The organisational silence of midwives and nurses: reasons and results

MINE YURDAKUL PhD[1], MELTEM AYDIN BEŞEN PhD Student[2] and SEMRA ERDOĞAN PhD[3]

[1]Assistant Professor, [2]Lecturer, *Mersin University School of Health Midwifery Department, Ciftlikkoy Kampusu, Mersin, Turkey and* [3]Assistant Professor, *Mersin University Medical Faculty Department of Biostatistics, Ciftlikkoy Kampusu, Mersin, Turkey*

Correspondence
Mine Yurdakul
Mersin University School of Health Midwifery Department
Ciftlikkoy Kampusu
Mersin
Turkiye
E-mail: yurdakul.m@hotmail.com

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Aim The study was conducted to determine the issues about which nurses and midwives remain silent and the reasons for it and the perceived results of silence.
Background Organisational silence is a vitally important issue in the health sector, due to the risks and mistakes that are not reported, and proposals for improvement that are not made.
Method The sample of this descriptive survey, which investigated a cause and effect relationship, was 159 nurses and midwives. The data were collected using a questionnaire and the organisational silence scale.
Findings Of the study participants, 84.9% were nurses and 15.1% were midwives. Of all participants 88.7% were women. 8.8% of participants stated that they never remained silent about issues related to work and the workplace. Respondents most often remained silent about issues related to ethics and responsibility. 'Limited improvement and development' was frequently mentioned as a perceived result of organisational silence.
Conclusion Our study determined that organisational silence is quite common among nurses and midwives.
Implications for nursing management Activities that raise the awareness of hospital administrations and employees about preventing the factors that cause and maintain silence in hospitals should be planned.

Keywords: midwives, nurses, organisational silence, Turkey

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Introduction

As Turkey's hospitals play a crucial role in providing the nation's health services, their main policy is to have qualified professionals offering services that are accessible, sustainable, effective, productive and respectful of patient rights. Despite all the advancements in technology and science, the most important resource in the field of health care is human, the chief asset for ensuring the improvement of service quality. The fundamental problems in health-care management in Turkey are that: (a) realistic policies are not implemented with regard to health-care staffing, the implementation of which requires serious amounts of time, effort and money, (b) more than one unit exists that has the authority to manage issues related to health-care employment policies and strategies, (c) the practical suggestions of those responsible for performing this job are not implemented and (d) a lack of communication and motivation (Mollahaliloğlu *et al*

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2007). Studies and experience have shown that the confidence of employees improves with good and effective information transfer in institutions, that information sharing increases by means of this confidence, and that all of these issues affect job satisfaction (Eroğlu *et al.* 2011). The high job satisfaction, motivation and engagement of the employees are important, as they serve to reduce incidences of resigning, asking for time off and absenteeism. In turn, low motivation and low job satisfaction of nurses and midwives affect patient safety negatively (Atasoy *et al.* 2010, Ovalı 2010).

Today, given the greater importance that communication has in health services, organisational silence functions as a communication and a management problem. Organisational silence prevents workers from openly expressing their opinions and concerns about organisational problems, an issue that has been discussed frequently in the nursing field in recent years. However, some aspects of this issue still need to be studied. Analysing the nature and main components of organisational silence will yield a better understanding of it. Morrison and Milliken (2000) define organisational silence as the act of employees choosing to withhold their ideas, opinions and concerns about organisational problems, while Pinder and Harlos (2001) define organisational silence as a reaction to injustice and unfairness. Çakici (2010) describes organisational silence as employees intentionally remaining silent and not sharing their superior information, opinions and ideas on technical or behavioural problems related to work or the workplace. A variety of causes are responsible for organisational silence, including concerns such as being seen as a complainer, losing respect and trust, damaging relationships, getting fired and not being promoted, as well as the belief that talking frankly will not have any impact on the choice to remain silent (Çakıcı 2008, Erigüç *et al.* 2014a,b). Besides, it is known that a society's cultural characteristics affect people's attitude and behaviour in business life. In Turkish culture, it has obviously been seen that there is a paternalist, centralist and low amount of participant organisational structure.

In the health sector it is vitally important when risks and mistakes are not reported, and proposals for improvement are not made. Vogus *et al.* (2010) draw attention to the importance of creating a culture of safety and of implementing feedback mechanisms in the health-care sector. These mechanisms do not work properly in cases of organisational silence. Henriksen and Dayton (2006) highlight that organisational silence is a hidden danger to the safety of patients. In institutions where organisational silence is common, problems and mistakes are ignored, and no feedback is offered. This eliminates opportunities to prevent or mitigate the problems and mistakes. It is reported that nurses/midwives do not mention medication errors because of the fear of exclusion and job loss (Mrayyan *et al.* 2007). Attree (2007) notes that nurses who perceive their institution as closed, secretive and accusatory remain more silent about issues related to patient safety. Such behaviour makes it difficult to ensure a secure atmosphere for patients and employees and to make good decisions. It also impairs the development and improvement of health-care institutions. Similarly, Çınar *et al.* (2013)reported in their study of the health sector that efforts by health professionals to collaborate for the sake of the institution diminish as organisational silence rises.

Resignations, reduced performances, absenteeism and tardiness are inevitable in organisations where job satisfaction is low and stress is high. In Turkey and throughout the world, various levels of nurse shortages have led to the closing of certain hospital services or to a reduction of hospital beds (Ritter 2011, Health Education and Health Manpower Status Report in Turkey 2014). Improving the service quality of health-care institutions as well as the commitment shown by nurses and midwives to their institutions can to help prevent shortages of nurses and midwives (Duygulu & Abaan 2007). Moreover, work environments with innovative hiring and retention policies have an effective role in providing quality patient care and they bring positive attention to the institution. With the turnover rate and desire to leave work being low in modern and democratically managed hospitals, these hospitals become magnet hospitals, drawing many job applications from nurses in other institutions (Ekici 2013). Magnet hospitals that have a practice of including nurses in administrative decisions attract and retain qualified nurses and offer long-term quality care (Ritter 2011, Intepeler 2014).

Accordingly, the objective of this study is to raise awareness about and overcome organisational silence by presenting the issues about which midwives and nurses remain silent, their reasons for doing so and the results of this silence on employees and institutions. The authors believe that universities should be institutions with the lowest levels of organisational silence. Thus, this study was conducted at a university hospital, with the aim of examining the organisational silence of midwives and nurses, who, as key health-care personnel, have the potential to be resources for

development and innovation in the field of health care, and helping organisations to perceive their inadequacies. The authors aim to contribute to the relevant literature by bringing a greater understanding to and preventing organisational silence and by making proposals to researchers and practitioners.

This research will attempt to answer the following questions:

1 What issues do midwives and nurses refrain from speaking up about, preferring instead to remain silent?
2 Why do midwives and nurses refrain from expressing their opinions on improving health-care services, preferring instead to remain silent?
3 What do midwives and nurses think will be the perceived results of organisational silence for themselves and their institution?

Methods

Research method

This study was designed as a descriptive survey study, where information was collected on the issues that nurses and midwives, employed by a research hospital at a university in Turkey, remained silent about and the causes and results of their organisational silence. The literature review was conducted in English and Turkish with no year range. PubMed, Ebsco Host, Elsevier- Science Direct and TÜBİTAK ULAKBİM (Turkish Academic Network and Information Center) were used to search original works in peer-reviewed journals published in English and Turkish.

Research sample

The study population involved 25 midwives and 274 nurses employed by a university hospital in the city of Mersin. The minimum sample size for the study was 117 people in total, of whom nine were midwives and 108 were nurses. This sample size number, which was calculated to have a 5% type sampling error margin, with ± 3 standard deviations on a five point Likert scale and 5% type one error margin, fulfilled the minimum sample size calculations (Bartlett *et al.* 2001). A total of 159 midwives and nurses participated in the study.

Data collection instruments

Data were collected using a 10-question socio-demographic data form prepared by the researchers and the Organisational Silence Scale (OSS) developed by Çakıcı (Çakıcı 2008). As the OSS was considered to be suitable for the analysis of organisational silence among nurses (Erigüç *et al.* 2014a,b), permission to use the scale was obtained from Cakıcı prior to conducting the study. The OSS is a 5-point Likert scale with three sections. In the first section, 25 statements are presented that identify the issues about which nurses and midwives remain silent. The frequency of their organisational silence is indicated as: (1) 'I never remain silent', (2) 'I rarely remain silent', (3) 'I sometimes remain silent', (4) 'I generally remain silent' and (5) 'I always remain silent'. In the second part, 30 statements are presented about their reasons for organisational silence, with the response options: (1) 'has no effect', (2) 'ineffective', (3) 'neither effective nor ineffective', (4) 'effective' and (5) 'very effective'. In the third part, 30 statements are presented about the perceived results of silence, with the response options: (1) 'I definitely do not agree', (2) 'I do not agree', (3) 'neutral', (4) 'I agree' and (5) 'I definitely agree'. The scale's Cronbach's alpha coefficient is 0.92. In this study the Cronbach's alpha coefficient scores for the organisational silence scale are as follows:

First section: the issues on which participants remain silent, 0.93; second section: reasons for remaining silent, 0.96; Third section: perceived results of silence, 0.96.

Higher average scores in the sub-dimensions of the scale were interpreted as causes of organisational silence. The data collection instruments were given to the nurses and midwives, who were selected by random sampling between 2 July 2013 and 28 September 2013 after permission was granted from the hospital and after the nurses and midwives were provided with an explanation of the aim of the study and their informed consents were received. The consent forms were returned within a week.

Data analysis

Normality was tested using the Shapiro–Wilk test. Student's *t*-test and one-way ANOVA tests were used for the differences in socio-demographic attributes and scale scores. The equality of variances was tested with the Levene test. Fisher's LSD test was used for paired comparisons. Minima, maxima, averages and standard deviation values were given as descriptive statistics. Pearson's correlation coefficient was used for the differences between scores and length of employment. The threshold for statistical significance was $P < 0.05$.

Limitations of the study

Given that the sample was limited to university employees, generalisations involving the midwives and nurses employed in public and private hospitals were unable to be made.

Results

A total of 159 participants, 135 (84.9%) nurses and 24 (15.1%) midwives, were included in the study. Of the nurses and midwives, 88.7% (141) were women and 11.3% (18) were men. The average age of the female participants was 32.3 ± 6.2, while for men it was 26.8 ± 4.4. The average age of all the participants was 31.7 ± 6.3. The average length of employment at the institution was 10.0 ± 7.3 years.

With regard to reflecting the problems related to workplace and sharing these with the administrators, 42.1% of the nurses and midwives generally talked to their administrators easily, while 61.6% of them remained silent about important problems. Of all the participants, 8.8% expressed that they never remain silent about work and workplace related issues, while 3.8% of them stated that they always remain silent (Table 1).

The sub-dimensions or issues about which they mostly remained silent were determined to be 'ethics and responsibilities' (3.62 ± 0.84), 'employee performance' (3.26 ± 0.83) and 'recruitment efforts' (3.20 ± 0.87). The sub-dimensions that they remained less silent about were; 'job opportunities' (3.18 ± 0.96) and 'administrative problems' (3.12 ± 0.92). 'Lack of experience' (3.64 ± 0.98), 'issues about work'

Table 1
The distribution of scale scores for issues about which the employees remain silent

The issues about which the nurses and midwives remain silent	*Min–Max*	*Mean ± SD*
Ethics and responsibilities	1–5	3.62 ± 0.84
Administrative problems	1–5	3.12 ± 0.92
Job performance	1–5	3.26 ± 0.83
Recruitment efforts	1–5	3.20 ± 0.87
Job opportunities	1–5	3.18 ± 0.96

The reasons nurses and midwives remain silent	*Min–Max*	*Mean ± SD*
Administrative problems	1–5	2.77 ± 1.01
Issues about work	1–5	3.33 ± 0.98
Lack of experience	1–5	3.64 ± 0.98
The fear of isolation	1–5	2.89 ± 1.01
The fear of damaging relationships	1–5	3.02 ± 1.07

Table 2
The distribution of participants' socio-demographic characteristics and the issues about which they remain silent

	Ethics and responsibilities			*Management problem*			*Job performance*			*Recruitment efforts*			*Job opportunities*			*Total score*		
	M	*SD*	*P*	*M*	*SD*	*P*	*M*	*SD*	*P*	*M*	*SD*	*P*	*M*	*SD*	*P*	*M*	*SD*	*P*
Gender																		
Female (n = 141)	3.63	0.83	0.749	3.13	0.90	0.887	3.24	0.79	0.480	3.20	0.83		3.22	0.93	0.167	3.32	0.69	0.876
Male (n = 18)	3.55	0.98		3.09	1.06		3.39	1.12		3.25	1.12	0.813	2.89	1.14		3.29	0.95	
Profession																		
Nurse (n = 135)	3.66	0.85	0.118	3.17	0.92	0.131	3.27	0.85	0.753	3.22	0.88	0.627	3.20	0.96	0.637	3.34	0.72	0.173
Midwife (n = 24)	3.37	0.78		2.86	0.89		3.21	0.76		3.13	0.77		3.10	0.92		3.13	0.71	
Marital status																		
Married (n = 103)	3.64	0.81	0.635	3.08	0.87	0.468	3.30	0.81	0.342	3.22	0.87	0.783	3.20	0.93	0.745	3.31	0.69	0.921
Single (n = 56)	3.57	0.91		3.19	1.00		3.17	0.86		3.18	0.86		3.15	1.00		3.30	0.79	
Educational status																		
High school (n = 9)	3.71	0.93	**0.036**[#]	3.61	0.92	**<0.001**[#]	3.26	1.15	0.797[#]	2.94	0.74	0.236[#]	2.89	1.05	**0.048**[#]	3.39	0.74	**0.010**[#]
Associate's degree (n = 24)	3.33	0.91		2.51	0.99[a]		3.21	0.94		2.97	0.73		2.93	1.05		2.96	0.74	
Bachelor's degree (n = 118)	3.62	0.82		3.16	0.84[b]		3.25	0.80		3.25	0.89		3.20	0.92		3.34	0.71[b]	
Postgraduates (n = 8)	4.32	0.58[b]		3.77	0.98[b]		3.54	0.64		3.56	0.88		3.96	0.70[a,b,c]		3.90	0.47[b,c]	

The differences according to [a]high school degree, [b]associate's degree; [c]bachelor's degree.
**P*-values of Student's *t*-test; [#]*P*-values of one-way ANOVA.

(3.33 ± 0.98) and 'fear of damaging relationships' (3.02 ± 1.0.7) were determined to be the reasons of remaining silent (Table 1).

In the analysis of whether profession, gender and marital status affected the issues about which the participants remain silent, no significant relationships were found. When analysed in terms of educational status, significant differences were found in the issues of ethics and responsibilities ($P = 0.036$), administrative problems ($P < 0.001$) and job opportunities ($P = 0.048$). In terms of ethics and responsibilities, the scores of postgraduates were higher than graduates with an associate degree ($P = 0.004$). In terms of administrative problem scores, high school graduates had higher score averages than graduates with an associate's degree ($P = 0.002$), while graduates with a bachelor's degree and postgraduates had higher score averages than graduates with an associate's degree (both P values were 0.001). Job opportunities scores increased in line with the rise in educational levels (P values were, respectively, 0.021, 0.008 and 0.030) (Table 2). The difference between high school graduates and postgraduates was $P = 0.021$; between associate's degree and postgraduates was $P = 0.008$ and between bachelor's degree and postgraduates was $P = 0.030$.

A reverse linear relationship was found between age and administrative problems ($r = -0.182$; $P = 0.022$). Administrative problems decreased with a rise in age. No linear relationship was found between working year and scale scores. Among all of the subscale scores, a direct linear relationship was observed (Table 3).

In the analysis conducted on whether there was a difference between scale scores of midwives and nurses according to socio-demographic attributes in terms of the reasons for remaining silent, the only significant differences found involved the relationship between educational status and the fear of damaging relationships and the fear of isolation (the P values were 0.019 and 0.029, respectively). The fear of isolation score averages of high school graduates were found to be higher than the same averages in graduates with an associate's degree ($P = 0.033$), and furthermore, these score averages were higher for the participants with bachelor's degrees than for those with associate's degrees ($P = 0.011$). When the average scores of participants who feared damaging relationships were analysed, the score average of high school graduates was found to be higher than that of the graduates with an associate's degree and postgraduates (the P values were 0.017 and 0.048, respectively), and the score average of university graduates were higher than graduates with an associate's degree ($P = 0.024$) (Table 4).

In the test conducted on whether the scale scores for the nurses' and midwives' reasons for silence varied by age and length of employment, these factors were found not to affect the scores. All the subscale scores for remaining silent were observed to have a direct linear relationship among themselves (Table 5).

Regarding the perceived results of organisational silence, the most common responses from nurses and midwives were that 'it inhibits improvement and development' (2.11 ± 0.76), 'it makes the employer unhappy' (2.01 ± 0.73) and 'it impairs performance and reduces synergy' (1.99 ± 0.80) (Table 6). In comparing the perceived results of organisational silence by gender and professional and educational status, no significant differences were found ($P > 0.05$). The only significant difference was in the sub-dimension of 'it makes the employer unhappy', where the scores of single participants were found to be lower than those who were married ($P = 0.031$). When the scale scores regarding perceived results of organisational silence and age and length of employment were compared, it was observed that while the scale scores were not affected by those features, all the subscale scores were affected by each other.

Table 3
The comparison of participants' ages and length of service and the issues about which they remain silent

	Ethics and responsibilities	*Management problems*	*Performances of the employees*	*Recruitment (rehabilitation) efforts*	*Job opportunities*	*Total score*
Age	−0.014	−0.182*	0.013	−0.013	−0.07	−0.09
Length of service	0.008	−0.117	0.008	−0.005	−0.016	−0.049
Ethics and responsibilities	1	0.596**	0.595**	0.693**	0.632**	0.899**
Administrative problems		1	0.468**	0.448**	0.594**	0.822**
Job performance			1	0.618**	0.363**	0.712**
Recruitment efforts				1	0.552**	0.789**
Job opportunities					1	0.754**

*$P < 0.05$; **$P < 0.001$.

Table 4
The distribution of participants' socio-demographic characteristics and reasons for remaining silent

	Administrative problems			*Issues about work*			*Lack of experience*			*The fear of isolation*			*Fear of damaging relationships*			*Total score*		
	M	*SD*	*P*	*M*	*SD*	*P*	*M*	*SD*	*P*	*M*	*SD*	*P*	*M*	*SD*	*P*	*M*	*SD*	*P*
Gender																		
Female (n = 141)	2.77	1.00	0.896	3.32	0.95	0.816	3.67	0.95	0.297	2.87	1.02	0.157	3.01	1.04	0.648	2.91	0.80	0.991
Male (n = 18)	2.74	1.11		3.38	1.19		3.42	1.19		3.03	1.00		3.13	1.26		2.91	0.91	
Profession																		
Nurse (n = 135)	2.76	1.03	0.774	3.33	0.99	0.928	3.64	0.95	0.943	2.89	1.02	0.999	3.00	0.94	0.606	2.90	0.81	0.837
Midwife (n = 24)	2.82	0.95		3.31	0.93		3.66	1.11		2.89	1.01		3.13	0.94		2.94	0.80	
Marital status																		
Married (n = 103)	2.78	0.97	0.874	3.31	0.89	0.704	3.71	0.89	0.251	2.81	0.93	0.225	2.94	0.98	0.198	2.91	0.75	0.852
Single (n = 56)	2.75	1.09		3.37	1.12		3.52	1.11		3.02	1.14		3.18	1.20		2.93	0.92	
Educational status																		
High school (n = 9)	3.00	0.70	0.197[#]	3.46	0.80	0.223[#]	3.81	1.01	0.876[#]	3.25	1.13	**0.019**[#]	3.56	0.97	**0.029**[#]	3.14	0.69	0.094[#]
Associate's degree (n = 24)	2.47	1.10		3.06	0.92		3.56	1.02		2.42	0.95[a]		2.57	1.09[a]		2.63	0.82	
Bachelor's degree (n = 118)	2.84	1.00		3.40	0.98		3.66	0.94		2.99	0.99[b]		3.10	1.05[b]		2.98	0.79	
Postgraduates (n = 8)	2.33	1.09		2.88	1.20		3.47	1.44		2.34	1.02		2.54	0.89[a]		2.51	0.97	

*P-values of the Student's t-test; [#]P-values of the one-way ANOVA.
[a]Shows the differences between high school graduates; [b]shows the differences between associate's degree.

Discussion

Today, the idea of democratic participatory management is gaining more value. Employees can make important contributions to management when they voice their thoughts, opinions and criticism. While members of the medical staff are expected to be confident and able clearly and without fear to express their opinions, suggestions and knowledge, in practice, information sharing and communication between staff are not supported in many workplaces (Erigüç *et al.* 2014a,b). Our study found that 42% of the nurses and midwives were able easily to voice their concerns about workplace, and only 8.8% of them never remained silent about work related issues. These figures suggest that problems exist with regard to the present management mentality and operation. Among the nurses and midwives, 61.6% responded in the affirmative to the question, 'Has there ever been a time that you could not talk to your administrators about a work related problem that concerned you?'. Similarly, in a study conducted in Turkey by Çakıcı (2008), 70% of the employees stated that they had experienced organisational silence for their entire working lives and consciously choose not to share their knowledge and experiences.

The training and research hospital where the study was conducted is a public institution. A hierarchical structure dominates public institutions in Turkey. The reason for the organisational silence of the more than 50% of the participants can be attributed to the traditional administrative structure. Unlike our findings, in a study that analysed the organisational silence of nurses employed in private hospitals, Yalçın and Baykal (2012) stated that most of the nurses (72%) did not remain silent about important problems and information.

In our study the sub-dimensions or issues they remained silent about most were found to be, in order of prevalence, 'ethics and responsibilities', 'employee performance' and 'administrative problems'. These findings are similar to the research findings of Morrison and Milliken (2000), who claim that the main reasons for organisational silence are related to ethics, responsibilities and mistreatment. 'Job opportunities' and 'administrative problems' were the sub-dimensions that caused the least degree of organisational silence in our study.

In the scoring system of our study, where three points indicated sometimes remaining silent and four points indicated generally remaining silent, the average score was more than three in all sub-dimensions. With

Table 5
The comparison of participants' ages and length of service and reasons for remaining silent

	Administrative problems	*Issues about work*	*Lack of experience*	*The fear of isolation*	*The fear of damaging relationships*	*Total score*
Age	−0.01	−0.079	0.09	−0.064	−0.111	−0.033
Length of service	0.033	−0.024	0.125	−0.047	−0.054	0.017
Administrative problems	1	0.690**	0.435**	0.648**	0.653**	0.912**
Issues about work		1	0.657**	0.719**	0.773**	0.884**
Lack of experience			1	0.556**	0.612**	0.683**
The fear of isolation				1	0.760**	0.826**
The fear of damaging relationships					1	0.841**

**$P < 0.001$.

Table 6
The distribution of scale scores for perceived results of organisational silence

Distribution of scale scores for perceived results of silence	*Min–Max*	*Mean ± SD*
Reduces performance and synergy	1–4.53	1.99 ± 0.80
Inhibits improvement and development	1–4.00	2.11 ± 0.76
It makes the employer unhappy	1–4	2.01 ± 0.73

the average scores being between 3.62 and 3.12, this means that the nurses and midwives remained silent in all sub-dimensions, especially in ethics and responsibilities. This result was not expected, given that the university is an institution that produces science and provides scientific training. Tangirala and Ramanujam (2008) study of nurses emphasised that organisational silence implies the loss of valuable information, which could be a primary resource for development and innovation. In our study, we determined that by not considering the positive and creative opinions of nurses and midwives, problems could be prevented from being resolved in a timely manner.

When the reasons for the organisational silence of nurses and midwives were analysed, it was observed that they largely remain silent due to, in order of prevalence, lack of experience, issues about work and the fear of damaging relationships. In the literature, managerial and organisational reasons feature more prominently than they did in our study (Yalçın & Baykal 2012). This could be attributed to the fact that our sample consisted of mostly young nurses and midwives. In agreement with the findings in the literature, work related issues and the fear of damaging relationships were commonly cited as causes of organisational silence. The participants in a study by Çakıcı (2010) stated that when they had information about the inadequacy of the job performance of their coworkers, they tended not to share it and remained silent. Studies show that when employees report problems and mistakes to administrators, they feel uncomfortable. Senior management similarly tends to avoid or delay feedback about poor performance (Ozdemir & Uğur 2013).

It was determined that the degree of organisational silence of nurses and midwives varied by age. A reverse linear relationship was found between age and administrative problems ($r = -0.182$; $P = 0.022$). Administrative problems cause less organisational silence as age increases. It may be that older employees did not refrain from talking because they knew and had internalised the institutional structure. Another cause of this difference could be ascribed to the diminished fear that the employees, who have earned retirement in the public institutions, have of losing their job. Bayın *et al.* (2015) reported that people remained silent less often about administrative and organisational issues as they got older; a finding that was consistent with this study's results.

When the remaining reasons for the organisational silence of the participants were analysed, it was determined that there was no significant difference between the professions (nurse and midwife), and organisational silence did not vary according to gender. Certain studies, however, have shown that women remain more silent than men (Erigüç *et al.* 2014a,b), while others, including our study, found no significant difference by gender (Ozdemir & Uğur 2013).

In 2007, the educational requirements for nurses and midwives in Turkey were standardised nationwide, being raised to the undergraduate level. However, most nurses still have a variety of educational levels (e.g. high school degrees, associate's degrees, undergraduate degrees). The findings of the study determined that there was a statistically significant correlation between these educational differences and the sub-dimensions of fear of being isolated and fear of damaging relationships ($P < 0.05$). The fact that high school graduates largely remain silent due to the fear of isolation and damaging relations may be the

result of their lack of professional awareness. Accordingly, they should be given university-level vocational training.

The nurses and midwives frequently stated that organisational silence inhibits improvement and development and makes employees unhappy. Impaired performance and lower synergy were mentioned less often. The perceived results of silence were not affected by socio-demographic variables. Being open to new ideas and valuing people are effective factors in developing commitment to an institution. People with high commitment tend to speak up and resolve problems as opposed to leaving the institution.

Conclusion

More than half of our sample has experienced organisational silence. This study found that the experience of organisational silence was influenced by age and educational level. It was determined that the nurses and midwives in our sample remain silent most about the issues of ethics and responsibilities and said that they remained silent largely because of their lack of experience. This study revealed that organisational silence is common among nurses and midwives at university hospitals, and that it acts as an obstacle to the enhancement and improvement of health care. In order to provide the worker's contribution as the source of innovation and alteration in hospitals, open communication mechanisms should be established. The thoughts of personnel should be taken into consideration about increasing the quality of care. Moreover, a corporate reporting system must be developed which records patients safety and medication errors without having a fear of dismissal, exclusion.

Implications for health service administrators

Establishing an open and sincere organisational culture characterised by the belief in benefiting from the diversity created by different ideas and opinions will ensure that employees express their ideas, opinions, concerns and suggestions about work. By improving the service quality of health institutions, establishing open communication channels between patients, patients' families and hospital employees and ensuring continuous and accurate flows of information, employee participation in organisational activities increases. Health service administrators must make efforts to establish and sustain organisational relationships based on mutual trust, shared competence and responsibility. This requires shared decision-making. Hospital administrators would be well advised to identify their institution's dominant tendencies regarding organisational silence so as to prevent its deleterious effects and to ensure better working environments for midwives and nurses. Activities that raise the awareness of hospital administrations and employees about preventing the factors that cause and maintain silence in hospitals should be planned, and a larger scale study of organisational silence should be conducted using other medical staff.

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Ethical approval

Prior to the research, written consent was received from the institution, ethical consent was received from the Clinical Research Ethical Committee of Mersin University (number and date: 2012/248; 5 July 2012) and both written and verbal consents were received from the participants after they were informed about the aim of the study. The participants were informed that their information would be kept confidential and not be used for any other purposes. The expenses related to the study were covered by the researchers.

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