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WHAT THEY DON'T TEACH YOU AT MEDICAL SCHOOL

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Whistleblowing

Introduction

The decision to be a whistleblower is one of the most difficult decisions a clinician can make. Doctors need to be encouraged and supported to raise concerns about a colleague's behaviour, health or professional performance or a situation where he/she has identified unsafe systems which are putting patients' lives at risk (Bown, 2011).

NHS organizations are required to have a whistleblowing policy but this is not always followed. The Kennedy Report highlighted these issues at the Bristol Royal Infirmary. The case involved complex heart surgery in infants between 1984 and 1995 associated with high mortality rates. A Public Inquiry was subsequently set up. It was clear from this that many of the health professionals knew that standards were suboptimal years before the scandal became public but either shrugged off responsibility or hoped things would get better.

An anaesthetist blew the whistle. His view was that the surgeons were not appropriately trained to perform the complex surgery required. He raised his concerns with 24 senior colleagues but was ignored. He said he was told that he would not have a future at the hospital if he continued to question the death rates and he and his family ended up moving to Australia as a direct result of the treatment he received after criticizing the conduct of paediatric cardiac surgeons (Lynch, 2009). This approach to whistleblowing obviously creates mistrust and encourages secrecy. In fact, a Medical Protection Society survey of its members from March 2012 showed that 49% believe that the current whistleblowing process is not effective because the fear of consequences is too great.

There are also instances where doctors believe they have had the whistle blown on them for malicious reasons. In the Medical Protection Society survey 16% of the 1544 respondents had been the subject of whistleblowing and, of this group, over half (51%) believed issues were raised as a result of 'professional jealousy'.

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General Medical Council guidance

The General Medical Council's (2006) *Good Medical Practice* states that the safety of patients must come first at all times. This suggests that if a doctor believes patient safety is or may be seriously compromised by inadequate premises, equipment or other resources, policies or systems he/she should put the matter right if he/she is able to do so. If this is not possible, doctors should raise their concerns with the organization they have a contract with or their employer (*Table 1*). The guidance goes on to say that a doctor must protect patients from risk of harm posed by another colleague's conduct, performance or health by taking appropriate steps immediately so that the concerns are investigated and patients are protected as necessary (General Medical Council, 2006).

The General Medical Council has recently issued new guidance, *Raising and Acting on Concerns about Patient Safety,* which states that doctors must also encourage and support a culture in which staff can raise concerns openly and safely (General Medical Council, 2012). The guidance states: 'You must not enter into contracts or agreements with your employing or contracting body that seek to prevent you from or restrict you in raising concerns about patient safety. Contracts or agreements are void if they intend to stop an employee from making a protected disclosure' (General Medical Council, 2012).

It should be noted that even for a newly qualified doctor, leadership by example applies at all levels of the organization and therefore if a junior doctor notes an issue that is or could be causing patient safety to be compromised, he/she should raise concerns with the appropriate individual or individuals (*Table 2*). It is interesting to note that the survey of Medical Protection Society members showed that 76% felt having 'supportive management' would support people to raise concerns.

Case scenario 1

Dr A was a foundation year 2 doctor working in general practice for 6 months. She was using a partner's room for an afternoon clinic. The computer was still 'locked'. Dr A unlocked it using the password provided to her by the clinic. She was horrified to find that the previous user had been accessing a website containing explicit pornographic images. Dr A informed the practice manager. The practice manager then decided to investigate. This revealed that one of the GP partners had been frequently accessing pornographic material on a practice computer. Some of the websites contained explicit images of children.

The new General Medical Council guidance provides helpful advice on steps to raising a concern in paragraphs 12 and 13. This suggests that if a doctor has reason to believe that there may be patient safety issues, he/she should report these concerns to the appropriate person or organization immediately. In this situation Dr A reported her concerns to the practice manager to enable her to undertake a further investigation (Birch and Stacey, 2011).

It is appropriate to raise concerns locally first. For junior hospital doctors this may be the consultant in charge of the team, the clinical or medical director or a practice partner if they are rotating through general practice. If the concern is about a senior colleague, it may be appropriate to raise the issue with the medical director or clinical governance lead responsible for the practice or hospital. Doctors in training may wish to take advice from the postgraduate dean.

In this particular case, owing to the serious nature of the allegations, the partner was dismissed from the partnership in accordance with the practice partnership agreement. The matter was referred to the primary care trust and under NHS (Performance List) Regulations he was suspended. The matter was referred to the General Medical Council and an interim orders panel was convened which suspended the doctor's registration. The case was reported to the police and he was convicted of a criminal offence and given an 8-month custodial sentence. Subsequently at a fitness to practise hearing, his name was erased from the register and the primary care trust removed him from the performers list, as any doctor who has a custodial sentence of more than 6 months is automatically removed from the list.

It is important to note that even though doctors may fear the consequences of raising concerns, the General Medical Council guidance on the matter is clear that the doctor has an obligation to do so where there are patient safety issues. Paragraphs 9 and 10 address this issue and specifically acknowledge the difficulties for doctors, and advise on overcoming such obstacles (General Medical Council, 2012).

Case scenario 2

Dr B was a senior house officer in surgery. He was called to theatre to assist a consultant surgeon Mr C with an appendicectomy. He became aware of an overwhelming smell of alcohol on Mr C's breath. Mr C did not seem at all well. He was slurring his words as he scrubbed up in preparation for the procedure. He insisted that he was fit to proceed with the operation. Dr B left the theatre and located the senior surgeon, Mr D. He told him what was happening and his concern that Mr C was not fit to proceed with the morning theatre list (Birch and Stacey, 2011).

Mr D agreed that it was not appropriate for Mr C to operate. He had another colleague take Mr C home and Mr D proceeded to do the list with Dr B. Mr C was advised to attend his own GP. Mr C had developed depressive and alcohol symptoms following an acrimonious divorce. After advice and treatment from his own GP he was able to return to work.

Patients can be at risk of harm as a result of a colleague's ill health. Many concerns can be addressed at a local level without referral to the regulator or another organization. In this case the health issues were addressed appropriately and promptly and the surgeon was able to return to work after a period of treatment and rehabilitation. It was also important that Dr B notified the senior surgeon, and did not directly involve other theatre staff. Raising such issues promptly – and discretely where possible – will help protect all those involved.

Furthermore, the General Medical Council (2012) states: 'Wherever possible, you should first raise your concern with

Table 1. Dos and don'ts of whistleblowing

Do:	Make an immediate note of your concerns and keep this secure for future reference
	Ensure your note is a factual account of what happened and avoid including opinion
	Convey your suspicions to someone with appropriate authority and experience
	Deal with the matter promptly, if you feel your concerns are warranted
	Request a copy of any minutes of meetings where you raised concerns with a senior colleague, and ensure these accurately reflect what was said
	Remember to be aware that the matter is likely to be both sensitive and confidential
Don't:	Do nothing
	Record your concerns in a patient's record
	Be afraid of raising your concerns
	Approach or accuse any individual directly
	Try to investigate the matter yourself
	Convey your suspicion to anyone other than those with the proper authority

Based on Lynch (2009)

Table 2. Checklist for how to raise concerns

Are your concerns objective and reasonable?
Have you sought advice from a senior colleague, medical or clinical director, local medical committee, defence body, deanery or trade union?
Have you documented your concerns, your actions and any outcome?

Based on Barr (2012)

your manager or an appropriate officer of the organisation you have a contract with or which employs you….'

The Public Interest Disclosure Act 1998

This act was introduced to protect employees who have concerns about issues in their place of work and wish to raise them openly. The act applies to all NHS employees and includes all self-employed NHS professionals. An employee will be protected from victimization if he/she discloses the information in good faith. If an employee is victimized for making a protected disclosure, he/she can bring an action for compensation against the employer at an employment tribunal. To qualify for protection, the doctor must make the disclosure in good faith and the wrongdoing must involve:

- A crime or breach of legal obligation
- A miscarriage of justice
- A danger to health and safety
- Damage to the environment
- Attempts to cover up malpractice.

Each NHS body should have its own policy and procedure for responding to an individual's concerns. A disclosure to the Department of Health is also considered to be a disclosure to a doctor's employer if he/she works within the NHS. A whistleblower is acting as a witness and not a complainant.

Any doctor who feels unable to raise the issue with his/her employer can seek advice from his/her defence organization or can contact Public Concern at Work (www.pcaw.org.uk/about-us). Other sources of help are listed in *Table 3*. The doctor may also feel more comfortable approaching a particular manager who he/she gets on well with, if he/she does not feel able to raise the issue with his/her direct line manager. Doctors should be careful, however, to observe their employer's policy for raising concerns. They must also remember that even where they are reluctant to raise concerns, even where there is fear of reprisals, they have an obligation to do so where patient safety is at stake.

Public Concern at Work

Public Concern at Work was established in 1993 to develop a new approach to whistleblowing. It promotes practical arrangements which help organizations to manage themselves better and to demonstrate this to their people and other stakeholders. The organization provided whistleblowing support to the NHS between 2008 and 2011.

Changes to the NHS Constitution

The Department of Health issued a report on the outcome of its consultation on the NHS Constitution and whistleblowing. Changes to the Constitution to afford greater protection to NHS workers who blow the whistle were introduced early in 2012. These include:

- An expectation that staff should raise concerns at the earliest opportunity
- A pledge that the NHS organization should support staff when raising concerns by ensuring that their concerns are fully investigated and that there is someone independent outside the team to speak to.

NHS whistleblowing helpline

A confidential helpline for whistleblowers in the NHS and social services was launched in January 2012. It aims to ensure that staff can raise genuine concerns about standards without fear of reprisal and provides advice on how best to raise those concerns. It also provides advice to those with responsibilities for developing whistleblowing policies and procedures for their organization. The helpline – 08000 724 725 – is provided by the Royal Mencap Society. It is operated Monday to Friday 08:00–18:00 with an out-of-hours service available on weekends and public holidays.

Conclusions

Patient safety must come first at all times. Even as a junior doctor, in a situation where you note unsafe practices by your colleagues or unsafe systems, you have a duty to raise concerns with the appropriate authority. Act promptly, document your concerns and speak to the relevant authority in the first instance. If you have any doubts about what to do, you can approach your defence organization for advice. **BJHM**

Table 3. Sources of help

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The General Medical Council (2012) guidance on raising concerns
Care Quality Commission (2011) guidance and whistleblowing policy
Public Concern at Work
Department of Health website for the NHS Constitution

Based on Barr (2012)

KEY POINTS

- There have been high profile cases of 'whistleblowers' being ignored and isolated.
- In recent years there has been further guidance and policies which clarify what is expected of doctors and outlines the protection available to them.
- Blowing the whistle can be difficult, but doctors at all levels have an obligation to put patient safety first.
- Doctors need support to raise concerns and it is important that they are aware of the relevant process and the resources available to them.
- Careful documentation, using reasoned judgement and showing sensitivity are important factors when raising concerns.

Conflict of interest: none.

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