An integrative systematic review of employee silence and voice in healthcare: what are we really measuring?

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Executive Summary

This integrative systematic review by Lainidi et al. (2023), published in Frontiers in Psychiatry, examines how employee voice and silence are conceptualized and measured in healthcare settings. Despite high-profile care failures driving substantial research investment, speaking-up interventions have produced consistently disappointing results. The authors conducted a systematic search across eight databases (January 2016–January 2022), identifying 76 quantitative studies involving 122,009 participants. Three central findings emerged: constructs and measures are highly heterogeneous across studies, no unifying theoretical framework exists, and insufficient distinction is made between safety-specific and general employee voice. The review identified 45 distinct measurement instruments, with only 10.5% of included studies rated as methodologically 'good' and 42.1% rated 'poor.' The sample was heavily skewed toward female nursing professionals, with cross-sectional self-report designs dominating. The authors conclude that voice and silence are likely distinct phenomena with separate antecedents that can operate simultaneously, and that the field's failure to integrate macro-level institutional and Industrial Relations perspectives alongside organizational behavior frameworks limits its explanatory and practical utility.

Key Insights

1. Employee voice and silence may be conceptually distinct phenomena with different antecedents that can co-exist simultaneously, rather than being simple opposites on a single continuum.

2. Across 76 studies, 45 distinct measurement instruments were identified, with no consensus on what should be measured — this heterogeneity undermines cross-study comparability and the development of effective interventions.

3. Only 10.5% of included studies were rated methodologically 'good,' while 42.1% were rated 'poor,' primarily due to cross-sectional designs, absent sample size justifications, and inadequate confounder control.

4. Safety-specific voice likely differs fundamentally from general employee voice, yet the majority of research conflates the two, potentially explaining why workplace speaking-up interventions have yielded disappointing results.

5. Positive forms of silence — such as prosocial silence — are rarely studied, creating an incomplete and potentially distorted picture of silence behaviors in healthcare organizations.

Practical Takeaways

• Organizations designing or evaluating speaking-up interventions in healthcare operate on a fragmented evidence base — the 45 distinct measurement instruments identified mean that findings

across studies are difficult to compare or aggregate into reliable guidance.

• Researchers and practitioners examining voice and silence in healthcare contexts may find that separating safety-specific voice from general organizational voice, and distinguishing silence antecedents from behavioral intentions and observed behaviors, produces more precise and actionable data.

Frameworks Mentioned

Job Demands-Control Model — Used to contextualize employee silence as potentially arising from resource depletion under high job demands and low control conditions.

Job Demands-Resources (JD-R) Model — Applied to explain how resource depletion in demanding healthcare environments may contribute to silence behaviors.

Conservation of Resources Model — Referenced to frame silence as a protective strategy when employees perceive resource loss or threat in organizational settings.

Critical Analysis

Strengths: The review is methodologically transparent, registered on PROSPERO, employs two independent reviewers with strong inter-rater reliability (Cohen's $\kappa = 0.96$), and draws on a large aggregate sample (N=122,009). It avoids WEIRD bias, with approximately 50% of studies conducted outside Western nations. The inductive thematic and constant comparative analysis approach is appropriate given the heterogeneity that precluded meta-analysis. Limitations: The six-year search window, while justified, may exclude foundational studies from earlier periods. Exclusion of non-English studies introduces potential language bias. The decision not to exclude any papers on quality grounds — despite 42.1% rated poor — may dilute the integrity of the synthesis. The review is itself largely descriptive and stops short of proposing a validated measurement framework. Bias: The authors' explicit argument for integrating Industrial Relations perspectives reflects a theoretical positioning that, while intellectually grounded, is not empirically tested within this review. The predominance of nursing samples and cross-sectional designs in the underlying literature is a field-level limitation rather than a review-level flaw, but it constrains the generalizability of all conclusions drawn.

Organizational Practice

The article documents that healthcare organizations have implemented speaking-up interventions following high-profile care failures, but these interventions have produced consistently disappointing results. Research is predominantly conducted in nursing populations using self-reported, cross-sectional survey instruments. Observational studies capturing actual speaking-up behaviors in simulation environments represent a minority (9.2%) of approaches. The Hospital Survey on Patient Safety Culture and the Speaking Up about Patient Safety Questionnaire are among the most frequently used instruments in practice-facing research. Hierarchy is identified as a documented structural feature of healthcare organizations that suppresses voice, particularly among nursing and allied health staff relative to physicians.

Strategic Implications

The review's findings point to a measurement fragmentation problem that may explain the persistent failure of speaking-up interventions in healthcare — without construct consensus, interventions are built on

incompatible theoretical foundations. The near-exclusive focus on patient safety voice in the literature leaves general organizational voice and employee well-being dimensions of silence largely unmeasured, suggesting a gap between what healthcare organizations study and the full range of voice behaviors that affect organizational functioning. The authors' call to integrate Industrial Relations and macro-institutional perspectives signals a potential broadening of the PMS research lens in healthcare beyond individual and team-level analyses toward systemic and political economy factors. The growth of multidisciplinary teams and digitization in healthcare contexts identified by the authors represents an emerging area where existing measurement instruments may be particularly ill-fitted.

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