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Abstract

Whistleblowing about critical issues by care staff is an essential component of any well-functioning health care system. During a pandemic, rapid communication of critical information is essential to identify and solve problems. In times of crisis, however, this kind of communication is difficult. In the province of Quebec, Canada, testimonies from nurses, licensed practical nurses (LPNs), and other health professionals during the COVID-19 pandemic indicate that the province's health care settings have met whistleblowers' concerns with insufficient corrective measures and, in some cases, retaliation against whistleblowers themselves. This crisis led a union to create an online platform to collect testimonials from the public and quickly make them available to the public and the media. By presenting a content analysis of testimonials submitted by nurses and LPNs, this article aims, on one hand, to identify the issues raised and, on the other, to examine the role and usefulness of this kind of platform for nurses who engage in acts of whistleblowing.

Key Words content analysis, whistleblowing, pandemic, nurses, retaliation

Nurses whistleblowing during the COVID-19 pandemic: Content analysis of the "Je dénonce" platform

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Introduction

Whistleblowing about critical issues by nursing staff (understood to include registered nurses and licensed practical nurses [LPNs]) is an essential component of any well-functioning health care system. It is particularly useful to highlight practices that threaten the safety and wellbeing of patients and workers. During a pandemic like that caused by the novel COVID-19 coronavirus, rapid communication of critical information is essential to identify and solve problems while the health system attempts to slow the pathogen's spread and limit its harmful, often lethal, effects on the population. In times of crisis, however, this kind of communication is difficult. It is also assumed that organizations under pressure are actually willing to receive this critical information. In Quebec, testimonies from nurses, LPNs, and other health professionals during the COVID-19 pandemic indicate that health care settings have met whistleblowers' concerns with insufficient corrective measures [see examples 1-3] and, in some cases, retaliation against whistleblowers themselves, despite the merits of their actions [see examples 4, 5].

In Quebec, the crisis prompted the province's largest nursing union, the Fédération interprofessionnelle de la santé du Québec (FIQ), to create an online platform. The Je dénonce ("I denounce") platform collects testimonials from the general population and professionals in caring and non-caring roles (across all occupations) and quickly makes them available to the public and the media in order to expose challenges in how the health care sector is managing the pandemic. Such a platform is unprecedented in health care. It therefore provides an opportunity to deepen our understanding about whistleblowing by nursing professionals who raise the alarm

about concerning, dangerous, or illicit situations in their practice settings. Through a content analysis of testimonials submitted to Je dénonce by nurses and LPNs, this article aims, on one hand, to identify the issues raised and, on the other, to examine the role and usefulness of this kind of platform for nurses who engage in acts of whistleblowing after witnessing unsafe or objectionable practices.

Background

In health care, people who blow the whistle do so after having witnessed professional/clinical practices (by health professionals) or administrative practices (by managers or decision-makers) that disregard applicable rules, norms, or laws. Here, "whistleblowing" is used as defined by Near and Miceli: "The disclosure by organisation members (former or current) of illegal, immoral or illegitimate practices under the control of their employers, to persons or organisations that may be able to effect action" [6 p4]. Current research shows that most people who reach outside an organization to raise their concerns first attempted to do so through internal channels. [7,8] The act of whistleblowing is usually perceived as an affront to organizational expectations of employee conformity and loyalty. [9,10] It is therefore generally assumed that external whistleblowing is only acceptable when all other (particularly internal) means of reporting have been exhausted. [see for example 11]

Nurses may have access to a variety of reporting options, including informing their superiors, filling out incident reports, or using anonymous internal reporting systems. [12] However, in many cases, these reports fail to produce concrete results and many whistleblowers note that issues persist. Numerous studies show that nurses have little confidence in organizational procedures for dealing with their complaints, [13,14] which may lead them to turn to external channels. Several authors believe that external whistleblowing is a clear indication of organizational failure that could be resolved if organizations strengthened their internal reporting mechanisms, efficiently managed the problems reported, and promoted a culture of integrity, transparency, and improvement. [8, 15, 16]

Whistleblowing has serious consequences for everyone involved. For whistleblowers, internal reporting can lead to increased surveillance of their work by their superiors, arbitrary performance evaluations, and peer isolation. [17, 18] In cases of escalating reporting strategies, whistleblowers' judgment and competence may be discredited and their performance increasingly monitored; they may also experience ostracism, harassment, threats, and retaliation up to and including loss of employment. Every study consulted reports serious emotional consequences: isolation; loss of self-confidence; disengagement with patients; desire to leave the profession; anxiety, depression; and, in more extreme cases, suicide. [17,18] For organizations, whistleblowing is generally negatively perceived, even when the issues in question have been recognized. (19) Although it is possible to implement constructive responses that do not affect the whistleblower, they are astonishingly rare. [9. 19] In most cases, constraints are rapidly put into place to control both the public impact of the whistleblower's actions (minimizing the situation, evoking an isolated incident, discrediting the whistleblower, etc.) and the whistleblower's ability to speak or act, often to an extreme extent. [7,9]

During the COVID-19 pandemic, whistleblowers came forward around the world and reports indicate that the aggressive responses they experienced during this crisis are no different from those in pre-pandemic times [for an overview of notable cases, see 20]. This is no less true in Canada, and particularly in Quebec, where nurses and nursing organizations (primarily unions) have spoken up in exceptional numbers. [21] In light of issues arising from the continued pandemic and its increasingly incoherent management, at the end of March the FIQ launched a platform called "Je dénonce" ("I denounce") to collect testimonials about unsafe and objectionable practices within the health care system.

Je dénonce is available to anyone who wishes to publicly denounce situations or practices that could or do place patients and health care workers (in care, non-care, management, and other roles) at risk. More specifically, the union seeks to position these testimonials in contrast to information about the crisis provided by government authorities. On the platform's website, the FIQ states that

This website was created to bring together all the testimonials about health professionals' on the ground experiences during the current public health crisis. We seek to highlight the gap between what the government says and the reality faced every day by health care professionals in the system. [22] (original translation)

In addition to this short description of the platform's objectives, one of the page's menu tabs presents potential users with considerations in both French and English. It specifically provides reminders about freedom of expression and its limits, while also offering guidance for how to safely sound the alarm, given the public nature of whistleblowing.

The whistleblowing tools itself presents users with a simple form to collect their name, job title, and workplace.

Whistleblowers can decide whether to make their identity public or not; most submissions consulted for this analysis indicate that whistleblowers prefer to remain anonymous. A description of the reported issue can be entered in a free text field, and users have the option to include photos or videos to support their testimonial. Each person's consent is confirmed before they can submit their testimonial to the platform. Testimonials are verified before being posted online (Fédération interprofessionnelle de la santé du Québec, personal communication, June 28, 2020). The first testimonials were submitted on March 29, 2020. The vast majority of whistleblowers are nurses and LPNs, but other types of workers (e.g. patient attendants, social workers, respiratory therapists, physicians, maintenance staff) and members of the public have also submitted testimonials.

The purpose of this study was to analyze the reports made public through the Je dénonce platform and to determine its degree of usefulness in addressing critical pandemic-related concerns. This article presents the results of a content analysis of nurses' and LPNs' testimonials submitted via Je dénonce over a two-month period; in doing so, it seeks to first identify the types of issues raised and second to examine the role and value of this kind of tool for nurses who engage in acts of whistleblowing after witnessing unsafe or objectionable practices.

Methods

In keeping with our goal to study nurse whistleblowing experiences, we analyzed testimonials submitted specifically by nurses and LPNs between March 29th and May 31st, 2020. This period was chosen to capture reports covering the platform's launch, the peak of the crisis, and the following weeks, while also obtaining a robust dataset. A total of 611 testimonials were initially collected for this time span, fourteen of which were discarded because they were provided by members of the public or were off-topic. Our sample consisted of 597 testimonials by nurses and LPNs.

Content analysis was performed on our dataset. This approach allowed us to identify and describe themes emerging from nurses' testimonials. Our analysis was conducted according to conventional principles for this approach. [23,24] We followed an inductive method and allowed categories to emerge from the analysis. To begin, 50 testimonials were randomly chosen to identify general themes. Next, 20 additional testimonials were added to test and refine our analytical strategy. This process produced twelve categories. We tested these categories with ten additional randomly chosen testimonials and, finally, with the entire sample. No ethics approval was required to conduct this analysis, as testimonials are freely available to the public.

Results

Through our analysis we identified 12 categories (Figure 1) and determined the frequency of each within our sample (Figure 2). The categories are: 1. Hierarchy; 2. Invalidation; 3. Instrumentalization; 4. Control measures; 5. Overwork; 6. Insufficient resources; 7. Multiple inconsistencies; 8. Violation of infection prevention and control standards; 9. Fear; 10. Suffering; 11. Resistance; 12. Resignation. Descriptions of each category are presented below.

Hierarchy

The notion of hierarchy is brought up in 48 testimonials (8%). Hierarchy is intrinsic to Quebec's health care system and determines its care management model. It also dictates the position of certain groups and specialties within that system. The pandemic appears to exacerbate inequalities between certain professionals; those of higher status benefit from better protection from the virus and different information about it, as illustrated in the following excerpt.

> I'm a nurse, they ask me to limit the use of medical equipment because of the PPE [personal protective equipment] shortage. But, for medical specialists (gynecologist), the recommendation is to wear a mask and glasses and/or shield at all times given the risk of community spread. (Testimonial 370).

Health care settings are also hierarchized. Consequently, disparities in equipment and budget allocations are reported across departments and specialties.

> At the long-term care centre, management wanted us to take every resident's temperature QD, but we don't have a portable thermometer, we asked for a thermometer on the COVID-19 budget. The answer was "Long-term care centres are last on the list to use the COVID-19 budget". (Testimonial 625)

Figure 1: Number of testimonials for each category

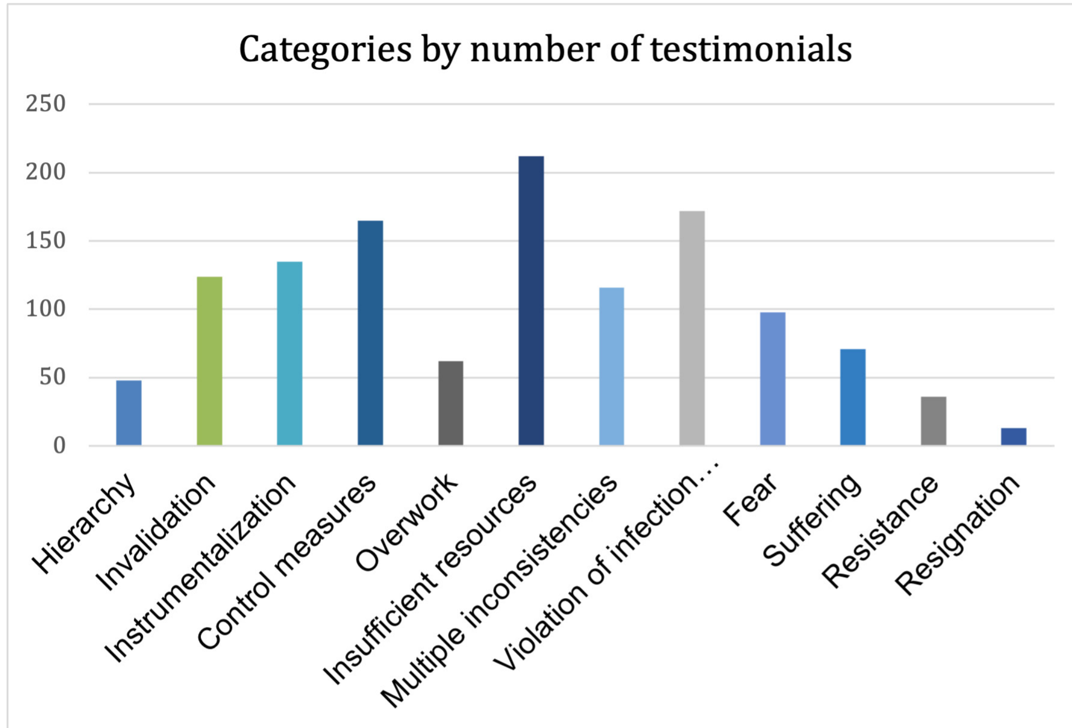
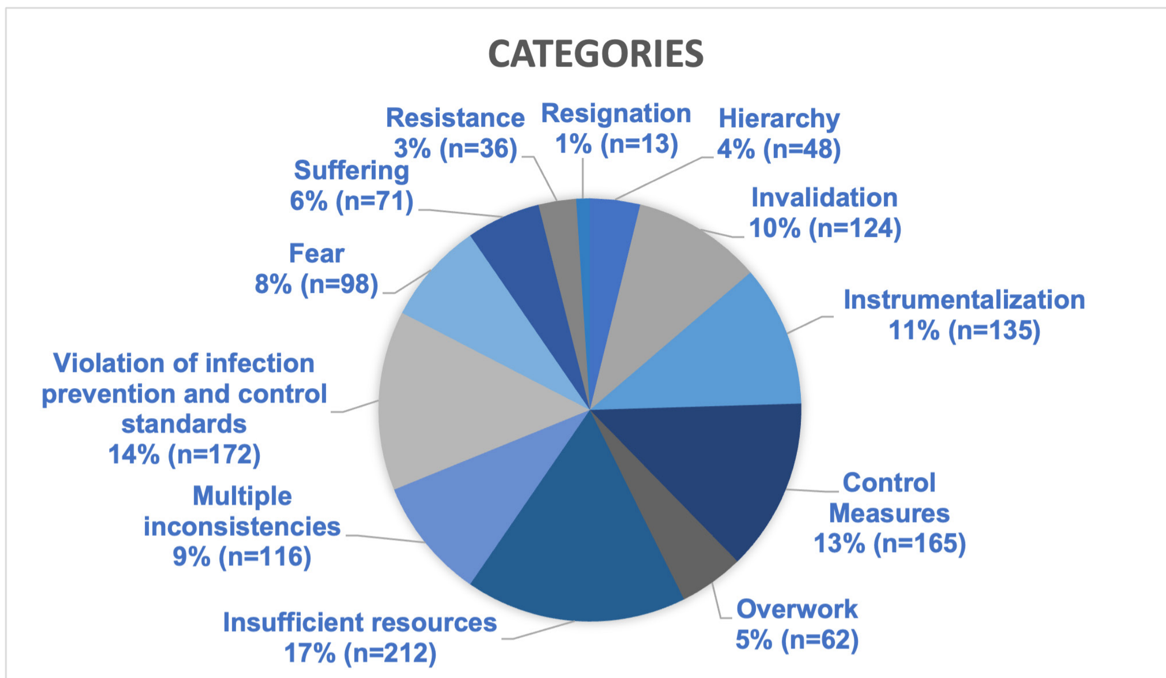


Figure 2: Distribution of percentages for each category (one testimonial can appear in more than one category)



Nurses and LPNs also report that immediate supervisors (department heads) have limited decision-making power and that problematic decisions are made by higher authorities.

> I'm not blaming management, because they're working the best they can, but really the problem is higher up. (Testimonial 831)

Invalidation

Being invalidated is reported in 21% of nurse and LPN testimonials (n=124). Invalidation is understood as having one's observations, concerns, and suggestions ignored. Many whistleblowers describe having their clinical expertise, experience, and judgment devalued in this way.

> One morning an infection prevention specialist came to talk to us… She gave us instructions that went against everything we had been taught and recommended to date… No gloves, we just have to wash our hands. No waterproof gown covering the entire body, the short yellow fluid-resistant gown is enough. (…) It didn't matter that we explained that once we're on the unit we have to intervene with patients who are decompensating. We're not just passing through here. We're at the bedside. We act, we are professionals who perform invasive acts. (Testimonial 706)

Many testimonials also recount difficulty getting answers to questions or even communicating problematic situations to a manager. The following excerpt describes such an instance.

> I knocked on every door, I wrote a 16-page testimonial to ask for help from several people… I sent emails, I used Messenger, I called… But no one came, no one helped us. (Testimonial 840)

Other testimonials denounce the fact that supervisors do not seem to consider nurses and LPNs as valid sources of information regarding issues such as changes on their unit for example.

> ... last Friday it was decided that a wing on my floor would be dedicated to COVID-19 and they decided to start on a Saturday, when I got to work nothing was ready, no one knew about it, no one on the floor had had a fit test in case a patient decompensated or presented severe respiratory symptoms. (…) Plus, there were no managers on site despite this unusual situation. I'm discouraged. (Testimonial 615)

A significant proportion of excerpts that mention the invalidation process also reflect nurses' and LPNs' feelings of discouragement and powerlessness – a point we will return to later.

Instrumentalization

Being instrumentalized was reported by 135 nurses and LPNs (23%). Instrumentalizing a person means treating them as an object rather than a human being. Submitted testimonials indicate that nurses seem to be perceived as interchangeable pawns that can be transferred across units and departments based on administrative needs, without regard for their skills or experience.

> We get the impression that HR management is taking advantage of the situation to increase workforce mobility, to put all the nurses on float teams, a management technique that will persist after the pandemic. They show that, for them, a nurse is the same as any other and the expertise gained in a specialized field means nothing, each nurse is easily replaced by another after perfunctory training. Thank you for showing your nurses just how easily replaceable they are, even when patients suffer from the loss of expertise in your facilities. (Testimonial 775)

In the same vein, testimonials point to a lack of concern for nurses' wellbeing and trivialization of working conditions in ways that compromise their physical and mental health.

> Since COVID-19 I have anxiety because I have to be on the front line (with patients) even though I have a chronic illness, uncontrolled asthma from birth. My employer does nothing and refuses to transfer me into a safe job for my condition (office work). He leaves me at home without pay, despite my desire to go work, he refuses! Despite a medical certificate. This is not how you take care of your staff or act like a human being. It's not normal, when I have a friend who works at Tim Hortons and is also asthmatic under control, and her boss understood, he is more humane than mine and sent her home and she's paid… IT DOESN'T MAKE SENSE, THIS IS HOW THEY TREAT US? (Testimonial 402)

Similarly, many testimonials indicate that pregnant and immunosuppressed nurses and LPNs are forced to work without being removed from risky environments.

> Even knowing my health status (immunosuppressed), they refused to take my specialist's medical certificate into consideration. I was told that I would be assigned to the hot unit this Sunday (very contagious zone), whose current COVID-19 status I know. (Testimonial 824)

This analysis highlights irritants in certain care centres regarding nurse compensation. For example, some testimonials describe how bureaucratic decisions allow some hospitals to evade payment of premiums meant to compensate nurses working in units impacted by the pandemic.

> We're a unit with several specialties, including pneumology. We won't get the 8% bonus promised by the government because the unit has two corridors and the other corridor is a cold zone, so we're penalized. (Testimonial 698)

> In my hospital, to avoid having to give the bonus to too many people, they changed the definitions of hot and warm zones. One of the floors has a section for

> suspected or positive covid-19 cases, but the people who work there won't get the bonus because now it's considered a "warm" zone. (Testimonial 873)

The instrumentalization expressed in these testimonials is striking, given the numerous statements by elected officials, health centre administrators and members of the public praising nurses' dedication and heroism. As such, the trivialized instrumentalization of nurses during the pandemic is at odds with how one might expect so-called "guardian angels" to be treated. Many nurses and LPNs denounce this situation and the perversity underlying the name "guardian angel".

> Angels? No. We're slaves to our system, at our own risk, at the risk of our children. Why do we have to be on the front lines, without protection, unpaid if symptomatic and with so little recognition. (Testimonial 287)

> We're like cannon fodder. Slaves to the CISSS [Integrated health and social services centre]. Treated like numbers. (Testimonial 102)

Control measures

Analysis indicates that 28% of testimonials (n=165) concern control measures imposed on nurses and LPNs. These measures, which narrowly restrict nurses' work to doing what is strictly expected of them, operate on different levels. For example, many testimonials describe how protective equipment is often controlled by being locked away so staff must obtain special permission to gain access.

> I'm in a nursing clinic in a local community service centre, since the beginning of the pandemic, we have only had access to surgical masks for the last few days, we have two boxes available in the clinic, the others are hidden and locked away. We're only allowed to use the masks for PICC line care and are monitored by the [assistant nurse clinician to the immediate supervisor] when we use them. (Testimonial 578)

> Masks locked away by our manager, hand sanitizer removed from our offices and home care supplies. Disinfectant wipes unavailable or in limited quantities to disinfect our home care equipment. We're regularly told that supplies are not available for disinfection. We feel like we're being watched every time we use supplies. In home care it is critical to disinfect our equipment between each client!!! (Testimonial 548)

Nurses and LPNs also report managers using threats to control the sharing of information.

> Every day our superiors send emails warning us not to denounce the lack of supplies and staff management. (Testimonial 508)

Many nurses and LPNs also report being bullied and suffering retaliation for questioning directives. Refusing to follow orders, even those contrary to public health directives, leads to sanctions. The example below was provided by an LPN working in a long-term care facility with no COVID-19 cases who refused to go work in another facility known to have around one hundred positive cases, for fear of triggering an outbreak in her original place of work.

> They tell me that I have the least seniority, so I'm the one who has to go and there could be sanctions if I REFUSE to go!! I ask what sort of sanctions? Because I don't want a note on my file! He (assistant head nurse) answers with uncertainty that he's heard of fines up to $4000 or that after 3 refusals they would take away all my seniority that I WORKED FOR AND DESERVE!! I think about it (…) I decide and say NO! After I refuse, my assistant contacts the coordinator who tells him to send me home!!! (Testimonial 856)

Many testimonials report tight controls imposed on workers according to ministerial orders. They describe administrators' abusive application of this exceptional measure to fill staff shortages that predated the pandemic, even in the absence of COVID-19 cases. These abuses translate into imposed full-time work over multiple shifts; the obligation to be mobile and transfer to other departments or even institutions; and the cancellation of vacation time.

> I find it strange that my institution is applying the ministerial order. They've already started to cancel vacations, stat holidays, and impose full-time hours even though there's absolutely no need… I work in intensive care where there have been no COVID cases because we transfer them automatically. We can't get the 8% bonus for this very reason! Why apply the decree since we aren't getting the bonus under the pretext that we are not in a COVID crisis!!! There are several staff surpluses every day but they're going to impose full-time hours? My institution uses the tools the government gives it even if it doesn't need them, just because they have the right! I'm discouraged. (Testimonial 797)

Such practices worry many whistleblowers, who fear these abusive management practices will become routine after the pandemic.

Overwork

Sixty-two nurses and LPNs (10%) report being overworked. This category reflects an imbalance between workload and the time and resources available to ensure quality care and patient safety. Nurses and LPNs attribute overwork primarily to increased complexity of care and lack of human resources across health professions (pre-existing staff shortages, absences due to COVID-19, etc.). This lack of resources creates unsafe nurse/LPN-to-patient ratios.

> It's not safe to work, no safety for patients, no confidence in the staff. I talked to a colleague yesterday, he feels the same way I do. This morning I heard that last night another colleague was… my god. He was all alone with a new nurse too and 1 casual care attendant. He said he didn't get a break, 1 fall and 2 deaths. A coordinator who only spoke to him on the phone told him to leave the bodies for the morning shift, inhumane. No physician to certify the deaths. (Testimonial 765)

As a result, care is not provided and patients suffer.

> A patient left in her room, poop on the floor, feverish. At 2pm lunch tray on the table untouched, breakfast tray in the garbage… Dehydrated++ No staff on the floor! It smelled like death in her room!!!! I screened her but I think that as I write these words, she must be dead from dehydration and not from COVID! CRIMINAL negligence!!! (Testimonial 925)

Insufficient resources

This theme emerges in 36% of testimonials (n=212) and focuses specifically on a lack of basic material resources to provide care, highlighting time lost and increased burden of care.

> There's a supply shortage. Yesterday to start an IV, I had to check stocks in 4 different departments (red, or yellow). This morning so I could continue the IV, for a resident who was transferred, I had to get special permission from the on-site department head to get the supplies I had set aside for her on a so-called red unit. An hour of time lost for two litres of solution, 1 vial of rocephin and some 100 ml NS pouches. (Testimonial 876)

Furthermore, physical environments are often inadequate. For example, in some places, workspaces do not allow physical distancing or they lack change rooms to change clothes before and after a shift.

> Most [patients] cough a lot and my workspace is less than 4 metres from patients. The morgue that comes to collect the bodies is better equipped than us (95, visor and full suit). (Testimonial 748)

Lack of protective equipment (medical/surgical masks, N95 masks, uniforms, gowns, gloves, etc.) is a problem for a large proportion of nurses and LPNs (178 testimonials, 84%). In the most extreme cases, they have to share protective equipment, reuse it, or even craft their own.

> Masks locked away by our manager, hand sanitizer removed from our offices and home care supplies. Disinfectant wipes unavailable or in limited quantities to disinfect our home care equipment. We're regularly told that supplies are not available for disinfection. We feel like we're being watched every time we take supplies. In home care it is critical to disinfect our equipment between each client!!! (Testimonial 548)

> I work on the floor where we now screen for COVID-19. (…) The day they wanted to admit these persons [COVID-positive patients], we had no masks, no visors, no gowns. One morning we were asked to watch a video to see how we're supposed to get dressed and undressed. The same morning they had us practice and at the end of the day they asked us to admit our first patients without protective equipment. Our administrative agency placed a rush order. We get glasses when we were only trained on visors. We have 10 disposable gowns for 16 hrs of work. And not enough N95 masks for everyone, there weren't enough of some sizes. So they ask us to wear expired masks. A binder was placed at the nursing station to find information, the binder is not kept up to date. The information is outdated. They ask us not to use all the recommended equipment for fear we'll run out. We have to direct our superiors to INSPQ [Quebec Public Health Institute] guidelines to get permission to use the equipment and we have to refuse to enter a room to get results. (Testimonial 39)

> We had to make our own "visors" out of acetate sheets that we shared and washed. It doesn't make sense and it's not at all professional. (Testimonial 166)

Multiple inconsistencies

One hundred and sixteen testimonials (19%) report multiple inconsistencies, that is, disconnection between information provided by health care administrators on one side and,

on the other, information required to perform one's work provided by public health authorities or obtained through professional training. Analysis of these testimonials reveals lack of communication, training, and consistency in the information provided. Nurses and LPNs also experience considerable stress due to inconsistent instructions and the speed at which information changes.

> ... this week, they showed us how to remove N95 masks with elastics very carefully by the elastics to avoid splashing and throw them out immediately during airborne isolation for an aerosol procedure with a COVID patient, they asked us to put the mask in a brown paper bag (supposedly so the mask can breathe…) and reuse the mask 5 times. To reduce contamination. It's an intubated person… At the same time they're trying to convince us, they post their own procedures in the rooms, step-by-step instructions for dressing and undressing for airborne isolation approved by the institution and the CIUSSS [Integrated University Health and Social Services Centre]. On this lovely sheet the procedure tells us to throw the mask in the garbage. (Testimonial 450)

> Department heads give us very little information and often contradict themselves. We ask them questions and they're often unable to answer. Not very reassuring, to say the least. The anxiety is palpable on the unit, the girls [nurses] are scared and many are saying they're going to quit if it starts to pose a risk for us and our families. We don't feel protected. (Testimonial 39)

Violation of infection prevention and control standards

Another high frequency category, violation of infection prevention and control standards, is described in 172 testimonials (29%). This theme reflects non-compliance with established standards to prevent the spread of COVID-19. Nurses and LPNs provide examples of inappropriate patient and personnel transfers between hot zones (units with patients confirmed positive for COVID-19), warm zones (units with patients suspected of COVID-19), and cold zones (units with no COVID-19 cases), as well as institutional non-compliance with directives from the Quebec Public Health Institute.

> At the long-term care centre where I work, there are no positive cases for now. But all weekend we had employees going from one centre to another including some who have worked in a centre with about ten cases. Managers are not respecting ministerial directives. (Testimonial 694)

Nurses and LPNs recognize that these situations are problematic, but indicate that they are not being listened to and lack the decision-making power to rectify the situation.

Fear

Ninety-eight testimonials (16%) reflect fear in nurses and LPNs who believe they put their safety and professional license at risk every day. They're also concerned with their health and that of their families, colleagues, and patients. Many also say they fear retaliation if, for example, they express their opinion or refuse a directive they consider unsafe.

> My biggest fear is the possibility of contaminating one of my vulnerable patients and them dying on my conscience. I would blame myself for the rest of my life… Nurses and other home care professionals all share the same fear. (Testimonial 430)

Suffering

Seventy-one testimonials (12%) describe intense physical and/or moral suffering. This suffering stems from nurses' and LPNs' difficult work conditions during the pandemic and it entails real consequences.

> In my case before the crisis I couldn't function anymore, I couldn't get to the end of the week, my morale is gone, I'm beat, tired, I won't last much longer. Every morning I wonder if I'll make it to work, every night I wonder how I made it through the day, there's no point living and working in these conditions. I'm sinking fast right now, I've become a shadow of myself. (Testimonial 788)

In these testimonials, lack of protection, not being heard, instrumentalization, and control measures are most frequently identified as sources of distress.

Resistance

Thirty-six testimonials (6%) report acts of resistance. Some nurses and LPNs indicate refusing to submit to pressures and threats and resisting their superiors. Several whistleblowers communicated with the media, others wrote letters and emails, while others still questioned procedures or outright refused to obey orders they deemed abusive or unsafe.

> I had been in contact with a patient suspected of having COVID whose result came back + yesterday during the day. I work nights, yesterday the department head wanted to move a nurse from this floor to care for patients in SSU [short-stay unit], us three nurses had to

> band together to refuse because we believed the risk of contaminating another department was too high. During this argument the IPC (infection prevention and control) specialist was present and didn't see a problem with transfers between floors with staff from the COVID floor. According to him, in principle there should be no risk of contaminating others if we follow hygiene measures… (that change by the minute). I told him that in principle the Concord Bridge overpass in Laval shouldn't have collapsed either!!!!!!! (Testimonial 522)

We can also consider using the Je dénonce platform as an additional act of resistance.

Resignation

Sixteen nurses and LPNs (2%) expressed a desire to resign or had already tendered their resignation.

> 24 years of service and the first time I'm seriously thinking about quitting! It's completely unbearable! (Testimonial 134)

> Unfortunately, I had to stop volunteering, because my physical and mental health can no longer be ensured by the long-term care centre or the CISSS [Integrated health and social services centre]. (Testimonial 840)

> Collectively, we're at the point of wanting to quit and recently our employer met with us to bully us. One nurse received a disciplinary notice yesterday, she quit on the spot which means the day shift has to do mandatory overtime. (Testimonial 571)

Resigning from one's position constitutes a significant act. These testimonials show that resignation, as a last resort, is used to protect nurses' and LPNs' physical and mental health from workplaces they deem intolerable.

Discussion

The 12 categories identified in the analysis of Je dénonce testimonials cover a broad range of intimately connected concerns, highlighting practices that harm patients' and nurses' wellbeing, safety, and rights. Although some of these issues are clearly linked to the pandemic (eg. availability of personal protective equipment, following public health directives), it should be noted that many of these concerns had already been the subject of analysis and criticism for several years, both in Quebec and elsewhere. Examples of these include organizational procedures that reify and invalidate care and those who provide it, abusive management practices, worsening conditions for care work, and muzzling of nursing staff [see 25-30 for instance]. In light of our analysis, it appears that the pandemic not only perpetuated, but also amplified these issues. In particular, the March 21, 2020 decree by the Ministry of Health and Social Services [31] allowing the suspension of many care workers' rights gave health care administrators unprecedented power to dispose of them as they wished within an absolute hierarchy, rather than through consultation, respect for professional expertise, and collaboration.

When contrasted with discourses dominating the public space since March 2020, which portray the work of health care professionals as nothing less than "heroic", testimonials collected through the Je dénonce platform reveal a completely different reality for nurses and LPNs. For example, the extent to which nurses' observations and opinions were ignored, and in many cases stifled, is difficult to explain given that managers and elected officials should be capitalizing on all available information to make consistent decisions to protect the (physical and emotional) health and safety of patients and care staff. Similarly, while managers lament the shortage of care workers to deal with the crisis, the number of nurses and LPNs who were suspended for refusing to obey orders that contradicted public health directives suggests that maintaining authority nonetheless remains the priority in many health care settings. This analysis demonstrates the extent to which the pandemic has created a fertile ground for mounting tensions among different understandings of issues (e.g. organization of care; administration of protective equipment; personnel management, including staff transfers) that can be difficult to reconcile when the health care system is already dealing with chronic management problems (especially of human resources), tense work environments, and diminished confidence between employers and employees. Each of these points clearly emerges from the corpus of testimonials. As noted by Simard et al.,

> when employees feel that the relational climate is positive and based on confidence and mutual respect, they identify more strongly with the [organization] and tend not to dramatize the risks in their work, while, conversely, if they feel that the relational climate is negative and based on domination and exploitation, they tend to perceive issues of health and safety as a symbol of their employer's lack of consideration for them. [32 p4] (authors' translation)

Research invariably shows that employees who lack confidence in their employer are more likely to turn to external

whistleblowing channels to expose recurring problems in their organization (7), an observation that is equally true for nurses. [33]

As the pandemic persists, the Je dénonce platform makes it possible to follow the emergence and evolution of critical issues in Quebec's health care system in near-real time. The fact that it represents the only tool of its kind available to health care workers and the public in Canada makes it an interesting object of study to better understand both nurse whistleblowing as a phenomenon and the forms it can take during a crisis. Significant use of the platform since launch shows that nurses and LPNs are ready to incorporate such a tool into their whistleblowing practices. It is also reasonable to conclude that they consider it a useful strategy to rectify problematic health care practices.

Potential advantages of the platform

We have compared the features of the Je dénonce platform to criteria set forth by whistleblowing researchers. Lee and Fargher have outlined the characteristics of different whistleblowing systems to determine which are most beneficial. [34] Although focused on the private sector, their analysis describes several elements applicable to public institutions. Specifically, they identify the opportunity for anonymous, confidential reporting as a vital component of effective whistleblowing tools. Moreover, maintaining whistleblowers' anonymity ensures protection against retaliation – a reality faced by a significant number of whistleblowers. [33,35] Whistleblowing tools should also be accessible, available, and easy to use. They should also give whistleblowers control over their information. Researchers and experts agree that whistleblowing tools must meet these criteria to encourage their use by whistleblowers.

Je dénonce meets all of these criteria by concealing informant identities, protecting them from retaliation, and giving them control over the information they wish to share. It is also easy to use (no training required), accessible (web platform), and available (online 24/7). It should be noted that it is also accessible to journalists and members of the public, who can consult testimonials whenever they wish. Regarding information control, the platform allows whistleblowers to decide on the amount of detail they want to share. They can formulate submissions in their own words and include supporting documents (photos, videos) if they choose. The platform also confirms the person's consent before registering their testimonial.

In terms of clinical and organizational practices, this kind of tool provides rapid access to critical information so essential during a pandemic (eg. to eliminate practices that facilitate pathogenic spread). It also facilitates detection of problematic patterns in specific settings or impacting certain professions. In addition, it allows a broader view of the issues and a means to identify potential systemic elements. A systemic perspective may also increase the likelihood of these issues being addressed; conversely, the perception that these problems are isolated cases or merely subjective interpretations reduces the probability of rigorous follow-up. [7,19] By consulting testimonials, journalists were able to paint a more complete picture of the evolution and effects of the pandemic throughout the health care system, the loss of control over outbreaks in some institutions, and the risks to which certain groups of workers were disproportionately exposed (eg. patient attendants, LPNs, nurses).

From a political point of view, we consider the Je dénonce platform an additional strategy available to nurses and other workers. It facilitates the transmission of critical information and therefore contributes to preserving the public interest. Furthermore, in cases where internal reporting procedures do not resolve the issue (a point often raised in testimonials), using external reporting channels like Je dénonce can help put pressure on organizations that ignore or respond ineffectively to concerns raised by their nurses, thereby changing the power dynamics between workers and employers.

Ultimately, we believe that Je dénonce is useful to researchers because it creates a dataset capable of revealing issues that may otherwise be difficult to access. It also creates opportunities to perform frequency, narrative, and simple or comparative analyses. Disseminating such analyses in public and academic forums can also help raise awareness and mobilize different groups to address the challenges faced by nurses during the pandemic. It amplifies the visibility of these issues and allows for deeper discussions about effective solutions.

Potential limitations of the platform

Various web-based tools have existed for many years to help whistleblowers share information safely. Generally speaking, reports submitted through these tools are received by designated agents (ombudsperson, compliance officer, etc.) whose responsibility it is to follow up. According to Lee and Fargher, follow-up is one of the criteria of a good whistleblowing tool [34]. In the case of Je dénonce, however, reports are not intended for someone with a specific mandate, but for anyone in the general population who might be interested in accessing the disclosed information. In other

words, the platform is not linked to a formal reporting process that follows a specific procedure intended to lead to remediation. Consequently, government representatives and leaders of institutions where these issues occur are free to ignore the reports published on the platform. The Je dénonce tool also lacks an integrated mechanism to ensure that those responsible for the sound governance of health care settings are held to account. Although this is not an objective of the platform, which is designed to enable the flow of information, the absence of a follow-up mechanism may discourage some whisteblowers from using it. [34]

Because the platform is accessible to all, it could be used inappropriately, for instance to make unfounded accusations or to burden the platform with provocative posts (trolling). That being said, a review of submissions before publication helps confirms their validity or delete corrupt ones, which addresses this issue. In the case of Je dénonce, our analysis reveals that nurses and LPNs submitted targeted, factual descriptions of serious problems. Furthermore, issues raised were abundantly documented elsewhere and recognized, indicating that nurses's and LPNs' reports were founded, unexaggerated, and submitted in good faith.

Given the often-critical nature of accounts submitted to Je dénonce, it is possible that some testimonials could be considered defamatory and subject to legal action in order to find their authors, shut the platform down, or act against the organization responsible for its operation (in this case, the FIQ union). Although this risk is theoretically possible, it is unlikely, given Quebec's current sociopolitical context. First, public opinion leaned heavily in favour of nurses following a number of reports exposing poor working conditions (eg. mandatory overtime, professional burnout, etc.); second, heavy media coverage allowed the public to see the gross mismanagement of the pandemic (and the resulting loss of life) and, therefore, whistleblowers' essential role in public life. Consequently, we believe there would be little interest and high political risk for governments and health administrators to undertake expensive legal proceedings, paid through public funds, to identify anonymous informants and act against them.

What does the future hold for whistleblowing platforms like Je dénonce?

Normalizing whistleblowing across all sectors is an essential step toward sound social and public governance. Creating effective whistleblowing systems and tools has in fact been identified as a necessity we can no longer afford to ignore. [7, 36]

We argue that tools like Je dénonce are socioeconomically and politically useful to counterbalance discourses and practices that go against the public interest. We believe they also facilitate the democratization of information because they are available to anyone wishing to expose issues within health care systems. Specifically, they increase the visibility of challenges faced by often-underrepresented workers (including non-care personnel) while also allowing health service users and the broader public to submit their own experiences and concerns. This platform sets itself apart by including people often excluded from conventional forms of consultation and by expanding debates that are traditionally dominated by health administrators and members of the medical profession. This redistributes both the power to speak and the information required to promote and protect the public interest.

In health care settings, the availability and transmission of information alone are insufficient to modify or eliminate practices that negatively affect the health of patients, care personnel, and health care settings themselves. Mechanisms are required to force such information in decision-making processes and ensure accountability, so that health care institutions can fully fulfil their mandate relating to quality and safety. These mechanisms are subject to various clinical, organizational, economic, ideological, and other considerations and can be disrupted during crises – precisely when they need to be most effective. Absent or ineffective mechanisms can create serious, lasting consequences. This also increases people's willingness to turn to whistleblowing to communicate their concerns to the public at large.

To this day, whistleblowing is rarely discussed in public spaces in Quebec and Canada. One could assume that current federal and provincial laws protect whistleblowers and make such debates unnecessary. However, according to many experts, existing legal frameworks are inadequate because the protection they provide is much too narrow and limited to be at all useful; their performance record is nothing short of dismal. [37-39] St-Martin suggests that effective whistleblowing tools could help remedy current legal shortcomings. [39] He argues that given the failure of current legislation to promote transparency and integrity in socioeconomic sectors (including health care), investigative journalism has positioned itself as one of the only entities in Canada capable of holding offending organizations to account. From this perspective, without effective mechanisms and reliable laws, facilitating the flow of information between whistleblowers and journalists, as does the Je dénonce platform, is a significant asset.

Conclusion

The impacts of the COVD-19 pandemic are rapidly evolving; decision-makers at every level (e.g. leaders in government, health care institutions, and care units) require the most up-to-date information possible. It is essential that information come from multiple sources to avoid blind spots that can hinder understandings about critical issues. [35] Whistleblowing platforms through which various actors can report reprehensible situations meet this need. But in times of crisis, a whistleblowing platform cannot effect change on its own. In the case of Je dénonce, whistleblowers seek changes that depend on other agents such as journalists and members of the public to hold decision-makers accountable for their management decisions during the crisis.

The Je dénonce platform was created when a need was identified to disseminate essential information on the evolution of the COVID-19 pandemic in health care settings. The platform's concrete impact is difficult, if not impossible, to qualify or quantify. The platform succeeded in capturing the attention of journalists writing about the effects of the crisis and the health care system's failures to manage it. It is more difficult to determine the extent to which it contributed to correcting objectionable organizational practices or policies. However, given the volume of testimonials submitted to the platform, there is no doubt that nurses and LPNs consider it a useful resource to raise their voices about dangerous, unethical, or unlawful situations.

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Acknowledgements
The authors thank the Centre for Free Expression for their support in writing this article and the Social Sciences Research Council of Canada for their financial support. This article is the translated version of an article previously published in French in 2020 in this journal (Volume 12, Issue 1). The translated version reflects the context during which the original article was published.

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