Whistleblowing and patient safety: the patient's or the profession's interests at stake?

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DECLARATIONS

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Introduction

Whistleblowing has a tortured history in the NHS although it has been recognized by authoritative reviewers as making an important contribution to patient safety.[1,2]

In a highly critical 6th Report the House of Commons Health Committee stated 'The NHS remains largely unsupportive of whistleblowing, with many staff fearful about the consequences of going outside official channels to bring unsafe care to light. We recommend that the Department of Health (DH) bring forward proposals on how to improve this situation.'[3]

Encouraging the medical profession to report poor care and to report incidents that occur in their practice has been problematical in modern healthcare although there are notable exceptions.[4] This article discusses why a change in the attitude of the profession is required, what the benefits will be and how it can be achieved.

Why 'blow the whistle'?

A whistleblower is defined as a person who raises concern about wrongdoing. The term is quintessentially English derived from the practice of police officers blowing their whistles to alert colleagues and the public when they saw a crime committed and needed assistance.

There are four common situations in which a clinician may consider raising concerns, although there is overlap in each situation:

(1) Reporting on the systemic failure of a trust to provide adequate nursing resources (e.g. Tameside General Hospital);
(2) Requesting review of the clinical outcomes of a whole department (e.g. Bristol paediatric cardiac surgery);
(3) Reviewing poor clinical outcomes involving a single individual over a period (e.g. Harold Shipman);
(4) Anticipating and reporting a single catastrophic event (e.g. 'Baby P' affair).

Current protection for whistleblowers

The Public Interest Disclosure Act (PIDA) of 1998, passed to protect whistleblowers in the wake of the Bristol paediatric cardiac surgery scandal, has not been as effective as anticipated.[5] Lewis concluded, 'PIDA 1998 has not adequately protected whistleblowers,' adding, 'common standards for their protection still seem a long way off.'[5] By comparison since the Enron scandal and '9/11' the US has developed systems to protect whistleblowers. The National Whistleblowing Center (see http://www.whistleblowers.org) has provided support for many US whistleblowers. Although 31% of US physicians remain reluctant to report impaired colleagues and 12% fear retribution for doing so these figures are better than UK junior doctors.[6,7] In 2003, the European Commission acknowledged the part that whistleblowers can play in the fight against corruption urging Member States to provide protection for them, but positive advocacy has not followed in the UK.

Role of the General Medical Council (GMC)

In the NHS 'Professional bodies may reinforce their members' natural reluctance to whistleblow by producing disciplinary codes which present additional obstacles'.[8] This reluctance can be traced back to the 1980s edition of the 'Blue Book' that cites 'depreciation by a doctor of the professional skill, knowledge, qualifications or services of another doctor could amount to Serious Professional Misconduct'. There have been cases where the GMC has investigated and in some cases prosecuted doctors who have raised legitimate concerns.[9] There continue to be echoes within the UK's regulatory and professional bodies that criticism of colleagues is somehow unacceptable. Additionally 'the obligation GMC members feel to those who elected or appointed them represents a conflict of interest that prevents the GMC from working for the good of the public'.[9] Recent regulations stipulate the Appointments Commission makes appointments to the GMC but this possible conflict of interest, by elected and appointed custodians of standards, remains.

Following the Mid-Staffordshire Hospital Inquiry the GMC is investigating the conduct and performance of doctors at Stafford Hospital after referral by the Medical Director for failing to report poor care. Essentially, the doctor is 'damned if they do and damned if they don't' report their concerns. The current situation is at best confusing where it appears that a doctor's registration can be held over their head like a 'Sword of Damocles' if they do blow the whistle, but conversely doctors have been investigated, or sanctioned, for failing to whistleblow.[10] The GMC may not act even when those who failed to report concerns must have known they should have done so, because they were themselves members of the GMC.

As a result, whistleblowing in the NHS is a traumatic undertaking and generally not to be recommended.[2,11] There is scant evidence for ethically sound disclosures, by morally and legally justified professionals, designed to improve outcomes for patients, delivering the requisite changes without repercussions. One example may be a surgical specialty in dealing with the problem of high complication rates following joint replacement surgery in treatment centres in the UK.[12] This is despite the exhortation of the GMC that doctors are obliged to report poor care that they witness in their practice. Thus if the GMC is to be involved in improvements to reporting poor care it is imperative that the Council urgently write clear and unequivocal guidance concerning whistleblowing. It should be comprehensive and recognize the dangers posed to all medical whistleblowers. The role of organizations such as the Care Quality Commision, Links, the Parliamentary Health Select Committee, Monitor, and others should be clearly stated and accessible to all doctors. It is vital for patient safety that statutory bodies play a leading role in assuring potential whistleblowers that they will not be penalized for raising concerns.

The question then remains 'How can it be that selfless and ethically sound behaviour continues to be punished by the medical establishment?' This is after inquiries into the Bristol Scandal, the serial killer Dr Harold Shipman, the Mid-Staffordshire NHS Foundation Trust, the 'Baby P' affair and the North Staffordshire Ward 87 debacle, have all confirmed that whistleblowers played a crucial and constructive part in the identification of poor patient care prior to deaths and patient harm attributable to that poor care. What chance in this environment does a reporter of poor care have? High profile scandals appear to produce recommendations with very little impact and even less improvement on the 'shop floor'. In 2008, the Health Commission's Report noted, 'One in ten patients admitted to hospitals will suffer from an error and around half of these could have been avoided'.

Unfortunately those inquiries did not address the fact that the analysis of routinely collected outcome data would have identified two of the more heinous episodes well before large numbers of patients perished.[13]

Vexatious whistleblowing

Recent examination of the CNEP Trials in Stoke-on-Trent have raised the issue of vexatious whistleblowing involving parents and press.[14] The possibility of unsubstantiated claims against

medical practitioners remains a constant possibility and we would agree with two of Neville Goodman's quotes in this journal that help to define the solution. Firstly 'there is no perfect solution'. Secondly there 'must be systems to support and investigate suspicion rather than systems that go out looking with suspicion'.[15] Although the solution proposed for the vexatious whistle blowing seen in the Stoke-on-Trent episode related to alleged research misconduct, such a system in clinical and research practice would seem to be designed to deal adequately with justifiable and unnecessary concerns in both fields of professional practice.[16,17]

Role of medical education

The medical profession is experienced and adept at promoting bad behaviour around reporting poor care, and can influence the behaviour of medical students during their training.[18] This behaviour change has been attributed to the 'informal' or 'hidden' curriculum of medicine and is well described.[19] Of even more concern is the distribution of ethical responses from the students at the start of their undergraduate training (only 13% of students would consider reporting a senior colleague at the start of their training and <5% at the end).[18]

Economic impact

In 1999, the Institute of Medicine, in a seminal publication entitled *To Err is Human. Building a Safer Health System*, attributed $17–29 billion of healthcare spending annually to the effects of systemic healthcare error in the US, and there is no evidence that the NHS is a safer healthcare provider.[20] Consequently the failures, deterrents and obstructions faced by whistleblowers in the NHS may be having a severe impact on the public purse as well as public safety. This year the Treasury has spent well over £3 million gagging whistleblowers, which will ensure that improvements to patient care will not occur.[21] Martin Fletcher, Chief Executive at the National Patient Safety Agency, has said: 'Good reporting is the cornerstone of patient safety. Safety cannot be improved without a range of valid reporting, analytical and investigative tools that identify the sources and causes of risk in a way that leads to preventative action.'

The management side

The past failures of medical managers and the DH to show moral leadership and support for whistleblowers, makes it unlikely they will be in the vanguard of change. The emphasis on financial goals, the lack of effective responsibility for the outcomes of care and of any widely accepted code of ethics for medical managers makes it unlikely that they can currently catalyse the necessary change.[22] The House of Commons Health Committee confirms that the lack of achievement of the Department of Health in dealing with harmed patients is 'appalling'.[3]

Need for change

Who can achieve the necessary change?

The medical schools will find the role of 'change leader' difficult because they select, encourage and perpetuate these undesirable norms.[23] What is less obvious, but equally logical, is that the majority of the medical profession, who have been trained in medical schools, with these behaviours and reflect that training, may also struggle to lead the change, although it may be possible with support.[7,24] This potentially sweeping exclusion of change leaders would automatically include the GMC, whose track record in this area is at best inconsistent, having attempted a complete U-turn in the last 21 years.

In the absence of the professional groups putting their heads together the problems of reporting poor care have not gone away but have possibly multiplied, as predicted by the *Lancet* at the time of the GMC verdicts on the Bristol doctors.[3,25] The prediction was inevitable without a serious change of attitudes at the top of the profession. In view of this professional intransigence, we would add the British Medical Association (BMA) Council to those from whom leadership in this area should not be expected without some difficulty. Like the professional members of the GMC, the BMA Council is elected by the profession and is therefore not likely to support reporters of poor care.[9,19] The logic is two-fold. First, the BMA is representative

of the profession, made up of doctors trained in medical schools, where whistleblowing is covertly discouraged; and second, the obligation elected and appointed members may feel to their professional colleagues will conflict with empathy for a whistleblower.[9] Therefore the BMA leadership is unlikely to lead change in supporting poor care reporters, who are reviled by sections of the profession.[2,26] This applies particularly to reporters in situations 2 and 3, involved in reporting a colleague's performance. A counter argument is that some groups within the BMA, most notably the BMA in Scotland, have produced constructive suggestions for encouraging medical whistleblowing. The most important of these is a retrospective review of responses to cases where doctors have spoken out and is one way forward.

The way forward

After excluding these groups, who is left to deal with reports of poor patient care? The answer should include some doctors with knowledge and experience in the area and patient and community representatives along the lines of Institutional Research Ethics Committees. Those acknowledged as most representative of their constituents, elected members of the House of Commons, have recognized the problem for a very long time. The comments of Members of Parliament have so far been supportive of clinical standards and whistleblowing in relation to orthopaedic specialists and complication rates in UK Treatment Centres (see pages 5 and 6 of http://www.official-documents.gov.uk/document/cm77/7709/7709.pdf) and patient safety.[3] These exposures of lower standards of clinical outcomes in non-NHS hospitals indicate the difficulties associated with clinicians working in unrelated healthcare providers (e.g. private and NHS hospitals). These observations also add considerable weight to the inclusion of publicly elected and appointed professional and lay representatives, with no perceived conflict of interest, to those handling reported poor care. It would be necessary to resource and train these groups to review reports of poor care brought to them on behalf of healthcare professionals (including doctors), patients and their relatives so that equable and fair review without punitive retaliation against the reporter could be achieved to improve the quality of services irrespective of their source (NHS hospital, primary care, treatment centres or private providers) or their provenance (medical, healthcare or patient-related sources). These groups should help to change the culture of the profession and could identify potential vexatious whistleblowers at an early stage.[14]

Our recommendations are firstly that the profession, through the GMC or BMA Council, should commission a Consultation Group on Reporting Poor Care. This Group will examine the consequences to all parties from incidents of reported poor care. Second, the Government should consider establishing a Health Select Committee Review of Whistleblowing that would make impartial recommendations to Government and the profession. Third, the Government should consider setting up and resourcing a National Whistleblowing Centre similar to that in the US. We believe that only by open public scrutiny will constructive change be cemented into exemplary clinical practice.

One question to answer

The question that individual medical professionals must answer is 'Which doctor would you prefer for your relatives or yourself? A doctor that is prepared to report poor care to improve your, or your relatives outcome, or one that is not prepared to do so regardless of the consequences to your relative or yourself?' When the profession can truthfully answer that question they will be able to put in place the necessary structures for change.

The people who deserve this most are our long-suffering patients.

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