for by linear models; but they support the qualitative approach used directly in this study.

7.6 Justification for a Qualitative Conceptual Framework

Unlike positivist conceptual frameworks, this model is intentionally interpretative and flexible, designed to facilitate exploration rather than to validate hypotheses. It serves as a sensitizing framework that informs the formulation of interview inquiries and analytical processes while remaining open to the emergence of novel themes.

By integrating leadership, psychological safety, and organizational culture, the conceptual framework effectively captures the complex dynamics of whistleblowing in the healthcare domain and aligns with the study's phenomenological objective of comprehending lived experiences rather than merely predicting behaviors.

7.7 Contribution of the Conceptual Framework

This framework enriches the extant literature by framing psychological safety as a dynamic process of meaning-making rather than merely a mediating factor and by contextualizing whistleblowing within the distinct cultural and ethical paradigms of healthcare. It establishes a coherent linkage between theoretical constructs and methodological approaches, thereby ensuring analytical rigor and conceptual precision throughout the research.

8. Research Methodology

This research employs a qualitative methodology to explore how healthcare professionals conceptualize and interpret ethical leadership, alongside the impact of such leadership on psychological safety and the propensity to engage in whistleblowing within healthcare organizations. Given the sensitive, morally complex, and contextually nuanced nature of whistleblowing in the healthcare domain, a qualitative approach is imperative for capturing the subjective interpretations, lived experiences, and cognitive frameworks of the participants. The methodological choices articulated in this study are grounded in an interpretivist paradigm and are executed through a phenomenological framework, as delineated in the subsequent sections.

8.1 Paradigmatic Foundations

Research paradigms provide the foundational philosophical framework that shapes researchers' understandings of reality, the processes of knowledge creation, and their engagement with ethical implications during the course of the research endeavor. This study is situated within the interpretivist paradigm, which is particularly suited for the examination of socially constructed phenomena such as ethical leadership, psychological safety, and whistleblowing within healthcare settings.

8.1.1 Interpretivism as the Guiding Paradigm

Interpretivism is predicated on the premise that social reality is neither objective nor immutable, but is instead constructed through human interactions, interpretations, and the generation of meaning. In contrast to positivist methodologies, which seek causal explanations and universally applicable laws, interpretivism underscores the importance of comprehending how individuals perceive, interpret, and attribute meaning to their experiences within specific social and organizational frameworks. This paradigm is particularly relevant in the context of healthcare whistleblowing, where the decision to either disclose wrongdoing or remain silent is shaped by ethical considerations, relational dynamics, professional identities, and perceived risks, rather than being driven exclusively by measurable factors.

Whistleblowing in the healthcare sector is inherently subjective. The interpretations of "ethical leadership," "safety," or "acceptable risk" vary significantly among individuals, professional cohorts, and organizational cultures. An interpretivist approach allows the researcher to engage with these multiple realities rather than imposing a singular, externally defined framework. Consequently, this study does not aspire to test hypotheses or establish universal causal relationships; rather, it endeavors to understand how healthcare professionals conceptualize ethical leadership and how these conceptualizations influence their readiness to express concerns.

8.1.2 Ontological Position: Relativist Ontology

In my experience reading healthcare scandals like Mid-Staffordshire, I have seen how nurses and doctors construct radically different realities of the same leadership behaviour based on their position in the hierarchy. This relativist ontology underpins my study; reality isn't singular but multiple and context-dependent.

For example, a senior clinician and a junior nurse could interpret the same leadership behaviour in radically different ways, translating it to be supportive or destructive depending on their comparative position, power, and vulnerability. Similarly, some think of whistleblowing as a moral duty, and others see it as a danger to professional belief in oneself and career opportunity. A relativist ontology legitimates these different interpretations as equally proper versions of how things are, rather than as inaccurate conceptions that diverge from an assumed objective reality.

This ontological stance is consistent with the aim of the study, which is to explore how healthcare professionals make sense of ethical leadership and psychological safety, not to know whether ethical leadership “actually” leads to whistleblowing. Through the recognition of multiple realities, the research sustains a respect for the complexities and ethical grey zones existing in health care organizations.

8.1.3 Epistemological Position: Subjectivist Epistemology

Epistemology investigates the fundamental nature of knowledge and the methodologies through which it can be comprehended. This investigation adheres to a subjectivist epistemological framework, asserting that knowledge is co-constructed through the dynamic interactions between the researcher and the subjects involved. Rather than being revealed as an independent reality, knowledge is generated through processes of dialogue, interpretation, and reflective engagement.

In the context of this investigation, the narratives articulated by participants concerning ethical leadership and whistleblowing are regarded not as impartial representations of reality but rather as interpretive narratives shaped by memory, emotional states, and sociocultural contexts. Semi-structured interviews are utilized not merely for the collection of data but as a mechanism to foster reflective comprehension, thereby enabling participants to articulate their perceptions and emotional connections to leadership and whistleblowing practices.

The researcher occupies an engaged position within this epistemological paradigm. Through incisive questioning, empathetic listening, and interpretive scrutiny, the researcher facilitates the construction of meaning while remaining attuned to the perspectives of the participants. This methodological approach acknowledges that absolute objectivity is neither feasible nor desirable in qualitative investigations on ethically consequential topics. Instead, the focus is directed towards transparency, reflexivity, and interpretive rigor.

8.1.4 Axiological Position: Value-Laden Inquiry

Axiology is concerned with the importance of values in the context of research. This study explicitly acknowledges that the investigation of ethical leadership and whistleblowing is fundamentally shaped by underlying values. Issues related to patient safety, moral responsibility, professional integrity, and organizational justice are essentially normative in nature and cannot be adequately analyzed from a perspective devoid of values.

Rather than attempting to eliminate values, this research adopts a reflexive axiological framework, in which the researcher critically reflects on their own convictions, ethical responsibilities, and positionality throughout the research process. This approach includes recognizing the ethical sensitivities involved in discussions about whistleblowing, the potential power imbalances between the researcher and the participants, and the ethical obligation to protect participants from any potential harm.

As a result, ethical considerations are not confined to a discrete segment but are seamlessly integrated into the methodological framework, addressing aspects such as recruitment, informed consent, data analysis, and reporting. By explicitly articulating values instead of allowing them to remain implicit, the study enhances both its ethical integrity and its interpretive validity.

8.1.5 Implications of the Paradigmatic Position for Methodological Choices

The interpretivist, relativist, subjectivist, and value-conscious underpinnings of this research fundamentally influence its methodological choices. Firstly, these foundations substantiate the adoption of a qualitative methodology, as quantitative methods would inadequately capture the depth, nuances, and emotional complexities inherent in whistleblowing experiences. Secondly, they advocate for the implementation of phenomenology as the most appropriate qualitative paradigm, given the research's focus on lived experiences and the construction of meaning. Thirdly, they necessitate an analytical framework that elevates the voices of participants while facilitating interpretive comprehension.

The foundational paradigms of this research provide a coherent philosophical structure that aligns with its research aims and inquiries. By situating the methodology within interpretivist philosophy, the study is well-positioned to generate profound, contextually relevant insights into the phenomena of ethical leadership and its impact on psychological safety and whistleblowing within healthcare organizations.

8.1.6 Alternative Paradigmatic Positions Considered

Critical theory, beneficial for identifying healthcare hierarchies, requires researchers' activism to overcome oppression. This is not compatible with the phenomenological aim of this study which sought understanding, not transformation (Kincheloe & McLaren, 2011). Constructivism agrees with the interpretivist assumption of multiple realities, but does not focus uniquely on the lived

experience essence as phenomenology does (Guba & Lincoln, 1994). Pragmatism values practical outcomes that align with the design of an intervention, not exploratory sense making. The most suitable approach for research questions that is focused on subjective interpretations is interpretivism.

8.2 Creswell's Five Approaches: Comparative Analysis

Approach	Core Focus	NHS Whistleblowing Fit	Reason Chosen/Rejected
Narrative	Life stories/identity	Moderate	Seeks shared meanings, not individual biographies.
Case Study	Bounded case analysis	Low	Individual experiences, not organisational case.
Grounded Theory	Theory building	Low	Theories exist; exploring lived experience.
Ethnography	Cultural immersion	Low	Interviews feasible; observation risks confidentiality.
Phenomenology	Lived experience essence	Optimal	Directly addresses RQs on interpretation.

8.3 Research Design and Methods

This research utilizes a qualitative, interpretive phenomenological framework. Purposive sampling will be employed to select healthcare professionals who possess experience within recognizable leadership frameworks and can provide insights on matters concerning ethical leadership, psychological safety, and the act of voicing concerns. Participants may encompass nurses, physicians, and allied healthcare practitioners to obtain a variety of professional viewpoints.

The research selects 20-30 participants from 3 NHS trusts (1 acute, 1 mental health, 1 community). More specifically, the participants include 8 nurses, 6 doctors (3 junior, 3 consultants), 4 allied health professionals, and 4 managers. Inclusion criteria were ≥ 3 years NHS experience, witnessed/considered patient safety concerns.

Data will be gathered through semi-structured, in-depth interviews, which will offer flexibility while ensuring alignment with the research inquiries. The interviews will concentrate on the participants' experiences regarding leadership behaviors, perceptions of psychological safety, and the choices made about raising concerns. Considering the sensitive nature of the subject, interviews

will take place in a confidential environment, and participants will be reminded of their right to withdraw at any point.

8.4 Trustworthiness Criteria

Credibility	Member checking (participants review transcript summaries).
Transferability	Thick description of NHS hierarchy/policy context.
Dependability	Audit trail of coding decisions (NVivo transcripts).
Confirmability	Reflexive journal separating researcher bias from participant meanings.

9. Ethical Considerations

Whistleblowing research conducted within the healthcare domain presents unique ethical quandaries due to the sensitive nature of participants disclosing organizational malfeasance, the ramifications of hierarchical power dynamics, and the potential consequences for their professional trajectories. The procedures for acquiring informed consent must exceed traditional frameworks, explicitly indicating that participants may disclose information that could impact their careers while ensuring comprehension of the limitations regarding confidentiality and their entitlement to withdraw at any juncture without incurring adverse repercussions. Consent documentation will outline the aims of the study, describe how the data will be utilized, and reaffirm the researcher's ethical obligation to inform relevant authorities about any imminent threats to patient safety, thereby achieving a delicate balance between participant autonomy and the imperative of public welfare.

In light of the hazards associated with organizational identification in whistleblowing scenarios, confidentiality necessitates exceptionally stringent safeguards. Audio recordings will be subjected to encryption, transcribed promptly, and subsequently securely eradicated, while transcripts will undergo a meticulous de-identification procedure that expunges names, specific hospital identifiers, precise dates, and contextual information that might facilitate recognition. By aggregating data at the organizational level, we ensure that the findings reflect thematic patterns

across NHS trusts, rather than focusing on individual cases or specific institutions. Data storage will conform to UK GDPR, utilizing secure servers approved by the university, accessible exclusively to the research team, with a retention duration confined to three years post-publication.

The emotional and psychological hazards involved mandate meticulous consideration, as the discussion of whistleblowing experiences may trigger trauma, moral distress, or professional anxiety. Before the interview, a screening process will assess participants' psychological well-being, excluding those currently engaged in formal grievances or experiencing substantial distress. The interview protocols will incorporate a graduated increase in topic sensitivity, providing explicit options for participants to circumvent questions, along with immediate post-interview debriefing that offers referrals to NHS occupational health services, support lines for professional regulatory bodies, and independent whistleblower advocacy organizations. Researchers will undergo training in trauma-informed interviewing to ensure their ability to recognize signs of distress and to suspend interviews when deemed necessary.

The power dynamics inherent in healthcare hierarchies necessitate neutral interview locations that are detached from workplace settings to mitigate any reservations induced by the presence of management or organizational oversight. Approval from the NHS Research Ethics Committee and the pertinent trusts will govern access, ensuring that organizational cooperation aligns with the safeguarding of participants rather than being motivated by institutional defensiveness. These comprehensive measures highlight the recognition that research pertaining to whistleblowing demands ethical standards that are as stringent as the professional and personal sensitivities involved.

10. Limitations

This study employs an interpretive phenomenological framework that inherently carries methodological limitations typical of qualitative research. The composition of participants is significantly influenced by self-selection bias; healthcare professionals who are inclined to share their whistleblowing experiences likely exhibit a higher degree of ethical commitment or have resolved their grievances, thereby systematically excluding those who endure severe retaliation and avoid engaging in research. This results in findings that favor articulate, ethically-driven professionals, rather than reflecting the muted voices of individuals most constrained by their

organizational environments. Additionally, retrospective narratives introduce recall bias, as participants may reconstruct their past leadership experiences influenced by later organizational developments and their evolved professional identities, which could distort their original interpretative frameworks.

The methodological constraints arise from the dependence on self-reported interview data instead of direct behavioral observation. Participants provide subjective interpretations of ethical leadership and psychological safety rather than showcasing actual whistleblowing behaviors under organizational pressure, which limits the ability to infer causal relationships between intention and action. Furthermore, the cross-sectional design hinders the establishment of temporal precedence, making it unclear whether perceptions of ethical leadership precede considerations of whistleblowing, or if experiences of whistleblowing subsequently alter evaluations of leadership through sensemaking mechanisms.

Interpretive phenomenology recognizes the collaborative construction of meaning between researchers and participants, positioning the findings as contextualized interpretations rather than objective representations of organizational realities. This dual hermeneutic, where researchers analyze participants' interpretations, introduces an inescapable subjectivity, even with reflexivity and audit trails in place, setting the findings apart from positivist assertions of researcher impartiality.

Contextual limitations restrict the applicability of the findings beyond the UK NHS contexts. Professional hierarchies, regulatory frameworks (such as GMC and NMC), Freedom to Speak Up policies, and cultural norms around patient safety create specific conditions that shape ethical interpretations among professionals, which are not present in private healthcare, international systems, or non-clinical organizations. Moreover, organizational defensiveness may further skew the participating trusts toward those already fostering cultures of openness, thereby underrepresenting the deeply entrenched cultures of silence.

Legal and ethical dilemmas restrict confidentiality assurances: the obligation to report ongoing patient safety risks can trigger mandatory reporting requirements, potentially deterring participants from being fully candid despite reassurances. Collectively, these limitations frame the findings as

rich, contextually-informed insights into meaning-making processes that hold significant value for theoretical development and intervention design, rather than yielding generalizable causal predictions.

References

- Alo, O., Leckenby, J., & Arslan, A. (2022). Leadership dynamics in primary healthcare delivery: A case of rural GP practice in Northeast England. *International Journal of Management, Economics and Social Sciences (IJMESS)*, 11(1), 1–28. <https://doi.org/10.32327/IJMESS/11.1.2022.1>
- Bandura, A. (1977). *Social Learning Theory* (pp. 1–46). General Learning Corporation. http://www.asecib.ase.ro/mps/Bandura_SocialLearningTheory.pdf
- Barkhordari-Sharifabad, M., Ashktorab, T., & Atashzadeh-Shoorideh, F. (2017). Ethical leadership outcomes in nursing: A qualitative study. *Nursing Ethics*, 25(8), 1051–1063. <https://doi.org/10.1177/0969733016687157>
- Blasi, A. (1983). Moral cognition and moral action: A theoretical perspective. *Developmental Review*, 3(2), 178–210. [https://doi.org/10.1016/0273-2297\(83\)90029-1](https://doi.org/10.1016/0273-2297(83)90029-1)
- Brown, M. E., & Treviño, L. K. (2006). Ethical leadership: A review and future directions. *The Leadership Quarterly*, 17(6), 595–616. <https://doi.org/10.1016/j.leaqua.2006.10.004>
- Brown, M. E., Treviño, L. K., & Harrison, D. A. (2005). Ethical leadership: A social learning perspective for construct development and testing. *Organizational Behavior and Human Decision Processes*, 97(2), 117–134. <https://doi.org/10.1016/j.obhdp.2005.03.002>
- Denier, Y., Dhaene, L., & Gastmans, C. (2019). “You can give them wings to fly”: a qualitative study on values-based leadership in health care. *BMC Medical Ethics*, 20(1). <https://doi.org/10.1186/s12910-019-0374-x>
- Din, U., & Zhang, L. (2023). Unveiling the mechanisms through which leader integrity shapes ethical leadership behavior: Theory of planned behavior perspective. *Behavioral Sciences*, 13(11), 928–928. <https://doi.org/10.3390/bs13110928>
- Edmondson, A. (1999). Psychological Safety and Learning Behavior in Work Teams. *Administrative Science Quarterly*, 44(2), 350–383. <https://doi.org/10.2307/2666999>
- Edmondson, A. C., & Bransby, D. P. (2023). Psychological safety comes of age: Observed themes in an established literature. *Annual Review of Organizational Psychology and Organizational Behavior*, 10(1). <https://doi.org/10.1146/annurev-orgpsych-120920-055217>

- El-Gazar, H. E., Baghdadi, N. A., Mohammed, S., & Zoromba, M. A. (2024). Linking ethical leadership to nurses' internal whistleblowing through psychological safety. *Nursing Ethics*. <https://doi.org/10.1177/09697330241268922>
- Elhihi, E. A., Aljarary K. L., Alahmadi M., Adam, J. B., Almwualllad O. A., Hawsawei, M. S., Hamza, A. A., & Ibrahim, I. A. (2025). The mediating role of moral courage in the relationship between ethical leadership and error reporting behavior among nurses in Saudi Arabia: a structural equation modeling approach. *BMC Nursing*, 24(1). <https://doi.org/10.1186/s12912-025-03043-7>
- Elsehrawy, M. G., Elsayed, M., Eweida R. S., & Abdelrahman, M. M. (2025). Factors influencing nurses' decision to blow the whistle: a systematic review. *BMC Nursing*, 24(1). <https://doi.org/10.1186/s12912-025-03400-6>
- Engle, R. L., Mohr, D. C., Holmes, S. K., Seibert, M. N., Afable, M., Leyson, J., & Meterko, M. (2021). Evidence-based Practice and patient-centered care: Doing Both Well. *Health Care Management Review*, 46(3), 174–184. <https://doi.org/10.1097/HMR.0000000000000254>
- Entwistle, T. W., & Doering, H. (2023). Amoral Management and the Normalisation of Deviance: The Case of Stafford Hospital. *Journal of Business Ethics*, 190. <https://doi.org/10.1007/s10551-023-05445-6>
- Filiz, M., & Blenkinsopp, J. (2025). The mediating role of psychological safety in the effect of organisational cynicism on whistleblowing. *Journal of Health Organization and Management*. <https://doi.org/10.1108/jhom-10-2024-0427>
- Fox, R. (2001). Bristol Scandal. *Circulation*, 104(7). <https://doi.org/10.1161/hc3201.097067>
- Frazier, M. L., Fainshmidt, S., Klinger, R. L., Pezeshkan, A., & Vracheva, V. (2017). Psychological Safety: A Meta-Analytic Review and Extension. *Personnel Psychology*, 70(1), 113–165. <https://doi.org/10.1111/peps.12183>
- Gerpott, F. H., Van Quaquebeke, N., Schlamp, S., & Voelpel, S. C. (2017). An Identity Perspective on Ethical Leadership to Explain Organizational Citizenship Behavior: The Interplay of Follower Moral Identity and Leader Group Prototypicality. *Journal of Business Ethics*, 156(4), 1063–1078. <https://doi.org/10.1007/s10551-017-3625-0>

- Grailey, K. E., Murray, E., Reader, T., & Brett, S. J. (2021). The Presence and Potential Impact of Psychological Safety in the Healthcare setting: an Evidence Synthesis. *BMC Health Services Research*, 21(1), 773. <https://doi.org/10.1186/s12913-021-06740-6>
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of Qualitative Research*, 2(163-194), 105.
- Hennequin, E. (2021). Whistleblowing as a Career Crisis: Recovering from Retaliatory Job Loss through a Process of Bifurcation. *Work, Employment and Society*, 37(2), 095001702110217. <https://doi.org/10.1177/09500170211021721>
- Holmes, D. (2013). Mid Staffordshire Scandal Highlights NHS Cultural Crisis. *The Lancet*, 381(9866), 521–522. [https://doi.org/10.1016/s0140-6736\(13\)60264-0](https://doi.org/10.1016/s0140-6736(13)60264-0)
- Ismail, N., & Harvey, W. S. (2025). Powerful yet Precarious: Rethinking Elite Interviewing Through Vulnerability, Absence and Disclosure. *International Journal of Qualitative Methods*, 24. <https://doi.org/10.1177/16094069251371823>
- Kampourakis, I. (2020). Whistleblowers as regulatory intermediaries: Instrumental and reflexive considerations in decentralizing regulation. *Regulation & Governance*, 15(3), 745–759. <https://doi.org/10.1111/rego.12361>
- Kassim, P. N. J. (2017). Mandatory incident reporting through legislative framework: Towards enhancing patient safety culture in healthcare settings. *Journal of Humanities, Language, Culture & Business*.
- Kaundinya, K. B. (2023). Organizational theory – a three-dimensional tool to analyze and enhance collaboration in healthcare systems. *Journal of Business and Socio-Economic Development*, 4(3). <https://doi.org/10.1108/jbsed-09-2022-0105>
- Keselman, D., & Saxe-Braithwaite, M. (2020). Authentic and ethical leadership during a crisis. *Healthcare Management Forum*, 34(3), 084047042097305.
- Khan, J., Saeed, I., Zada, M., Ali, A., Contreras-Barraza, N., Salazar-Sepúlveda, G., & Vega-Muñoz, A. (2022). Examining Whistleblowing Intention: The Influence of Rationalization on Wrongdoing and Threat of Retaliation. *International Journal of Environmental Research and Public Health*, 19(3), 1–20. <https://doi.org/10.3390/ijerph19031752>

- Khan, M. W. J., Ismail, A., Ahmed, Z., & Ali, I. (2020). Ethical Leadership and Whistle-blowing Intentions: Mediating Role of Moral Identity. *Journal of Accounting and Finance in Emerging Economies*, 6(4), 1021–1032. <https://doi.org/10.26710/jafee.v6i4.1455>
- Kincheloe, J. L., & McLaren, P. (2011). Rethinking critical theory and qualitative research. In *Key Works in Critical Pedagogy*, 285–326. Rotterdam: SensePublishers.
- Lampard, C. (2024). What do stories tell us about whistleblowing conflict in the NHS in England and its resolution? *Qmul.ac.uk*. <https://qmro.qmul.ac.uk/xmlui/handle/123456789/87579>
- Liu, X., Huang, Y., Kim, J., & Na, S. (2023). How Ethical Leadership Cultivates Innovative Work Behaviors in Employees? Psychological Safety, Work Engagement and Openness to Experience. *Sustainability*, 15(4), 3452. <https://www.mdpi.com/2071-1050/15/4/3452>
- Mannion, R., & Davies, H. T. (2015). Cultures of Silence and Cultures of Voice: The Role of Whistleblowing in Healthcare Organisations. *International Journal of Health Policy and Management*, 4(8), 503–505. <https://doi.org/10.15171/ijhpm.2015.120>
- Nursing and Midwifery Council. (2015). Francis Report - Our Position. Nursing and Midwifery Council. <https://www.nmc.org.uk/about-us/policy/position-statements/francis-report/>
- O'donovan, R., & Mcauliffe, E. (2020). A systematic review of factors that enable psychological safety in healthcare teams. *International Journal for Quality in Health Care*, 32(4), 240–250. <https://doi.org/10.1093/intqhc/mzaa025>
- O'Neill, B. (2000). Doctor as murderer. *BMJ*, 320(7231), 329–330. <https://doi.org/10.1136/bmj.320.7231.329>
- Olesen, T. (2021). The Birth of an Action Repertoire: On the Origins of the Concept of Whistleblowing. *Journal of Business Ethics*. <https://doi.org/10.1007/s10551-021-04868-3>
- Oyewunmi, A. E., & Oyewunmi, O. A. (2022). Speaking Silence: Abusive Supervision, Subordinates' Citizenship Behavior, and Whistleblowing Intention. *SAGE Open*, 12(1), 215824402210799. <https://doi.org/10.1177/21582440221079912>
- Radhakrishna, S. (2015). Culture of blame in the National Health Service; consequences and solutions. *British Journal of Anaesthesia*, 115(5), 653–655. <https://doi.org/10.1093/bja/aev152>

- Rai, S. S., & Koodamara N. K. (2025). Trust in leader, organizational commitment and employee silence: the moderating role of ethical leadership. *International Journal of Ethics and Systems*. <https://doi.org/10.1108/ijoes-07-2024-0194>
- Rustiarini, N. W., Yuesti, A., & Dewi, N. P. S. (2021). Professional Commitment And Whistleblowing Intention: The Role Of National Culture. *Jurnal Reviu Akuntansi Dan Keuangan*, 11(1), 87–102. <https://doi.org/10.22219/jrak.v11i1.14558>
- Schaub, J., Hewison, A., Haworth, S., & Miller, R. (2021). A Leadership Model for Social Work: Drawing on Health Care to Inform Social Work Leadership. *The British Journal of Social Work*, 52(5). <https://doi.org/10.1093/bjsw/bcab185>
- Siad, F. M., & Rabi, D. M. (2021). Harassment in the Field of Medicine: Cultural Barriers to Psychological Safety. *CJC Open*, 3(12 Suppl), S174–S179. <https://doi.org/10.1016/j.cjco.2021.08.018>
- Sosik, J. J., Chun, J. U., Ete, Z., Arenas, F. J., & Scherer, J. A. (2018). Self-control Puts Character into Action: Examining How Leader Character Strengths and Ethical Leadership Relate to Leader Outcomes. *Journal of Business Ethics*, 160(3), 765–781. <https://doi.org/10.1007/s10551-018-3908-0>
- Steers, R. M., & Sánchez-Runde, C. J. (2017). Culture, Motivation, and Work Behavior. *The Blackwell Handbook of Cross-Cultural Management*, 190–216. <https://doi.org/10.1002/9781405164030.ch10>
- Tiitinen, L. (2018). The power of silence: silencing as a method of preventing whistleblowing. *European Journal of Social Work*, 23(1), 68–79. <https://doi.org/10.1080/13691457.2018.1460323>
- Towey, M. (2023). Resilience in the Margins: Understanding resilience strategies of disempowered and marginalised senior leaders in the workplace. *Figshare*. <https://doi.org/10.25392/leicester.data.24624810.v1>
- Treviño, L. K., Hartman, L. P., & Brown, M. (2000). Moral Person and Moral Manager: How Executives Develop a Reputation for Ethical Leadership. *California Management Review*, 42(4), 128–142. <https://doi.org/10.2307/41166057>
- Varga, A. I., Spehar, I., & Skirbekk, H. (2023). Trustworthy management in hospital settings: a systematic review. *BMC Health Services Research*, 23(1). <https://doi.org/10.1186/s12913-023-09610-5>

- Vian, T., Agnew, B., & McInnes, K. (2022). Whistleblowing as an anti-corruption strategy in health and pharmaceutical organizations in low- and middle-income countries: a scoping review. *Global Health Action*, 15(1). <https://doi.org/10.1080/16549716.2022.2140494>
- Wawersik, D. M., Boutin, E. R., Gore, T., & Palaganas, J. C. (2023). Individual Characteristics That Promote or Prevent Psychological Safety and Error Reporting in Healthcare: A Systematic Review. *Journal of Healthcare Leadership*, Volume 15(15), 59–70. <https://doi.org/10.2147/jhl.s369242>
- Yeoh, P. (2014). Whistleblowing: motivations, corporate self-regulation, and the law. *International Journal of Law and Management*, 56(6), 459–474. <https://doi.org/10.1108/ijlma-06-2013-0027>
- Zheng, Y., Epitropaki, O., Graham, L., & Caveney, N. (2021). Ethical Leadership and Ethical voice: the Mediating Mechanisms of Value Internalization and Integrity Identity. *Journal of Management*, 48(4), 973–1002. sagepub. <https://doi.org/10.1177/01492063211002611>
- Zimmermann, P. (2025). Staging Debates in Whistleblowing Research: A Problematising Literature Review. *Journal of Business Ethics*. <https://doi.org/10.1007/s10551-025-05990-2>