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Whistle blowing

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> "A practitioner shall be free, without prior consent of the employing authority to publish books, articles, etc. and to deliver any lecture or speak, whether on matters arising out of his or her hospital service or not". Paragraph 330, Terms and Conditions of Service for Hospital Medical and Dental Staff

> "The culture of honesty and high integrity in British public service is something that needs to be sustained. Half of all fraud is detected by staff who spot something dodgy and report on it. One of the best antidotes to fraud is an open attitude with staff". Andrew Foster, Controller of the Audit Commission (1994)

> "I am appalled at the thought that there remain in the NHS some people who feel that they work in a climate that prevents them from freely expressing their views. That is not the kind of organisation I wish to lead. I do not believe that there is any place for 'confidentiality for commercial reasons' in the family of the NHS". Alan Langlands, Chief Executive of the NHS Executive (1995)

For the purpose of this article, I am using a definition of whistle blowing which was used at a conference in November 1995 at the Royal Society of Medicine:

> "Reporting serious concern about patient care, past present or future, to people beyond the immediate circle of the clinical team. This could be 'local' – within the organisation – or 'more distant' for example to a professional organisation, the Secretary of State, politicians, or the media."

Two points need to be emphasised. First, the definition includes reporting to local staff (internal whistle blowing) and also expressing serious concern about future standards of care, which might result from the implementation of plans which are being considered by a Trust or Health Authority. Secondly, the reporting can be done by any person, for example, by a nurse about a doctor (as in the case of Dr Cox, who unlawfully killed a patient suffering from distressing and uncontrolled pain), or by a patient or relative.

I have excluded the clinical team from the whistle blowing scene because discussions, suggestions, criticisms, and reviews of untoward incidents, should be part of the clinical team's regular work. Readers may feel that this view is unduly optimistic. There must certainly be a channel for referring unresolved serious concerns elsewhere, and there are some grey areas, for instance, are the night staff part of the clinical team? A group of people who are less closely observed and supervised, and who do not regularly meet the rest of the day-time team are at risk of providing poor care.

The theme of this article is that health professionals have an ethical duty to report their serious concerns and to respond to such reports from others, but the pathways for reporting and for responding are seen as unclear and hazardous. Thus professional self-regulation is at present failing and requires attention. It is my belief that consultant psychiatrists, who have lived with regulations from the workings of the Mental Health Act, The Health Advisory Service and from the fairly searching visits of inspection and training by the Royal College of Psychiatrists and JCHPT, can give a lead in improving matters.

The past

The problems of whistle blowing in the NHS go back many years, they cannot all be laid at the door of the more recent reforms. An excellent book by Martin (1984) gives an account of the scandals occurring in psychiatric institutions in the 1960s

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and 1970s. More recent situations where the whistle blowing has been 'external', nearly always to the media or to the Secretary of State, are discussed by Birley (1994). Some general findings were:

(a) The whistle blowers were usually low in the hierarchy and were rarely doctors. They were often newly arrived staff or students who were not acclimatised to the bad situation which had been going on for a long time and was well-recognised locally.
(b) Whistle blowing was a last resort after attempts to use internal procedures had failed because of inertia or active suppression by senior management who felt threatened by the disclosures, often with good reason.
(c) Whistle blowers were often victimised and threatened both verbally and physically.

Some of the conditions which were commonly found as contributing to these situations were:

(a) Isolation – both professional, geographical and personal. Scandals often occurred on particular wards of hospitals which were otherwise functioning quite well.
(b) There was a lack of leadership from senior staff, particularly from doctors, nurses and managers, who were either ignorant or dismissive of recent developments or advances in treatment, and were content for things to carry on as they always had. In some cases, doctors had deserted their long-term wards for acute units elsewhere. Boards of Management felt they were presiding over benign institutions, and were unaware of what was really going on.
(c) The principle of the 'professional autonomy' of consultants inhibited managers from interfering with practices which were idiosyncratic and harmful.

The present

The setting of psychiatric care

Old fashioned situations, such as those described by Martin (1984), still occur in hierarchical and rigid psychiatric systems such as the special hospitals – as indicated by the recent report on Ashworth Hospital (Department of Health, 1992). But the situation in the 1980s and '90s has changed. Large long-term institutions are fading from the scene and are being replaced by a network of scattered homes, often privately run, which may not be thoroughly inspected and where standards are bound to vary. Furthermore, these places have visiting professional staff who may not be part of the local management and whose responsibilities, in terms of standards of care and detection and rectification of abuse, may be unclear. Acute units are often overcrowded, with a high turnover, and may contain very disturbed individuals, many of them on compulsory sections of the Mental Health Act. This, combined with a high staff turnover, can affect standards of care.

Finally, there are the patients in community care obtaining treatment based on out-patient, day hospital or home care, from multidisciplinary teams. Recent reports of tragedies involving homicides have underlined the problems of providing treatment for patients who move about frequently and who accept treatment irregularly or not at all.

In summary, the present system of psychiatric care includes settings where poor standards and abuse can easily occur. For the potential whistle blower the situation has also altered. There is more awareness of the existence and risks of abuse – but not yet enough. For instance, neither our own College nor the Royal College of Physicians have yet issued any guidance to their members on the detection of abuse or neglect of elderly people, either at home or in institutions. There is more discussion of abuse, more investigative reporting in the media and some external whistle blowers have become heroes or heroines. There is now greater recognition of the value of whistle blowers and a Private Members Bill to protect them has been introduced by Dr Tony Wright, but not passed.

'The ethical imperative'

The ethical duty of the doctor to report concerns, and to respond to reported concerns, has recently been re-emphasised both by the General Medical Council (GMC) and by the NHS Executive (NHSE). In 1993 the GMC gave a judgement on Dr Dunn who, as Chairman of a local anaesthetic division, failed to heed warnings from theatre staff about the dangerous behaviour of a locum anaesthetist. He was found guilty of serious professional misconduct, but was allowed to continue to practise. The GMC in their press release stated that:

> "They wished to remind Dr Dunn and all registered practitioners of our professional duty to protect patients. Doctors who had reason to believe that a colleague's conduct or professional performance presents a danger to patients must act to ensure patient safety. Before taking action in such a situation, doctors should do their best to establish the facts. Where there is doubt, it is unethical for any doctor to give a reference about a colleague,

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particularly if it may result in the employment of that doctor elsewhere. References about colleagues must be carefully considered; comments made in them must be justifiable, offered in good faith and intended to promote the best interest of patients....

The Committee has already drawn attention to the existence of appropriate procedures for response to reports of evident and dangerous incompetence. Doctors have a duty to activate those procedures promptly where such cases arise. Another working party is expected shortly to report to the Secretary of State about such procedures within the National Health Service. At all times safety must take precedence over all other concerns, including understandable reticence to bring a colleague's career into question".

This judgement received some publicity at the time, but whether it has penetrated the minds of 'all registered practitioners' seems rather unlikely. I have yet to meet a psychiatrist who has ever heard of Dr Dunn and the GMC's judgement. If another such case comes to the GMC it may feel that even stronger action will be needed to engage the medical profession's attention.

1993 also saw the publication by the NHSE of its *Guidance for Staff on Relations with the Public and the Media*. Like so many recent NHS documents, its title is rather misleading as it is largely concerned with internal reporting rather than external. However it affirms that:

"Individual members of staff in the NHS have a right and a duty to raise with their employer any matters of concern they may have about health service issues concerned with the delivery of care or services to a patient or client in their authority, trust or unit. [And that] every NHS manager has a duty to ensure that staff are easily able to express their concern through all levels of management to the employing authority or Trust. Managers must ensure that any staff concerns are dealt with thoroughly and fairly".

The procedures for reporting

While the ethical imperative to report is clear, the correct procedures for reporting are not. The GMC in its judgement of 1993 refers to "existing procedures". Clearly these exist in any organisation for flagrant cases such as seriously dangerous incompetence, drunkenness on duty or very inappropriate behaviour to patients or staff. An employee can be suspended from duty at short notice. But those cases are exceptional, things usually get bad gradually rather than suddenly.

There are also professional constraints on reporting. Doctors, and especially consultants, do not like reporting on each other, or only in private. They are a 'company of equals', as Eliot Freidson – the most distinguished and sympathetic sociologist of the medical profession – described them some years ago. Trainees have an understandable anxiety about their careers, in which patronage still plays a part, and they have no model to follow of doctors seriously criticising each other in public – apart from friendly arguments at training occasions – as this goes on behind closed doors. Consultants vary a good deal as to how much they encourage and accept criticism in the setting of the clinical team. Loyalty, kindness, not being the first to cast a stone in a glass house which depends a great deal on mutual trust, there but for the grace of God: all these can be invoked as reasons for limiting or suppressing reporting. While understandable, they are in serious situations unacceptable as they do nothing to improve patient care. Eliot Freidson has recently been reported as saying that:

"it was the (American) profession's own failure to regulate itself in the public interest that created the legal, economic and political pressures of the past twenty-five years." (Bunker, 1994)

One of the constraints, which may reflect the profession's own views in the past, is that the procedures for reporting consultants (and GPs) are disciplinary rather than remedial and thus likely to be contentious and unproductive. The Professional Review Machinery, HC(90)a, for consultants was set up in 1986 to deal effectively with the small number of consultants who were not pulling their weight in the NHS, and consists of a small panel who consider such allegations, interview and, where appropriate, warn the consultant concerned.

The Intermediate Procedure is a more elaborate one 'to deal at an early stage with problems involving professional conduct or competence'. The Regional Director of Public Health asks the Joint Consultants Committee to nominate two assessors from another region, and the doctor concerned may also nominate persons to be interviewed. The Central Consultant and Specialists Committee (CCSC) of the BMA recommends this procedure:

"to prevent the development of intractable situations which can ultimately lead to formal disciplinary procedures which are traumatic for the

Box 1. The ethical imperative

NHS staff have an ethical duty to report serious concerns about poor care of patients

In 1993, the GMC found a consultant guilty of serious professional misconduct for failing to respond to reports of such concerns from his staff

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individual concerned, disruptive to other staff, expensive for the Health Authority and damaging to the profession".

A non-disciplinary procedure is the 'three wise men' (a panel nominated by the medical staff) which is designed to prevent harm to patients, arising from a doctor's illness or disability. It is the responsibility of employers to ensure that all staff concerned know of the machinery and the identity of the panel members. It seems to be rarely used, except in extreme cases, and informal channels are generally followed more effectively for staff sickness.

NHS Executive 1993

Guidance for Staff on Relations with the Public and the Media is largely concerned with 'internal' reporting. It starts with some unexceptional principles: that the culture of the NHS should be of openness, and that under no circumstances should employees who express their views according to the guidance be victimised. They recommend setting up both formal and informal local procedures, and possibly appointing a designated officer to bypass long chains of management, and confirm the staff's right to consult their own professional organisation or trade union, to complain to the Ombudsman or (concerning detained patients) to the Mental Health Act Commission.

When it comes to the subject matter of its title the iron fist begins to emerge from the velvet glove. Staff can consult with MPs 'in confidence' but disclosing matters to the media should be seen as a "last resort which if entered into unjustifiably, could result in disciplinary action and might unreasonably undermine public confidence in the Service." Staff are advised, before doing so, to discuss matters with their own professional bodies, their colleagues and, where appropriate, their line or professional managers.

Another worrying element in the guidance is the obfuscation created by the concept of patient confidentiality. The guidance, in several places, emphasises the great importance of this:

> "Unauthorised disclosure of personal information about any patient or client will be regarded as a most serious matter which will always warrant disciplinary action. This applies even where a member of staff believes that he or she is acting in the best interests of a patient or client by disclosing personal information" (Clause 8).

But what exactly is patient confidentiality? Certainly, some Trusts seem to be extending the concept. Three examples illustrate this point.

> Example 1: "All members of the Trust should be aware that any information which comes into their possession regarding health service patients or their affairs must be treated in the strictest confidence. *Similarly* (my italics) information relating to health service business under consideration by the Trust is also regarded as confidential and must not be communicated to persons who do not require the information for Health Service Purposes".
>
> Example 2: "*In the interests of patients and the Trust's commercial interests* (my italics) staff must adhere to the normal rules governing patient confidentiality ...".
>
> Example 3: "Confidential information includes information relating to the Trust, its activities, its finances, its customers and suppliers, *its patients and their diagnosis and treatment*" (my italics).

A further ambiguity is introduced in clause 9, which states that:

> "Employees also have an implied duty of confidentiality and loyalty to their employer. Breach of this duty may result in disciplinary action, whether or not there is a clause in their contract of employment expressly addressing the question of confidentiality".

Clause 10 qualifies this slightly stating that:

> "...the duty of confidence to an employer is not absolute and it may be claimed that disclosure of confidential information was made in the public interest. Such a justification in a disputed case might need to be defended and so should be soundly based".

In addition, mention must be made of paragraph 330 of *The National Terms and Conditions of Service for Hospital Medical and Dental Staff*, quoted at the beginning of this article, which allows free public expression of their views. The BMA have asked for this to be included in all Trust contracts, but the Department of Health has refused to agree to this saying that "it will be for Trusts to determine the provisions they consider appropriate in this respect".

Box 2. The obstacles

Reporting concerns about doctors' performance at present leads to disciplinary action, not remedial

Clauses on patient confidentiality, in contracts devised by Trusts, may inhibit reporting

Pathways for reporting are being devised by Trusts. The guidelines from the NHSE explicitly disapprove of reporting to the media and fail to mention reporting to the Secretary of State – the two most frequent pathways used by external whistle blowers in the past

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In summary, therefore, the guidance advocates the use of local mechanisms for 'internal whistle blowing' which should be negotiated and used by the staff and managers. But it gives ambiguous guidance on the concept of confidentiality, which has been used coercively by some Trusts, and it ranks as 'highly risky' one of the traditional outlets for external whistle blowers – the media – without mentioning the Secretary of State. We are a long way from the state enrolled nurse who, in 1967, wrote to the News of the World making allegations – amply justified – of poor care at Ely Hospital, which led to a series of important revelations and enquiries all over the country.

Comment

The Executive are perfectly correct in advocating an efficient sympathetic local mechanism for internal whistle blowing, but their guidance is, in my opinion, flawed. Its title is misleading, the contents are ambiguous, and the threats against public disclosure are unhelpful – even MPs should only be approached "in confidence". Does that mean that MPs cannot take the matter further, or ask questions in the House? These ambiguities, and the gap between the realities of the NHS and what is published in soothing press releases breeds distrust. As does the gap between draconian management advice on patients' confidentiality on one hand, and rather cavalier advice concerning patients' confidential information on computer systems on the other. This is very unfortunate, as two new pathways for internal whistle blowing are being proposed to deal with the sensitive and important issue of professional performance of doctors, both of which will depend upon local mechanisms and a climate of trust.

The future

The General Medical Council

The GMC's professional performance procedures have been approved by Parliament and are due to be introduced in 1996. This allows the GMC to assess and take action about a doctor's poor performance using an educational rather than a disciplinary approach. Poor performance includes not only professional skills but also knowledge and professional attitudes towards both staff and patients. Complaints can come from any NHS member of staff, patient or relative, but the GMC will only act over problems of professional performance "which are so serious that they will call into question the doctor's unrestricted registration". The approach will be remedial. Assessment will be by a panel consisting of two doctors and one lay person – who will "help to identify the training needs of any doctor whose performance is found to be seriously deficient". The criteria for standards of performance will be provided by the Royal Colleges who are preparing clinical guidelines for this purpose.

This extension of the GMC's powers, and its remedial approach, has been generally welcomed by the profession, but it creates new situations, including the criteria of assessment, the techniques and cost of re-training and assessing its success. For our purposes, the main interest is the reporting and identification of poor performance. Reports may have to be initially filtered locally before being passed on to the GMC, and there may be levels of poor performance which do not reach the criteria for GMC action but yet are causing local concern.

The Calman Committee on Poor Performance of Doctors

A working party was set up by the Chief Medical Officer in 1992, concerning professional poor performance in the NHS. The report was completed in January 1995, but only published – after a change of Secretary of State – in August. Its brief was "to review the existing guidance for identifying and dealing with doctors whose performance, for whatever reason, falls below an acceptable standard". Not surprisingly, they find this confusing, but they make no significant or substantive recommendations for change. Their most important statements appear in the first two sentences of their report:

> "The professional responsibility to monitor the standard of colleagues' professional performance needs to be reinforced for all doctors. There is a need for action to establish a culture and a climate of opinion within the NHS which is sympathetic to the problems of doctors whose practice standards are poor to encourage colleagues to take appropriate action before patients suffer or extreme sanctions are needed."

Unfortunately, perhaps because of its brief, the emphasis of the report is all about procedures and it says nothing about the action which is needed to change the culture to one in which doctors can be more open about their own and each others' poor performance. Richard Smith, in his review (1995*b*) has commented that:

> "the primary diagnosis of the report is surely right, but the exploration of the problem is shallow and

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the prescription inadequate. The report contains no data and no references to the considerable world-wide experience of poorly performing doctors".

The important topic of the interaction between the new GMC procedures and the NHS is discussed and two recommendations are made. First, that the GMC should notify employers of allegations not within the GMC's criteria but which might be appropriate for action by the employer. Secondly, that UK Health Departments should issue guidance to NHS employers as to when to notify the GMC that they are taking action against a doctor on matters of professional incompetence or misconduct and the outcome of their actions.

Central guidance will certainly be needed, and the Committee comments that "the establishment of NHS Trusts as employers of consultants has resulted in a diffusion of expertise in handling disciplinary issues", leading to misunderstanding and a lack of skills. They also "recognise that the locally generated procedures are more likely to be understood than complex central guidance", but at the same time they "are concerned about the potential for fragmentation and confusion if locally generated processes diverge too much from a single pathway".

The Committee seems to be blowing a discreet whistle about the risks to the NHS which may arise from the current policy of leaving it to the Trusts.

The role of the College in whistle blowing

The College does a good deal of 'central' whistle blowing, generally through official channels rather than the media. This depends, as always, on obtaining accurate and systematic information from its members, using an evidence-based approach. In addition, the College provides support for members who are having local difficulties in their attempts to maintain professional standards, for instance in patient care, computer confidentiality, or consultant appointments. The College should also give advice and encouragement to its members in developing and negotiating appropriate local procedures for whistle blowing which are professionally acceptable. This can be a difficult task, and the experience and advice of a local BMA Industrial Liaison Officer should also be obtained.

However, the most important contribution of the College lies in continued professional education which should regard advances in psychiatric treatment as a broad subject. This should include treatment of isolation (including an exaggerated respect for clinical autonomy) and poor leadership.

Box 3. The future

The GMC's new professional performance procedures take a remedial approach, and are concerned with problems "which are so serious that they will call into question the doctor's unrestricted registration"

The DOH has recently published a report reviewing guidelines for identifying and reporting on poorly performing doctors. Their recommendations are limited and do not address the need, identified in their report, to change the culture and climate of opinion in the NHS

Isolation

When do independence and clinical autonomy – the proud hall-marks of the consultant – become isolation? It is quite easy for a consultant, even in a teaching hospital, to become professionally isolated, and this is more likely to happen in geographically isolated places, which may apply to sector teams working in community based premises. Local educational events such as the 'open, peer-based professional training linked to audit' recommended at the Core Values Conference (BMA, 1995) may be important, but these are time consuming and will only be useful if they are valued as stimulating, and thus time is set aside for them.

Two groups of isolated psychiatrists require special mention. The first are those, already alluded to, who are visiting nursing homes and other care facilities, such as children's homes, as consultants. These are the places where large numbers of vulnerable people are to be found, in settings where standards vary considerably and where scandals have been recently reported. Their professional position, as whistle blowers, is very important – but they may not see it as their role as they are not part of the management. That view is incorrect, both ethically and professionally. These psychiatrists must insist that their contracts include a right to report both routinely and also immediately to the senior management responsible for these homes. Special educational meetings for psychiatrists working in these settings might well be valuable.

The second group are those psychiatrists, a considerable number, occupying the non-training grades. These often work in professionally isolated situations, and are in charge of patients with long-term psychiatric disabilities – a potentially dangerous mixture. Their continued education by *Advances in Psychiatric Treatment* and other College activities must be encouraged.

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Leadership

This was recently discussed by John Reed (1995) in an article which should be studied by all consultants. He defines leadership as: "discovering the route ahead and encouraging and inspiring others to follow. A good leader should both show the way and make others enthusiastic about following it". Of particular importance is the 'imperative of example' – a leader must share the problems of the team, and not be a 'Chateau General'.

In terms of whistle blowing, the route ahead involves creating an atmosphere which is sufficiently secure and rewarding to tolerate and encourage careful and constructive reviews of mistakes and of untoward events, often very painful ones such as suicides. This should go beyond the clinical team to peer review where both good and bad practice can be discussed freely, and some consultants may consider the possibilities of changing their clinical habits. This may sound idealistic and/or impossible – particularly in an atmosphere where there is more distrust than trust, and where fear of victimisation is widely prevalent, but I suspect that there are already good examples of this, involving people who are sufficiently modest both to make it work, and not to report it widely.

One final new training development should be mentioned – the retraining of doctors whose performance has been found to be poor. This comparatively new experience has been discussed by Sir Donald Irvine, the new President of the GMC (Smith, 1995*a*). It may seem separate from whistle blowing, but it is the end-point to which some internal whistle blowing inevitably leads. If it is apparent that this is being taken seriously and is found to be effective, then the internal reporting procedures are more likely to be used.

Some practical tactics

Having retired from the NHS five years ago, I hesitate to give advice on the practical tactics of whistle blowing. But the following principles may still apply:

(a) Whistle blowing must be based on evidence and done in cold rather than hot blood.
(b) It is much more effective in these matters to act as a co-ordinated group rather than individually.
(c) It is highly advisable, before taking any action, to discuss the matter with an uninvolved and trusted colleague, in particular, to assess how much of the proposed action may be based on personal rather than professional grounds.
(d) Whistle blowing is not 'gesture politics'. Its timing and its focus should be clearly thought through as part of a co-ordinated campaign to bring about necessary changes.

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