When speak-up fails: Whistleblower gaslighting as a risk to patient safety and organisational learning

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Speak-up is an early warning system: reports of risks, deviations and unclear responsibilities enable learning, prevention and safe care. In the reality of care delivery within hierarchical systems, however, staff repeatedly find that reports are not only ignored but actively reinterpreted – to the point of questioning the competence, motives or stability of the person making the report. In addition to general psychological mechanisms, a real power imbalance operates in the workplace: employers have legal and organisational powers to issue instructions, evaluate performance and impose sanctions, which reinforce interpretative power and dependencies. In high-pressure situations, these asymmetries can overlap psychodynamically (e.g. through parental transference onto authority figures), which can further hinder speak-up behaviour. Furthermore, patient participation is also described as a key component of patient safety work (Koch et al. 2023). We use the term ‘whistleblower gaslighting’ to describe such patterns: a form of systematic undermining that erodes one’s own judgement (Abramson 2014) and devalues testimony (Spear 2019). Unlike fair, evidence-based criticism, this does not result in verifiable clarification; instead, the focus shifts from the issue to the person. In Germany, the focus on whistleblower protection and compliance (HinSchG) intensifies the pressure to act: if a reporting channel exists formally but expectations of sanctions persist informally, speaking up tips over into silence and pseudo-compliance – formal conformity without reliable implementation in day-to-day healthcare practice. The aim of this article is to provide a concise, practical guide: (1) conceptual clarification and demarcation, (2) mechanisms and typical risk patterns, (3) specific intervention points for leadership, quality management and teams.

Concept and definition: from fair criticism to epistemic devaluation

>> Gaslighting aims to destabilise the other person’s reality check. In an organisational context, this often occurs not as an outright lie, but through repeated relativisation (isolated incident), reinterpretation (misunderstanding), pathologisation (oversensitive) or redirection (wrong channel) – until those affected give less weight to their own perceptions and withdrawal becomes the obvious choice. Philosophically, this can be understood as epistemic injustice: testimony and experience are systematically given less weight (Spear 2019).

Summary

Introduction: Whistleblower gaslighting refers to communication and process patterns through which whistleblowers are systematically undermined in terms of their perception and legitimacy – with risks for speak-up, error reporting systems and organisational learning. A gap can thus arise between whistleblowers and compliance requirements

(including the HinSchG): reporting channels exist formally, but informally, reports are devalued, delayed or turned against the person making the report. The aim is to refine the conceptual framework, distinguish it from fair criticism, and provide practical guidance for patient safety.

Methods: Conceptual paper with a narrative literature review; summarised using boxes, vignettes and three figures.

Results: Mechanisms (double binds, framing/euphemisms, epistemic devaluation) and consequences (silence, pseudo-compliance, loss of learning) are described, as well as interventions such as non-retaliation, documented feedback loops, multi-channel reporting routes including an ombudsman or external body, team routines for psychological safety, and clinical support during periods of high stress.

Discussion: Crucial is the linking of formal compliance to verifiable processes and a learning-oriented culture.

Keywords

Speak-up, whistleblower protection, patient safety, psychological safety, organisational learning, pseudo-compliance, gaslighting, ethical leadership

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Key messages (for practice)

- Gaslighting is a pattern: not a single conflict, but repeated devaluation coupled with blocked clarification.
- Pseudo-compliance arises when a response is given on paper, but verifiable remedial action fails to materialise.
- Non-retaliation, feedback loops and independent escalation channels are key protective structures

Gaslighting must be distinguished from fair criticism and performance management. Fair criticism remains verifiable, objective and reversible (through evidence or correction). Gaslighting, by contrast, is typically characterised by (a) pattern-like behaviour, (b) power asymmetry, (c) a lack of verifiable clarification and (d) covert punitive effects. This distinction is crucial for care provision, as otherwise both legitimate criticism and legitimate feedback are framed in toxic terms – a driver of silence.

It is important to use technically accurate language: the term is used here as an organisational risk pattern, not as a clinical diagnosis. It concerns observable communication and process signals that impair patient safety and organisational learning.

Note on language: For the sake of readability, predominantly gender-neutral terms (e.g. whistleblowers, staff, managers) are used.

Mechanisms and organisational consequences

Double binds (pseudo-speak-up):

Paradoxical messages are typical: officially, openness is emphasised (please report early), whilst informally this is followed by devaluation, career consequences or changes to duty rosters. At the same time, the

contradiction is denied (as a purely organisational matter), thereby blocking metacommunication. Double-bind logic promotes learned speechlessness and inaction (Watzlawick et al. 2011).

Frames, euphemisms and pseudo-compliance:

Organisations can resolve problems through language – via appeasement, PR frames or ritualised meetings without measurable implementation. Frames determine whether a suggestion is interpreted as a sense of responsibility or disloyalty (Lakoff 2016). Pseudo-compliance refers to the discrepancy between formal conformity and a lack of reliable implementation in day-to-day care; organisational 'bullshit' discourse describes an indifference towards verifiable truth (Frankfurt 2005; Spicer 2017).

Consequences for teams and patient safety:

When reporting is perceived as a threat, reporting rates fall, near misses remain hidden, and learning shifts from system correction to self-protection. In addition, withdrawal, staff turnover and sick leave increase. As a result, a safety risk is not only overlooked but structurally entrenched. For whistleblowers, the perceived breach of institutional trust can be deeply distressing (Ahern 2018).

Consequences of stress and risks to care: Why it doesn't end with well-being

Whistleblower gaslighting acts as a chronic stressor: alongside the factual issue (risk/report), a relational signal emerges (your perception does not count). Repeated uncertainty, isolation and overload increase the overall burden and can contribute to withdrawal, symptoms and incapacity for work (Ahern 2018). In high-stress systems, it is important to note that long working hours are associated with increased health risks (Conway et al. 2017). For heuristic classification, Figure 1 (stress barrel) and Figure 2 (diathesis-stress model; resilience × life situation) visualise cumulative stress and threshold logic.

Stress Barrel (Allostasis) for Whistleblowers

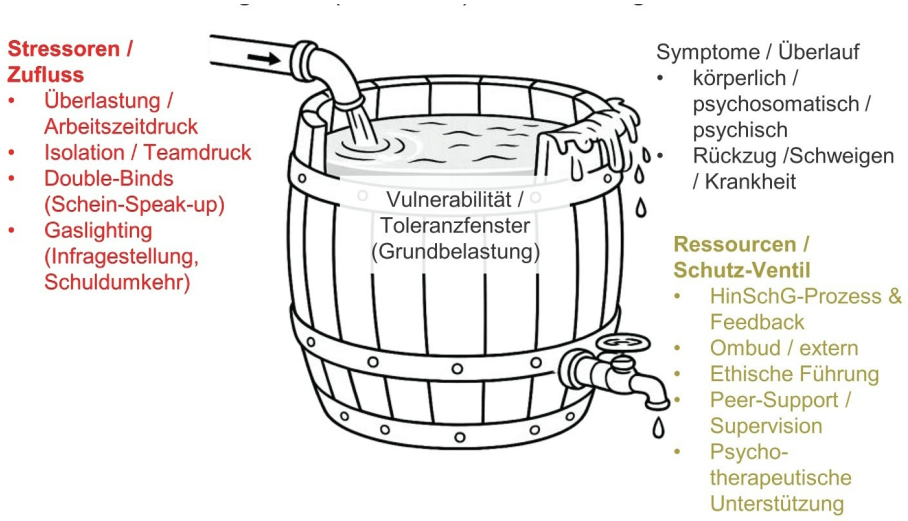


Fig. 1: **Stress barrel (allostasis) for whistleblowers: cumulative stress caused by gaslighting, double binds, isolation and work pressure versus safety valves (Whistleblower Protection Act processes, ombudsman, ethical leadership, supervision/psychotherapeutic support). Own illustration.**

Diathesis-stress model in the speak-up context

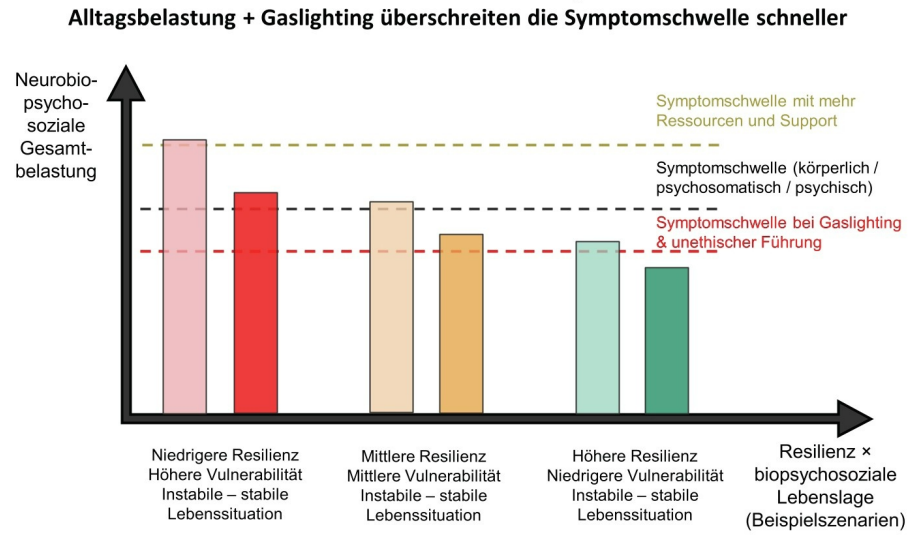


Fig. 2: **Diathesis-stress model in the speak-up context (resilience × biopsychosocial life situation; example scenarios): Y-axis: total biopsychosocial stress. X-axis: Resilience × biopsychosocial life situation (example scenarios); six scenarios are shown (high/medium/low vulnerability = low/medium/high resilience), each with an unstable versus stable life situation (paired in each case). The three horizontal lines mark the symptom threshold with greater resources and support (top), the symptom threshold (physical/psychosomatic/psychological; middle) and the symptom threshold in cases of gaslighting and unethical leadership (bottom). Note: The vulnerability levels are schematic and are compatible with, amongst other things, structural concepts from ISTDP/EDT (e.g. 'fragile character structure' – 'resistance with repression' – 'psychoneurotic'; cf. Ab-bass & Town 2025). The symptom threshold is illustrative and represents different thresholds depending on the symptom level – ranging from mild stress reactions (e.g. irritability, tension headaches) to pronounced psychosomatic/psychological complaints (e.g. functional gastrointestinal complaints, suicidal crisis symptoms); several thresholds may be crossed simultaneously. (EDT/ISTDP; abbreviation: Experiential Dynamic Therapy / Intensive Short-Term Dynamic Psychotherapy). Own illustration.**

The systemic perspective is crucial here: clinical support can provide relief in individual cases, but does not replace organisational intervention. Prevention must structurally safeguard the chain of reporting – investigating – providing feedback – learning.

As a complementary form of clinical support – without replacing the need for organisational changes – a structured, evidence-based short-term psychotherapy approach can be helpful. Intensive Short-Term Dynamic Psychotherapy (ISTDP) is a manualised approach that supports those affected in recognising and regulating stress and anxiety reactions, as well as typical defence mechanisms, at an early stage – both in patient contact and in stressful team interactions. Hofner and Bawks (2025) describe, among other things, effects in psychiatric practice on self-monitoring, affect/anxiety regulation and burnout prevention, as well as possible positive side effects on collaboration and the leadership climate, particularly when such skills are transferred within teams via supervision, peer formats and leadership development. For complex and chronic conditions, care and cost aspects are also discussed (Abbass & Town 2025).

For the early assessment of current stress and fragile states, brief, standardised screenings can be helpful as a supplementary measure; to assess cognitive-perceptual disruption, COPEDS, a psychometrically evaluated instrument, has been introduced (Eielsen et al. 2025). In cases of acute symptom burden, time-limited psychopharmacological support can provide relief; in the medium and long term, psychotherapeutic and psychosocial interventions remain central and should – where possible – be available preventively and with low barriers to access (Standal et al. 2025;

DGPPN 2025).

The chain of interactions from reporting concerns to organisational pseudo-compliance can be depicted as a gaslighting spiral (see Fig. 3).

Interventions and protective factors (Box 2)

Effective prevention addresses structure, not just attitude. Key elements are a. protection against retaliation, b. transparent handling, and c. visible learning.

Box 1: Red flags of institutional gaslighting (observational indicators)

- No acknowledgement/no documentation of reports; repeated framing of incidents as isolated cases.
- Shift in focus from the issue to the person (motives, stability, ability to work in a team).
- Paradoxical messages: openness combined with implicit punitive effects (duty rosters, rotations, projects).
- Clarification without evidence: decisions without a verifiable data basis or justification.
- Ritualised formats without follow-up (meetings replace implementation).
- Abusive mediation despite power imbalance; pressure to reach agreement rather than examination of the facts.
- Isolation of the person reporting (social, informal, communicative).
- Linguistic appeasement/euphemisms that render risks abstract.

Rule of practice: Individual points are non-specific; the combination over time plus the absence of feedback loops is highly predictive.

Gaslighting spiral

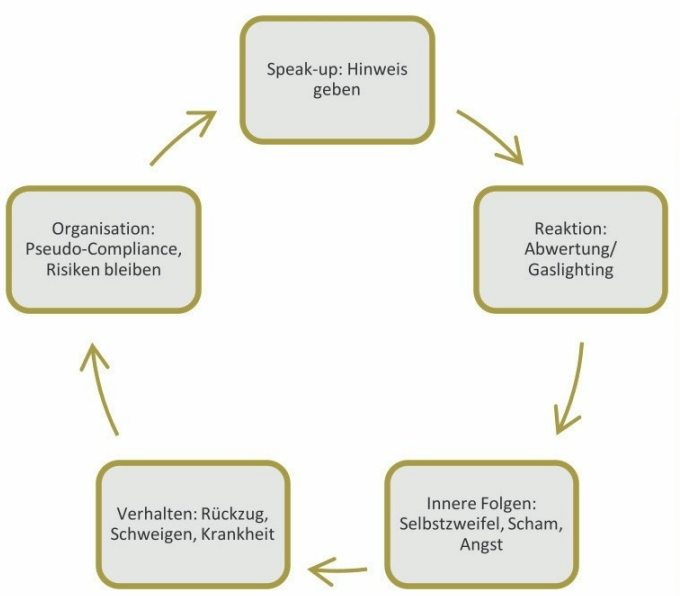


Fig. 3: **Gaslighting spiral: Speak up > Devaluation/reinterpretation (gaslighting) > Internal consequences (self-doubt, shame, fear) > Withdrawal/silence > Organisational pseudo-compliance (risks remain). Intervention points: Non-retaliation & feedback, ombudsman/external, psychological safety, clinical support. Own illustration.**

Box 2: 10-point checklist (implementation in clinical practice/QM)

- 1) Non-retaliation mandatory: policy, exemplary communication, protection in individual cases.
- 2) Multiple reporting channels: internal, ombudsman, external/compliance; optional anonymity.
- 3) Acknowledgement + deadlines: Every report receives confirmation of receipt and details of next steps.
- 4) Separate facts from interpretation: structured documentation, audit trail.
- 5) Independent review: Board/review with an external voice in conflict situations.
- 6) Double-bind check: Make contradictions explicit; allow meta-communication.
- 7) Safeguard agreements: no transfers or rota changes during the investigation without justification.
- 8) Team routines: debriefs, peer support, supervision; training in psychological safety (e.g. informed ISTDP/EDT).
- 9) Monitoring: processing times, feedback loops, indicators of psychological safety.
- 10) Reflecting on learning: lessons learnt, visible process changes, feedback to whistleblowers.

Box 3: Two short vignettes (fictional, de-identified composites)

Vignette 1 (medical): A junior doctor reports repeated discrepancies between prescriptions, administration and documentation in the electronic medication system (particularly following night shifts), substantiated by case notes (e.g. gaps in documentation, delayed additions or unclear termination of prescriptions). Openness is emphasised in the quality circle; shortly afterwards, she loses projects and is rotated for organisational reasons. In discussions, her mindset is questioned; the factual review remains vague.

Vignette 2 (nursing): A nurse points out unclear isolation procedures and a lack of supplies. Thereafter, night shifts become more frequent, the team avoids contact, and the audit states that processes were followed. Only an ombudsman's office validates the observations and structures the clarification.

Ethical leadership can increase the likelihood of internal reports (Cheng et al. 2019). The Just Culture approach, as a leadership and safety principle, is also highlighted in MVF as a key lever for patient safety (Bresser 2024).

Conclusions and outlook

Whistleblower gaslighting jeopardises patient safety because it systematically undermines speak-up and organisational learning. The key lever lies in governance: non-retaliation, documented feedback loops and independent escalation pathways reduce pseudo-compliance and increase

the likelihood that reports will be translated into verifiable improvements. At the system level, reforms to hospital funding can strengthen accountability structures and reduce volume-based incentives, lower contextual stress levels and thus facilitate speak-up; corresponding models are being discussed in MVF (Wilbert et al. 2023).

There is a particular need for research into prevalence rates, process indicators (reporting quality, processing times) and the effectiveness of protective interventions in different care settings.

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When Speak-Up Fails: Whistleblower Gaslighting as a Risk to Patient Safety and Organisational

Learning

Introduction: Whistleblower gaslighting refers to organisational patterns that undermine the credibility and reality-testing of people who raise concerns, weakening speak-up, incident reporting and organisational learning. Even under whistleblower protection and compliance requirements, a gap may persist: reporting channels exist on paper whilst informal practices devalue reports, delay clarification or shift the problem onto the reporter. We define the phenomenon, distinguish it from fair performance management, and derive practical implications for patient safety.

Methods: Conceptual paper with a narrative synthesis of literature and practical observations, structured using boxes, vignettes and three figures.

Results: Mechanisms include double binds, framing/euphemisms and epistemic undermining; consequences include silence, pseudocompliance and reduced learning. Intervention points comprise non-retaliation, documented feedback loops, multi-channel reporting including an ombudsman or external route, team routines for psychological safety, and clinical support when the burden is high.

Discussion: Improvement requires aligning formal compliance with verifiable processes and a learning-oriented culture.

Keywords

speak-up, whistleblowing, patient safety, psychological safety, organisational learning, pseudo-compliance, gaslighting, ethical leadership

Data Availability Statement

This article presents a conceptual framework and does not report any new empirical dataset. Ethics Statement: Not applicable. This work does not involve human participants, identifiable clinical data, or secondary analyses of patient records. All case vignettes are de-identified fictional composites created for training and illustration purposes. Author Contributions: EN conceived the hypothesis and theory, developed the conceptual model, conducted the literature review, and wrote the manuscript. Funding: No specific funding was received for this work. Conflict of Interest: The author declares no competing interests. Use of AI: AI was used to support language editing and literature organisation. Responsibility for content, accuracy and final version remains with the author.

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