Organizational Silence among Nurses: A Study of Structural Equation Modeling

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Abstract

To provide a literature scale which is accepted in Turkey and can be used in order to evaluate when and for what nurses remain silent, and how to evaluate results of silence as an appropriate model for nurses. The research was carried out using a survey form which is used in Turkish literature and developed by Çakıcı (2010). The study was carried out between January-February 2013 and the survey form was applied to 137 nurses. Response rate was determined to be 68.5%. Findings obtained as a result of the survey were exposed to confirmatory factor analysis (CFA) by using Lisrel 8.71 program. According to the findings obtained from this study, confirmatory factor analysis results of this scale enable structure validity. As a result, structural equation modeling which is obtained as a result of confirmatory factor analysis shows that organizational silence scale can be used. It is thought that this new scale is an appropriate model for nurses working at health institutions in Turkey.

Key Words: silence, organizational silence, hospital, structural equation model, nursing, Turkey

1. Introduction

Organizations are composed of people who gather in order to realize an objective. It is accepted that the most important factor which enables an organization to be successful is its human resources. Human factors and behaviors should not be ignored in order to manage an organization in a healthy way. Behaviors exhibited by employees of an organization are of great importance for its operation. These behaviors may create positive or negative effects within organizations, in other words they may either contribute to, or prevent its development. With this regard, sense of modern management gives particular importance to improving knowledge, skill and ability of employees and creating benefits for both organization and employee from this. New administrative techniques focus on making employees strong, enabling open communication within organizations and adopting the view of employees, making an effort for being competent, identified with the organization and participative (Çakıcı 2007; Erigüç 2012; Yalçın & Baykal 2013).

In another words, organizations are increasingly demanding more and more from their employees such as taking initiative, speaking up and accepting responsibility. The reasons are more intensive competition, higher customer expectations, more focus on quality, indicating a constant world of change. In order to survive, organizations need employees who are responsive to the challenges of the environment, who are not afraid to share information and knowledge, who can stand up for their own and their team beliefs (Vakola & Bouradas 2005). However many employees state that information sharing and communication are not supported in their organization. Employees may not express their knowledge and opinion about any problem or issue openly.

Because they believe that their current position would be affected, they would seem likely to a problematic person, their suggestions or ideas would not make any difference. Moreover there are other reasons such as lack of employee's self-confidence, regarding talking as risky, fear of being excluded, and fear of damaging relationships within the organization.

However, most of the employees consent to the suggestions of others and adjust to the idea of community. In this way, communication becomes unclear, employees do not share their knowledge and thoughts about an organization and remain indifferent to its problems. These behaviors of employees are named as "organizational silence" (Gül & Özcan 2011; Taşkıran 2011; Yalçın & Baykal 2013).

1.1. Organizational Silence

Pinder and Harlos (2001) who have important studies about this subject in the literature define the term "organizational silence" as individuals who work within an organization deliberately and intentionally not telling behavioral, cognitive and emotional evaluations about organizational conditions to the individuals (managers/leaders) who are perceived as capable of making any change or correction. Morrison and Milliken (2000) who are other researchers working intensively on this issue define organizational silence as employees not telling their views and ideas about organizational issues or problems openly and keeping them to themselves. Van Dyne et al. (2003) present a conceptual framework suggesting that employee silence and voice are best conceptualized as separate, multidimensional constructs. Building on their conceptual framework, they propose that silence and voice have differential consequences to employees in work organizations (Van Dyne et al. 2003). Organizational silence is regarded as a hindrance for organizational change and development. It is expressed that many employees do not talk about problems with managers although they are aware of specific issues and problems, and that this is the fact in many organizations. In this way, organizational silence becomes an issue which should be emphasized and analyzed thoroughly (Çakıcı 2007).

To respond appropriately to dynamic business conditions, make good decisions and correct problems before they escalate, top managers need information from employees at lower levels in the organization. Otherwise this information may not come to their awareness. Likewise, if groups are effective and make good decisions, they need honest input from their members. But research has shown that employees are often reluctant to speak up both to those in positions of authority and their teammates when they have potentially important information to share. In this case, key decision makers or teams may not have the information that they need to make appropriate decisions or to correct potentially serious problems (Morrison 2011).

Human resource is the most important resource which is required by health systems to provide effective and productive health services provided by, and for people. Mental and physical capacity of the human resource in the health institution is the focus point in health services management. The quality of service presented in health institutions is considerably determined by its health human resource. The success of health institutions is closely related to employees being participative, their commitment to occupation and institution and their devotion (Erigüç 2012).

In addition, one of the important characteristics of health institutions is the intensive functional dependency among departments. A service is carried out with simultaneous and common activities of more than one unit or occupational group. Multidisciplinary team work is essential in the health sector. Team work is the tool for having an effect on the medical care process in the sense of management of health institutions. In the team work, the manager who takes leadership on can eliminate uncertainties and enhance service quality. Characteristics of an effective team are: (1) a natural and relaxed environment; (2) participation of each member in discussions; (3) comprehension and adoption of team tasks by members; (4) members listening to each other; (5) taking decision through reconciliation; (6) and constructive criticism, which aims to solve problems.

The success of team work considerably depends on the success of members. A team approach focuses on intra-group discussions. Thoughts of team members play an important role in problem solving. Therefore an appropriate environment should be created for expressing thoughts. Mutual cooperation is required among departments in order to manage mutual connections between them and their functions in a health institution effectively (Kavuncubaşı & Yıldırım 2010).

Organizational silence that occurs due to intra-organizational dynamics of health services which are based on team work may result in cases which include irrecoverable moral and conscientious responsibility.

When organizational silence occurs amongst nurses; it is stated that nurses are afraid of making their voices heard and of coming together since many managements in health care organizations react adversely to the nurses who make their voice sound more, and criticize specific issues. It is stated that nurses generally prefer silence when they try to protect both their personal rights and the rights of patients according to their education and experience, and confront the reactions of institutional managers and their colleagues (Yalçın & Baykal 2013).

It has been emphasized that to date, in the course of their clinical work, team communication research has attended to the *presence* of speech in the form of what team members are saying to one to another, or what they should be saying to one another. According to Lingard (2012) the *lack* of speech has received very little attention. Lingard (2012) stresses that the importance of this distinction is clear for everyone who has spent time with health teams in the workplace, and that to be in communication in the team does not just involve what has been *said*, there is so much more. Teamwork is also full of meaningful *silences* (Lingard 2012).

Vakola and Bouradas (2005) reported that supervisors' and top managers' attitudes to silence and communication opportunities are associated with, and predict, employees' silence behavior. These dimensions are also associated with organizational commitment and job satisfaction (Vakola & Bouradas 2005). Bowen and Blackmoon (2003) touch on that individuals are more likely to speak up when they believe that their position in the organization is supported by others, and remain silent when they believe that it is not.

Milliken et al. (2003) interviewed with 40 employees working in different institutions. They found that being silent about work issues or problems is very common. In addition, they identified the most common "silence" issues as: 1) concerns about a colleague's or supervisor's competence, 2) problems with organizational processes, performance, or suggestions for improvement, 3) concerns about pay or pay equity. The most frequently *mentioned* reason for remaining silent was: 1) the fear of being viewed negatively, 2) the fear of damaging valued relationships, 3) feelings of despair generally (Milliken et al. 2003).

1.2. Developing Research on Organizational Silence

It is observed that interest towards studies on organization silence in all sectors have increased in recent years in Turkey. When these studies were evaluated in general, it was seen that studies were carried out in institutions which operate in different sectors and industries such as universities, other educational institutions, banks and hotel managements. Data were generally collected with survey techniques. Results of studies generally focus on reasons, possible results and the effects of silence behavior. It was seen that the relations between commitment to an organization, organizational citizenship, leadership behavior, job satisfaction, silence climate, organizational justice, focus of audit, power distance and organizational stress with organizational silence were analyzed (Taşkıran 2011; Ülker & Kanten 2009; Kılıç et al. 2013). Scale development studies were also carried out on this issue (Kahveci & Demirtaş 2013). The term organizational silence among nurses has not been analyzed adequately at international level and this issue is of great importance to health services, and especially for nurses who adopt the role of defender of patient rights (Yalçın & Baykal 2013).

Edmonson (2003) examined learning in interdisciplinary action teams and for this collected data from 16 operating room teams learning to use a new technology for cardiac surgery. Edmonson explored what leaders of action teams do to promote speaking up and other proactive coordination behaviours as well as how organizational context may affect these team processes and outcomes. Qualitative data analyses show the importance of leaders creating an environment that people feel comfortable with in the event of problems. In doing so, the leaders have created a climate of psychological safety for acceptable worries or problems occurring in the group to be addressed. Also Edmondson' data pointed out dangers when employees remain silent about concerns. Speaking up enabled successful implementation of new practices, whereas reluctance to speak up inhibited implementation. Speaking up is important in the process of team learning (Edmondson, 2003).
Current studies shows that less than 10% of the physician, nurse or clinic staff can be faced directly when colleagues become aware that a clinical decision can hurt a patient, or is missing. Not only do nurses avoid talking to doctors and other nurses, physicians also rarely speak with the nurses about any problems they had seen in the hospital. Lack of confidence in the health service providers, having concerns about the effects of their participation and fear of revenge are important reasons for lack of communication with colleagues (Henriksen & Dayton, 2006).

Canam (2008) examines the relationship between nurses' silence and the discourse of technical and maintenance and proposes focusing on encouraging nurse practices so that the nurses will know what to do.

In the study, the silence of nurses is identified with some power dynamics. Technical rationalist rhetoric and empirical knowledge, results in nurses remaining silent. Nurses are silent because, they aren't provided with a language to express themselves in operational technical and maintenance health care environments. Nurses are silent because in the power dynamics of the health care system, they do not have a language to express themselves.

There is quite restricted number of studies carried out in health institutions about organizational silence in Turkey (Yalçın & Baykal 2013) and these studies focus on reasons and results of organizational silence as well. It was also seen that content analysis have been carried out about why nurses remain silent (Can & Alparslan 2012). It is expected that new findings will emerge as more and more studies are carried out about organizational silence which is a recent subject in health sector. There is a restriction in presenting various aspects of silence since most of the studies carried out about this subject are theoretical. Considering in this sense, it is thought that developing a scale that can be used to measure silence behavior in the field of health would contribute to the literature. Therefore the aim of this study is to develop a scale which measures the term organizational silence in nursing.

2. Aims

This study was designed in order to describe relationship between subject which nurses remain silent about, effect level of reasons of silence and results of silence. It was aimed to determine the causality between reasons of organizational silence, subject which remain silent, results of silence and observed and latent variables. Structural Equation Model was used for this aim. In here, while the latent variables are referring the factors, observed variables are referring the items of each factor.

3. Method

3.1. Sample and procedure

The population of study was composed of 548 nurses who are working at a state hospital. 200 nurses were selected by simple random sampling method. The information related to nurses was provided by the hospital human resources department. Nurses' names were written one by one and put in a pouch, to make sure every nurse has a chance. The survey form was distributed to 200 nursing staff. When examined to collected survey forms, 63 unvalid survey form was excluded from analysis. Analysis performed on 137 valid survey form. Therefore response rate was determined to be 68.5%.

3.2. Survey Instrument

The survey used in the study is composed of questions which determine the issues about which employees remain silent and perceived results of silence. While survey form was developed by Çakıcı (2008); twelve academicians served as "referee" in order to enable content validity. The survey form was applied on 10 academic 10 administrative personnel as a pre-test. In this form, the survey was composed of 84 questions in total. There are 25 items concerning subjects which nurses remain silent, 31 questions concerning why they remain silent and 28 questions concerning perceived results of silence. 5-graded Likert-type scale was used in the study. As a result of factor analyses carried out by Çakıcı (2008) items concerning subjects which employees remain silent were grouped in 5 factors. Names of these factors are ethics and responsibilities (7 items); management problem (6 items); performance of employees (3 items); amendment efforts (4 items) and working opportunities (3 items).

Statements according results of factor analysis concerning employees remaining silent were grouped in 5 factors. These factors are administrative and organizational reasons (13 items), issues about work (6 items), lack of experience (4 items), fear of isolation (4 items) and fear of damaging relationship (3 items). There are 3 factors according to results of factor analysis concerning perceived results of silence. These were named as results preventing performance and synergy (15 items), results preventing enhancement and improvement (7 items), results making employees unhappy (4 items). These factors and items were exposed to exploratory factor analysis. As a result of exploratory factor analysis since the communality of item "failure and mistakes in the process and operation at workplace" (0.439) which is one of the items asked for determining the subject nurses remain silent is below 0.500 it was excluded from the analysis. After the removal of this item, CFA has been applied. In addition the results of the exploratory factor analysis have been the subject of another research that is why they are not included in this study.

In Çakıcı' (2008) study, the KMO statistical value of the data set, concerning the issues that the nurses remain silent, was found %94.2. This shows that factor analysis can be applied to the data set.

Besides, Barlett's test of sphericity was used to test factor analysis variance. In the study, Barlett's tests of sphericity provided this result: x^2= 7909.633; df=300; p<0,001. These results show that the applied approach of factor analysis is acceptable. KMO statistics of the data set concerning the reasons of the nurses to remain silent was found %95.5. According to Barlett's test of sphericity, x^2= 8544.224; df=435; p<0,001.

KMO statistics of the data set concerning the perceptional consequences of silence was found %60.838. According to Barlett's test of sphericity, x^2= 8475.243; df=325; p<0,001.

In the survey of Çakıcı, cronbach alpha value of the section which includes questions about subjects which nurses do not openly discuss with managers is 0.940; cronbach alpha value of the section which includes questions about reasons nurses do not openly discuss with managers but remain silent is 0.949 and cronbach alpha value of the section which includes questions about possible results nurses remaining silent against issues/problems is 0.957 (Çakıcı, 2008). In the reliability analysis of this study, cronbach alpha value of the section which includes questions about subjects which nurses do not openly discuss with managers is 0,947; cronbach alpha value of the section which includes questions about reasons nurses do not openly discuss with managers but remain silent is 0.964 and cronbach alpha value of the section which includes questions about possible results nurses remaining silent against issues/problems is 0.983. Cronbach alpha value about all questions in the survey form was found to be 0.979.

3.3. Data Analysis

The study was carried out between January-February 2013. In the study structural equation modeling was used and confirmatory factor analysis was done in order to see how much the statements included in the survey which is developed by Çakıcı (2008) explain variables which were aimed to measure in the sense of organizational silence of nurses. The analysis show extent to the data set complies with variables through goodness of fit index. In the study, SPSS 15.0 program was used in order to do reliability analyses. Lisrel 8.71 program was used in order to do confirmatory factor analysis and structural equation model. The weakness of the study is that the lack of sample size to be tested simultaneously.

4. Results

4.1. Structural Equation Model

Structural Equation Model is a statistical technique which is used in testing causality between observed and latent variables and solving problems confronted in formulating theoretical structures (Uzkurt 2007). Technically, structural equation model is used in estimation of unknown parameters in linear structure equation set. Variables in the equations are generally directly observed variables and latent variables which are related with observed variables. SEM assumes that there is causality between latent variables set and latent variables can be observed through observed variables (Yılmaz 2004; Yılmaz and Çelik 2005). In this study, research models were tested with structural equation model since there are latent variables.

There are various goodness-of-fit indexes and statistical function of these indexes used in evaluation of suitability of the model. Goodness-of-fit measures (covariance and correlation) compatibility of observed input matrix estimated from suggested models or coherency of model with empirical data (Schermelleh-Engel et al. 2003).
The most commonly used similarity rates among suggested indexes are chi-square statistics (χ2), RMSEA (Root-mean-square error approximation), GFI (Goodness-of-fit index) and AGFI (Adjusted Goodness- of-fit index) (Yılmaz 2004).

In Table 1, acceptable limit and values of most commonly used goodness-of-fit criterion and results of confirmatory factor analyses of the scale were given (Schermelleh-Engel et al. 2003).
Acceptability of model depends on goodness-of-fit statistics being below or above specific values as a result of analysis. In this study; goodness of fit index-GFI, adjusted goodness of fit index-AGFI, normed fit index- NFI, root mean square residual-RMR, standardized RMR and root mean square error of approximation-RMSEA values were considered.

It is expected that GFI is above 0.95 however value below 0.90 is in fact acceptable. Value above 0.90 for AGFI shows a good coherency however 0.85 is an acceptable value as well. GFI and AGFI are two values which should be controlled especially when confirmatory factor analysis is used (Erenler 2010).

Apart from this, normed fit index (NFI), non-normed fit index (NNFI), comparative fit index (CFI) values are considered as well. It is expected that normed fit index and comparative fit index values should be in the range of 0 and 1. While approximation of CFI, NFI values to 1 means high goodness-of-fit; NFI being above 0.90 means acceptable goodness-of-fit. Moreover, CFI being above 0.90 points out to acceptable goodness-of-fit, being above 0.95 points out to fine goodness-of-fit (Erenler 2010).

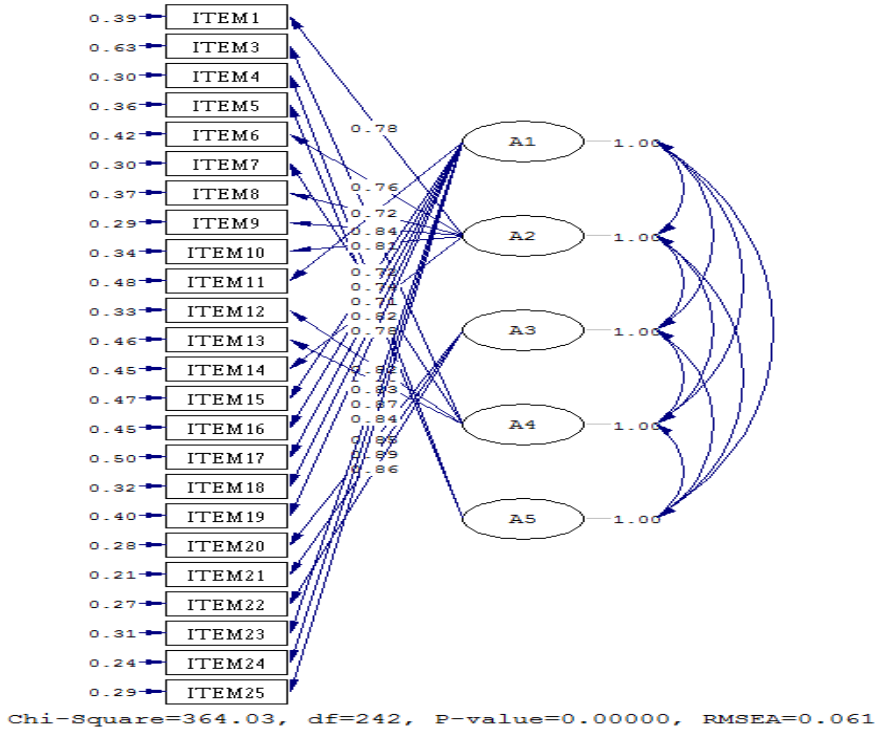
Table 1. Goodness-of-Fit Measures and Measured Values Assumed for Structural Equation Model

Goodness-of-fit measures	Good fit	Acceptable fit	Values measured		
			Issues nurses remain silent	Reasons for remaining silent	Perceived results of silence
Chi-Square/df	<2	<3	1.50	1.77	1.12
RMSEA	0<RMSEA<0.05	0.05≤RMSEA≤0.10	0.061	0.075	0.030
SRMR	0≤SRMR≤0.5	0.05≤SRMR≤0.10	0.08	0.07	0.04
NFI	0.95≤NFI≤1	0.90≤NFI≤0.95	0.96	0.96	0.98
NNFI	0.97≤NNFI≤1	0.95≤NNFI≤0.97	0.98	0.98	1.00
CFI	0.97≤CFI≤1	0.95≤CFI≤0.97	0.99	0.98	1.00
GFI	0.95≤GFI≤1	0.90≤GFI≤0.95	0.98	0.98	1.00
AGFI	0.90≤AGFI≤1	0.85≤AGFI≤0.90	0.97	0.98	1.00

It is of quite importance that root mean square residual-RMR and root mean square error of approximation-RMSEA should be considered. RMSEA is a value which measures model's goodness of fit with data. If RMR and RMSEA values are below 0.05, model's goodness of fit is excellent; and 0.08 value is an acceptable limit (Erenler 2010).

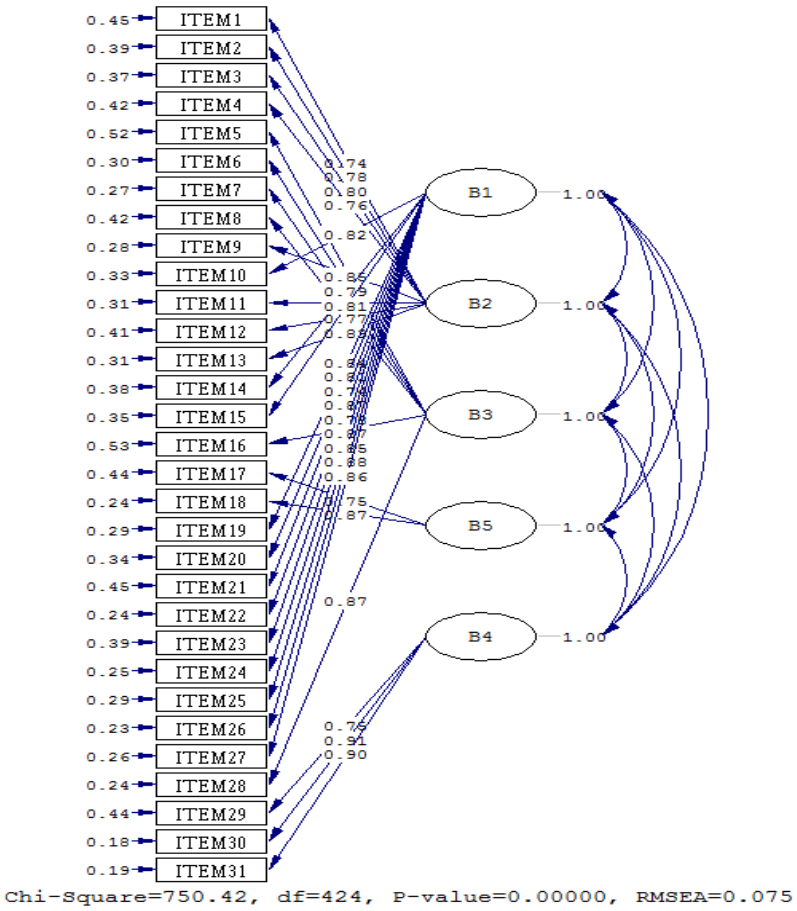
As it is seen in Table 1, if model measures are within the limit of goodness-of-fit, this means data statistically has excellent goodness-of-fit and quite coherent. According to findings obtained from this study, confirmatory factor analysis results of this scale enable structure validity. In order to evaluate concordance, chi-square/degree of freedom should be <3, RMSEA≤0.08 and at least two of the goodness-of-fit indexes should be above 0.90 which means model is acceptable; its being above 0.95 means there is high goodness-of-fit.

Figure 1. Structural Equation Model Showing Issues about Which Nurses Remain Silent



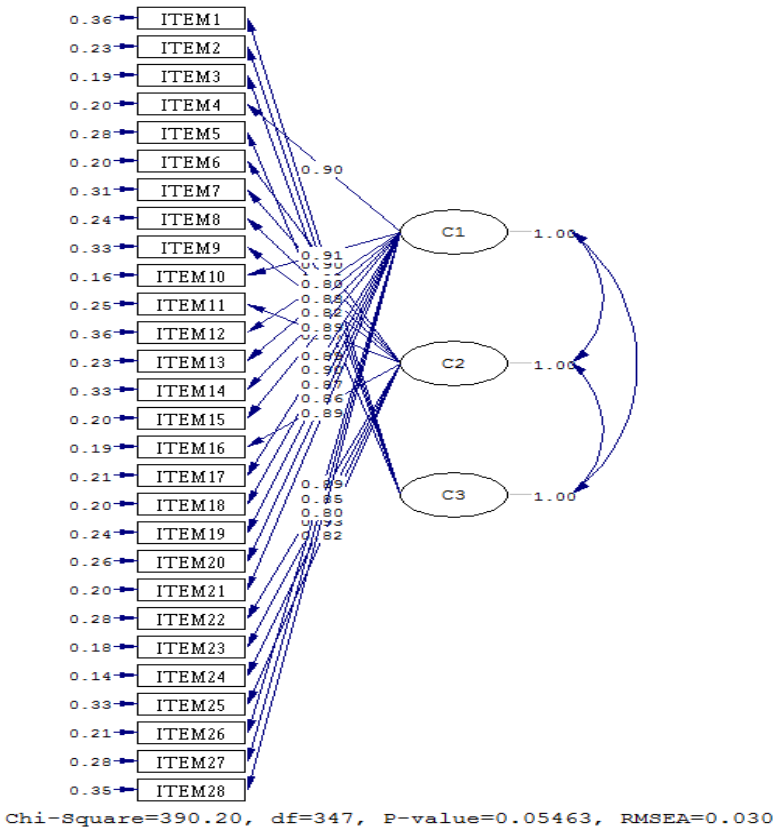
In Figure 1, confirmatory factor analysis issues about which nurses remain silent was given. As it is seen in the figure, the latent variable; "Administrator Performance and Working Facilities" (A1) has 9 items. It is seen that these items have positive coefficients. The greatest coefficient belongs to 24th item which is "Infrastructural and structural problems" (0.87). The latent variable; "Employee Performance and the Use of Administration" (A2) has 6 items. The greatest coefficient belongs to the item; "Company policies or decision that you disagree" with (0.84). "Responsibility" (A3) variable has 3 items and the greatest coefficient belongs to "Shrinking and laziness" (0.89). "Ethics" (A4) variable is composed of 4 items and the greatest item belongs to "Ill-treatment" (0.83). Finally, "Department Performance" (A5) variable is composed of 2 items and coefficients of both items are 0.78.

Figure 2. Structural Equation Model Showing Reasons for Remaining Silent



Confirmatory factor analysis for reasons for nurses remaining silent is presented in Figure 2. As it is seen in Figure 2, the latent variable "Administrative Reasons" (B1) has 11 items and the greatest coefficient belongs to the item; "The belief that the administrators do not keep their promises" (0.88). "Isolation And Fear of Relationship Damage" (B2) variable has 6 items and the greatest coefficient belongs to "Fear of the loss of support" (0.89). "Fears About The Work" (B3) variable has 6 items and the greatest coefficient belongs to "Lack of experience concerning speaking openly" with 0.89. "Lack of Experience" (B4) variable has 3 items and the greatest coefficient belongs to "Lack of a formal mechanism that facilitates open speech" with 0.91. Finally, "Organizational Position" (B5) variable has 2 items and coefficients of items are 0.87 and 0.75 respectively.

Figure 3. Structural Equation Model Showing Perceived Results of Silence



Confirmatory factor analysis about perceived results of silence was given in Figure 3. "The Consequences Affecting Performance and Synergy" (C1) variable is composed of 14 items and the greatest coefficient belongs to "The employee gets stressed" with 0.91. "The Consequences Hindering Identification of Problems and Employees' Trust" (C2) variable is composed of 10 items and the greatest coefficient belongs to "The problems are not solved on time, they grow bigger" with 0.93. "The Consequences Preventing Organizational Development" (C3) variable is composed of 4 items and the greatest coefficient belongs to "The administrators lack of significant knowledge and data while they are making decisions" with 0.91.

5. Discussion

Human resource is the most important value for health institutions. Today the contribution of human to the institution is considered as important, efforts are made for developing method and models enabling effective and efficient working condition in which employees would be satisfied from work due to sense of management that puts human to focus point. While such efforts continue, specific cases which emerge in working life may prevent contributions that employees can provide and his expectations from working life. Silence in organizations is one of these cases. Organizational silence is employees deliberately sparing his thoughts, emotions and knowledge for enhancing his work and workplace. Silence behavior of employees may bring negative results for their institution. Reliable and valid assessment tools are required in order to observe and analyze the term in health sector in Turkey.

Therefore, this study was carried out in order to make and assessment tools that would put forward issues nurses remain silent who are an important employee group in health institutions, reasons for being silent and perceived results of being silence both for nurse and for the hospital. There are restricted number of studies about organizational silence and employee silence in health sector in Turkey. However it is observed that there is an increasing interest towards this issue. It was thought that an assessment tool should be included in the literature and this study was carried out therefore. In this study it was aimed to develop a scale which determines perception of Organizational Silence of nurses who serve in health institutions. For this aim, it was evaluated whether the scale developed by Çakıcı (2008) and used in further studies (Çakıcı 2010) would be suitable for nurses or not. Confirmatory factor analysis was carried out in order to test structure of factors in the survey of Çakıcı.

As a result of confirmatory factor analyses, it was observed that normed chi-square ($\chi 2$/df) value for subject which nurses remain silent is 1.50; GFI value is 0.98; CFI value is 0.99; RMSEA value is 0.061; for reasons of remaining silent ($\chi 2$/df) value is 1.77; GFI value is 0.98; CFI value is 0.98; RMSEA value is 0.075; and for perceived results of silence ($\chi 2$/df) value is 1.12; GFI value is 1.00; CFI value is 1.00; RMSEA value is 0.030. According to the values obtained, it can be said that model has excellent goodness-of-fit values. Moreover, it was observed that there is a difference between factors of survey developed by Çakıcı and factor of survey obtained from this study. However, values obtained as a result of analyses carried out on data obtained in developing organizational silence scale show that the scale is sufficiently valid and reliable.

As a result of confirmatory factor analysis, a scale was attained including 24 items composed of 5 aspects for the issues which nurses remain silent, 31 items composed of 5 aspects for reasons of remaining silent and 28 items composed of 3 aspects about perceived results of silence. In the original form of scale there are 25 items composed of 5 aspects for the issues which nurses remain silent, 31 items composed of 5 aspects for reasons of remaining silent and 28 items composed of 3 aspects about perceived results of silence.
As a result, structural equation modeling which is obtained as a result of confirmatory factor analysis shows that organizational silence scale can be used. It is thought that this scale is appropriate for analyzing organizational silence of nurses working in health institutions.

6. Limitations

This research has some limitations. The modelling has done according to Çakıcı's (2008) questionary which used extensively in Turkish literature. The other questionnaires have extended the research. This research has another limitation that it includes nurses working in public hospitals in Turkey. That's why these results not generalized all of the health workers.

7. References

Bowen, F. and Blackmon, K. (2003) "Spirals of Silence: The Dynamic Effects of Diversity on Organizational Voice", *Journal of Management Studies*, 40(6):1393-1417.

Can, A. and Alparslan, AM. (2012) "Why Do Nurses Remain Silent? A Content Analysis Study", Health and Hospital Management Congress Proceedings, 261-266.

Canam, C. (2008) "The Link Between Nursing Discourses and Nurses' Silence: Implications for a Knowledge-based Discourse for Nursing Practice", *Advances in Nursing Science*, 31(4):296–307.

Çakıcı, A. (2007) "Silence at Organizations: Theoretical Backgrounds of Silence and Its Dynamics", *Journal of Çukurova University Institute of Social Sciences*, 16(1):145-162.

Çakıcı, A. (2008) "A Research on Issues, Casues and Perceptional Results of Silence at Organizations", *Journal of Çukurova University Institute of Social Sciences*, 17(1):117-134.

Çakıcı, A. (2010) *The Silence of Employee in Organizations*, Ankara: Detay Press.

Edmondson, AC. (2003) "Speaking Up in the Operating Room: How Team Leaders Promote Learning in Interdisciplinary Action Teams", *Journal of Management Studies*, 40(6):1419-1452.

Erenler, E. (2010) *The Relationship of Employee Silence Behaviour with Some Personal and Organizational Features: A Field Study on Tourism Industry*, Ph.D. Dissertation, Hacettepe University, Ankara.

Erigüç, G. (2012) Human Resources Management in Health Care Institutions and Importance of Medical Personnel. In M. Tatar (Ed.). *Health Care Management-1.* Eskişehir: Anadolu University Press.

Gül, H. and Özcan, N. (2011) "The Relationshpis Between Mobbing and Mobbing and Organizational Silence: An Empirical Study in the Special Provincial Administration of Karaman", *Kahramanmaraş Sütçü Imam University Faculty of Economics and Administrative Sciences Journal,* 1(2):107-134.

Henriksen, K. and Dayton, E. (2006) "Organizational Silence and Hidden Threats to Patient Safety", *Health Services Research*, 41(4):1539-1554.

Kahveci, G. and Demirtaş, Z. (2013) "Development Study of Organizational Silence Scale For Teachers", *Electronic Journal of Social Sciences*, 12(43):167-182.

Kavuncubaşı, Ş. and Yıldırım, S. (2010) *Hospital and Healthcare Management*, Second Edition, Ankara: Siyasal Press.

Kılıç, G., Tunç, T. Saraçlı, S. and Kılıç, İ. (2013) "The Effect of Organizational Stress on Organizational Silence: An Application in Five Star Thermal Hotel Establishments", *Journal of Business Research-Turk,* 5(1):17-32.

Lingard, L. (2012) "Productive Complications: Emergent Ideas in Team Communication and Patient Safety", *Healthcare Quarterly,* 15*,* 18-23.

Milliken, FJ., Morrison, EW. and Hewlin, PF. (2003) "An Exploratory Study of Employee Silence: Issues that Employees Don't Communicate Upward and Why", *Journal of Management Studies*, 40(6):1453-1476.

Morrison, EW. (2011) "Employee Voice Behavior: Integration and Directions for Future Research", *The Academy of Management Annals*, 5(1):373-412.

Morrison, EW. and Milliken, FJ. (2000) "Organizational Silence: A Barrier To Change And Development In A Pluralistic World", *Academy of Management Review*, 25(4):706-725.

Pinder, CC. and Harlos, KP. (2001) "Employee Silence: Quiescence And Acquiescence As Responses To Perceived Injustice", *Personnel and Human Resources Management*, 20, 331-369.

Schermelleh-Engel, K. Moosbrugger, H. and Müller, H. (2003) "Evaluating The Fit of Structural Equation Models: Tests of Significance and Descriptive Goodness-of-Fit Measures", *Methods of Psychological Research Online,* 8(2):23-74.

Taşkıran, E. (2011) *Interaction Between Leadership and Organizational Silence*, Istanbul: Beta Press.

Uzkurt, C. (2007) "The Effect of Customer Value and Customer Satisfaction on Customer Future Intentions After – Buying", *Dumlupınar University Journal of Social Sciences*, 17, 25-43.

Ülker, F. and Kanten, P. (2009) A Researh on the Relationship Between Climate of Silence, Employee Silence and Organizational Commitment in Organizations, Management and Economics Conference Proceedings, 4, 67-80.

Vakola, M. and Bouradas, D. (2005) "Antecedents and Consequences of Organisational Silence: An Empirical Investigation", *Employee Relations*, 27(5):441-458.

Van Dyne, L., Ang, S. and Botero, IC. (2003) **"**Conceptualizing Employee Silence and Employee Voice as Multidimensional Constructs", *Journal of Management Studies*, 40(6):1359-1392.

Yalçın, B. and Baykal, Ü. (2012) "The Subjects of and Reasons for Nurses' Remaining Silent in Private Hospitals and Relative Factors", *Journal of Education and Research in Nursing,* 9(2):42-50.

Yılmaz, V. and Çelik, HE. (2005) Investigating The Relation Between Customer Loyalty to Bank and Customer Satisfaction in Banking Sector With Structural Equality Models. VII. National Econometrics and Statistics Symposium, 26-27 May 2005. Istanbul.

Yılmaz, V. (2004) "Structural Equation Modeling with LISREL: Application of Consumer Complaints", *Anadolu University Journal of Social Science*, 4(1):77-90.

Table 2. The Issues That the Nurses Remain Silent

		Factor Weights
A1	**I. Administrator Performance And Working Facilities**	
Item 11	Utilisation of individual interests more than organizational interests	0.72
Item 15	Suggestions about improvement of your work	0.85
Item 16	Unjust activities (discrimination, favouritism, inequities etc.)	0.74
Item 17	The rules that do not serve the purpose	0.71
Item 18	Low performance of your administrators	0.82
Item 19	My personal development and need for learning (my shortcomings)	0.78
Item 23	Inappropriate manners and behaviours of your administrators	0.83
Item 24	Infrastructural and structural problems	0.87
Item 25	Insufficiency of equipment	0.84
A2	**II. Employee Performance And The Use Of Administration**	
Item 1	Incapacity of your colleagues (knowledge, skill and ability)	0.78
Item 6	Incapacity of other fellow employees	0.76
Item 8	Low performance of your colleagues	0.72
Item 9	Company policies or decision that you disagree	0.84
Item 10	Personal carrier topics or issues	0.82
Item 14	Incapacity of your administrators (knowledge, skill and ability)	0.74
A3	**III. Responsibility**	
Item 20	Responsibility towards the environment (environmental pollution, improper practices against the society)	0.85
Item 21	Shrinking and laziness	0.89
Item 22	Wastage and losses at your workplace	0.86
A4	**IV. Ethics**	
Item 3	Molestation	0.82
Item 7	Ethical issues (malpractice, absenteeism, falsity, theft, dishonest behaviours etc.)	0.82
Item 12	Personal rivalries and conflicts that paralyse work)	0.82
Item 13	Ill-treatment (profanity, insult, accusation, violence, overworking, conscious damages etc.)	0.83
A5	**V. Department Performance**	
Item 4	Suggestions about improvement for the department/unit that you work	0.78
Item 5	Low performance at the department/unit that you work	0.78

Table 3. The Reasons of the Nurses to Remain Silent

		Factor Weights
B1	**I.Administrative Reasons**	
Item 10	No support given by the administrators for talking plainly.	0.82
Item 14	The idea that the administrators do not pay attention	0.85
Item 15	The administrators' attitude of "I know the best"	0.79
Item 19	Mistrust towards the administrators	0.84
Item 20	A working culture that does not support open talking	0.81
Item 21	Distant relations	0.74
Item 22	Administrators seem like "as if" they were interested.	0.87
Item 23	Fear of relationship damage	0.78
Item 24	The opinion that the administrators are not compatible with the right manners and principles of the work/profession	0.87
Item 25	Individuals, who spoke plainly, were treated unfairly or subject to ill-treatment and they set a precedent	0.85
Item 26	The belief that the administrators do not keep their promises	0.88
Item 27	The fear of reprisal of administrators and colleagues	0.86
B2	**II. Isolation And Fear Of Relationship Damage**	
Item 1	Fear of being called as a trouble maker/complainer	0.74
Item 2	Negative reactions of the administrators towards negative feedback	0.78
Item 3	Fear of the loss of trust and reputation	0.80
Item 4	The belief that plainly speaking is useless	0.76
Item 9	The strict structure of the hierarchical structure (chain of command)	0.85
Item 11	The thought that the administrators would not like	0.81
Item 12	Fear of being called as a mischief maker	0.77
Item 13	Fear of the loss of support	0.89
B3	**III. Fears About The Work**	
Item 5	Fear of unemployment or dismission	0.79
Item 6	The change of workplace or position	0.81
Item 7	The opinion that informers of the problems are not treated well	0.77
Item 8	Lack of experience concerning speaking openly (junior works, young workers etc.)	0.89
Item 16	Fear of lack of promotion	0.87
Item 28	Fear of the increase of workload	0.87
B4	**IV. Lack Of Experience**	
Item 29	The concern that ignorance and inexperience are noticed.	0.75
Item 30	Lack of a formal mechanism that facilitates open speech	0.91
Item 31	The belief that the administrator should know everything	0.90
B5	**V. Organizational Position**	
Item 17	The idea that topics and issues are not a concern of employees but of administration	0.75
Item 18	Having a low position (lack of status)	0.87

Table 4. The Perceptional Consequences of Silence

		Factor Weights
C1	**I. The Consequences Affecting Performance And Synergy**	
Item 4	The employee thinks of changing workplace	0.90
Item 10	The employee gets stressed	0.91
Item 12	The employee feels agony and unable as he cannot speak	0.80
Item 13	No practical solutions are produced for problem solving.	0.88
Item 14	The employees lose their respect towards their administrators	0.82
Item 15	The employees turn into individuals who do only the given tasks without contributing to the organization	0.89
Item 17	Employees' feeling of ownage/adoption diminishes	0.89
Item 18	Lack of ideas and diversity is experienced in the organization	0.90
Item 19	The employee does not make an effort for self-improvement.	0.87
Item 20	Status quo in the organization is maintained	0.86
Item 21	Employee loses his motivation towards his work and workplace	0.89
Item 26	Open communication and constructive dialogs are prevented at the workplace.	0.89
Item 27	Sharing knowledge and experiences is out of question	0.85
Item 28	Lack of multi-perspectives and options	0.80
C2	**II. The Consequences Hindering Identification Of Problems And Employees' Trust**	
Item 6	The employee thinks of changing his unit/department.	0.80
Item 7	Faults/setbacks/problems are pigeonholed.	0.88
Item 8	The employees lose their trust towards their administrators	0.88
Item 9	No organizational learning occurs by taking lessons from mistakes.	0.82
Item 11	Ideas and opinions remained behind closed doors; they are not delivered to the authorities.	0.89
Item 16	Insensitivity and desperation become accepted behaviours	0.86
Item 22	Negativities are ignored.	0.89
Item 23	The sense of "do your work and do not get involved in anything" is settled.	0.85
Item 24	The problems are not solved on time, they grow bigger.	0.93
Item 25	Activation of working process and services and their improvement are neglected.	0.82
C3	**III. The Consequences Preventing Organizational Development**	
Item 1	The administrators lack of significant knowledge and data while they are making decisions.	0.91
Item 2	Effective and productive results are not achieved with the current sources.	0.82
Item 3	The speed of desired changes in the organization slows down.	0.89
Item 5	The speed of organizational development and progress slows down.	0.89