Reviewer’s report

Title: Factors Affecting Nurses' and Physicians' Fear of Repercussions for Reporting Errors

Version: 3 Date: 5 February 2015

Reviewer: Garry Gray

Reviewer's report:

1. Major Compulsory Revisions

Dear Authors,

An interesting study that addresses an important topic: the reporting of medical errors.

The major concern that I see with this paper is that it lacks an appropriate grounding in the literature and theory on what we do know about speaking up about safety and fear of retaliation. The introduction/theory/literature section is incredibly thin (pages 3-5) and does fully address the depth of studies that have looked at fear of repercussions for reporting medical errors (or speaking up around safety issues). In other words, it's not accurate to state that 'little is known'.

In addition, given that the biggest finding from the study is that organizational factors are important (and that a focus on clinician level demographics is not) I think the paper would be strengthened by engaging what we do know about organizational leadership and team safety in healthcare organizations. For instance, see some recent work by Singer et al. (1,2) that engaged mixed methods (safety climate surveys, qualitative interviews, and participatory group projects among the participants). This mixed method work on the culture of healthcare organizations reveals that your suggestion (on page 15) that “patient safety improvement strategies should be tailored separately” for nurses and physicians needs more context.

There is also a conceptual issue. The article is framed up front as a study of ‘safety climate’ (a group of workers ‘shared perceptions’ of the climate of study in their setting), yet, on page 15 the article states that the results “should be generalizable” to other “healthcare organizational structures and safety cultures”. Safety climate and safety culture are not necessarily the same thing (in fact, they are quite different). However, this is not detrimental for your article; it just simply means that you should engage organizational safety culture research more deeply given that you show that organizational factors to be important (see references 3, 4, 5 below).

Overall, I would encourage you to go further and really explore what studies of safety culture have told us about speaking up, reporting, and fears of retaliation.
For instance, in a recent study (6) Susan Silbey and I went inside various organizations to look at the different positions, expertise and autonomy of actors to understand how rules and regulations (such as reporting) are interpreted within organizations (by different actors, including those in healthcare organizations – see the discussion section of this article). You might also want to look at some of the work on the responsibilization strategy of health and safety (7) and how it influences speaking up for safety. There is a great deal of literature that has examined speaking up and fear of repercussions (see also 8,9,10) in both hospital settings and across other organizational settings. The references provided here are far from exhaustive. Indeed, there is a great deal of additional literature that explores the concepts that are central to your study. However, I have seen a tendency in safety climate studies to avoid addressing these other streams of safety culture research that look at the same thing (see reference 5 below for a call to be more interdisciplinary and open to mixed methods in safety climate/culture research).

I hope you find these suggestions useful.

Good luck and Best wishes on the further development of the conceptual aspects of your paper.


Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:
I declare that I have no competing interests