Debate & Analysis

‘Don’t shoot the messenger’:

the problem of whistleblowing in general practice

BACKGROUND

On the 9 June 2010 the then Secretary of State for Health, Andrew Lansley, announced a full public inquiry into the role of the commissioning, supervisory, and regulatory bodies in the monitoring of Mid Staffordshire NHS Foundation Trust. The Inquiry was chaired by Robert Francis QC, who has made recommendations to the Secretary of State based on the lessons learned from the failures of care provided by the Trust between January 2005 and March 2009.[1]

The Inquiry heard oral evidence from six GPs whose surgeries are situated within the Trust catchment area. This focused largely on the extent to which the GPs were aware of problems at the Trust.

The Francis Report raises a number of serious issues about NHS ‘whistleblowing’ and identifies failures in the application of current whistleblowing policies. The NHS, and GPs in particular, face unique problems in whistleblowing.

A CAUTIONARY TALE

a. ‘The GMC guidance states that GPs have a duty to raise concerns. When I contacted the GMC, they recommended that I contact the BMA. The BMA recommended that I contact my [medical defence organisation] MDO. My MDO recommended that I contact the BMA’

All doctors have a duty to act when they believe patients’ safety is at risk or that patients’ care or dignity is being compromised.[2] This paper defines ‘raising a concern’ as doing so through the normal internal structures of accountability and ‘blowing the whistle’ as highlighting a concern to individuals outside of these structures, often externally, and normally after failing to successfully raise the issue through the expected internal routes.

When a GP decides to act as a ‘whistleblower’, for example because of concerns about the patient care provided by a GP colleague, he or she may have an additional challenge because in a practice partnership professional, financial, and social interdependency coincide; this is very different to the position of other doctors in a secondary care setting who have a contractual relationship with, and are normally employees of, an NHS body such as a trust. The GP contract however, is not a direct contract of employment and

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although under the current law, the Public Information Disclosure Act (PIDA)[3] should, in principle, give protection to all ‘workers’, this protection has not yet been defined for GPs. A ‘test case’ is shortly to go before the courts but as things stand, NHS bodies can claim that whistleblowing policies only apply to employees and that they have no specified duties towards GPs. This is further complicated by the fact that GPs may be both providers of care and private employers at the same time. In the case of salaried GPs, where a GP is an employer, the situation can become even more complicated and at present the position remains unclear.

In addition, the MDOs may take the view that their duty is not to support one doctor making allegations against another and professional bodies such as the Royal Colleges do not themselves currently provide formal individual support to whistleblowing members; rather generic advice and ‘signposting’ to available websites and information.[4] The whistleblowing policy of other professional organisations such as the BMA, which might have been expected to provide individual support to members, provides advice to secondary care employees or medical students and may take a similar view to that of NHS trusts towards GPs. Furthermore, local medical committees (LMCs) may find themselves with conflicts of interest if one or both doctors are members of an LMC.[5–7]

All of this means that a GP whistleblower may find themselves in a situation where they have little or no professional support, and this, of course, may act as a profound disincentive for a GP to ‘stick their head above the parapet’. When this is added to the current NHS ‘blame culture’ towards individuals[8] and the substantive risks of whistleblowing in terms of hostility, marginalisation and the threat to a doctor’s career,[9] it is quite remarkable that there have ever been any GP whistleblowers at all!

b. ‘I contacted ‘Public Concern at Work’ and ‘Patient First’: both organisations gave advice and offered sympathy but gave me no practical support’

Recent changes to the NHS Constitution contain an expectation that NHS staff will raise concerns about safety, malpractice or wrong doing at work that may affect patients, the public, other staff, or the organisation itself as early as possible and will be supported in doing so.[10] The Care Quality Commission (CQC) classifies GPs as ‘other workers who provide services to the registered provider’ as they are not directly employed by the NHS[11] and their website guidance for providers does give a full explanation of the policies, the law, and expectations on how to raise a concern. Public Concern at Work (PCAW) is the whistleblowing charity established in 1993 which provides free confidential advice to people who are concerned about crime, danger, or wrongdoing at work.[12]

However, although a number of such resources are available to GP whistleblowers (such as Whistleblowing Helpline [http://wbhelpline.org.uk/] and Patients First [http://www.patientsfirst.org.uk/]), many of them are not ‘fit for purpose’, since they do not offer a great deal in the way of practical support through the specific complexities faced by GP whistleblowers. Such practical support must be the role of the professional organisations.

c. ‘I did face immediate hostility, was marginalised and a campaign of retribution lost me my position and yet nobody seemed willing or able to influence this’

Although legislation was passed 14 years ago to support the rights of whistleblowers,[3]

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there is little evidence that it has in practice provided protection to individual NHS whistleblowers: indeed the consequences for an individual whistleblower can still be devastating as the quote above from the 'live' case illustrates.

Hammond[13] in his evidence to the Francis Inquiry stated that 'staff that do blow the whistle are frequently marginalised, counter-smeared and suspended and many agree to a modest payoff with a gagging clause to protect themselves from personal and professional ruin'.

There are many recent examples of such denigration and 'gagging clauses' (compromise agreements) in the NHS.[9]

The widespread use of compromise agreements in the NHS is clearly contrary to the public interest, especially when it involves issues of patient safety. The recent letter from Sir David Nicholson (Chair of the National Commissioning Board) about adequate support being provided to whistleblowers in the NHS and the requirements of Health Services Circular 1999/1998[14] sought to discourage the use of such agreements, but this was more of a request rather than an instruction.

There is no doubt that whistleblowing can be a courageous, difficult, and detrimental thing for the individual. To report any sort of concern, let alone whistleblowing, means bringing into question the judgement of another doctor or health professional; something which is (rightly) taken very seriously. However, since patients trust their GPs more than any other professionals, they are more likely to confide in them and expect them to take action when issues about patient safety are brought to their attention.

WHAT NEEDS TO BE DONE?

The failures of care in Mid Staffordshire were quite appalling and all doctors including GPs, should and are required to raise concerns which they may have about patient safety.[2] This did not happen and it is thought that up to 1200 patients received dreadful care, dying prematurely while managers were chasing productivity targets.[1]

In such circumstances there is an ethical imperative for us as GPs to act, initially by 'raising a concern' but if our legitimate concerns are not properly addressed, then whistleblowing may have to be our last recourse; with all the potentially disastrous consequences for us as individuals. The creation of clinical commissioning groups (CCGs) offers an opportunity for some of these issues to be addressed and the issuance of Whistleblowing Guidance to CCGs is not only an imperative but also a matter of urgency if tragedies like the Mid Staffordshire case are not to occur again within the NHS.

RECOMMENDATIONS

- The respective roles of the professional bodies (the GMC, BMA, MDOs, LMCs and the Royal Colleges) need to be clarified in cases of GP whistleblowing: a joint statement about the position of GP whistleblowers should be agreed and publicised.
- Whistleblowing policies and guidance for CCGs should also be distributed: these could be developed from existing resources such as the whistleblowing helpline[12] and the recently adopted RCGP policy.[4]
- The RCGP and other Royal Colleges should offer generic support and guidance for whistleblowing members by signposting available resources and providing referral to appropriate sources of advice.
- All practices should have whistleblowing policies in place and GPs should know who to go to for advice and support when they have concerns about the quality or safety of patient care.

Finally, and most importantly, we all need to help create a responsive, open, and supportive cultural environment in the NHS: not only by improving transparency but also by using the legislation which already exists to protect whistleblowers from retribution.

We owe this to our patients.

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Provenance
Freely submitted; not externally peer reviewed.

Consent
Quotations a, b, and c are from a 'live' GP whistleblower case and are used with the full knowledge and consent of the person concerned.

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REFERENCES

1. The Mid Staffordshire NHS Foundation Trust Inquiry. *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009. Volume 1. Chaired by Robert Francis QC*. http://www.midstaffsinquiry.com/assets/docs/Inquiry_Report-Vol1.pdf (accessed 15 Feb 2013).
2. General Medical Council. *Raising and acting on concerns about patient safety*. GMC, 2012. http://www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp (accessed 15 Feb 2013).
3. Public Interest Disclosure Act (PIDA): Section 43K ERA. http://www.pcaw.org.uk/pida43g-section11#43k (accessed 15 Feb 2013).
4. Royal College of General Practitioners. Whistleblowing in the NHS. RCGP Policy document. http://www.rcgp.org.uk/policy/rcgp-policy-areas/whistle-blowing-in-the-nhs.aspx (accessed 15 Feb 2013).
5. BMA. Practical Support at Work: Whistleblowing — who can help you. http://bma.org.uk/practical-support-at-work/whistleblowing/who-can-help-you (accessed 15 Feb 2013).
6. BMA. *Whistleblowing. Advice for BMA members working in NHS secondary care about raising concerns in the workplace*. BMA, 2009; document no: 50185. (accessed 28 Jan 2013).
7. BMA. Negotiating for the profession. Whistleblowing. http://bma.org.uk/working-for-change/negotiating-for-the-profession/whistleblowing (accessed 15 Feb 2013).
8. BMA. NHS culture adds whistleblowing insult to patient injury. BMA, 2012. http://bma.org.uk/news-views-analysis/news/2012/october/nhs-culture-adds-whistleblowing-insult-to-patient-injury (accessed 15 Feb 2013).
9. Hammond P, Bousfield A. *Shoot the Messenger. How NHS whistleblowers are silenced and sacked*. http://drphilhammond.com/blog/wp-content/uploads/2010/07/Shoot_the_Mesenger_FINAL.pdf (accessed 15 Feb 2013).
10. National Health Service. *The NHS Constitution*. http://nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx (accessed 15 Feb 2013).
11. Care Quality Commission. Whistleblowing: guidance for providers. CQC, 2011; http://www.cqc.org.uk/search/apachesolr_search/guidance%20on%20whistleblowing (accessed 15 Feb 2013).
12. Public Concern at Work (PCAW). http://www.pcaw.org.uk/ (accessed 15 Feb 2013)..
13. Witness Statement from Dr Phil Hammond to Francis Inquiry. http://drphilhammond.com/blog/2013/01/18/private-eye/witness-statement-from-dr-phil-hammond-to-francis-inquiry/ (accessed 15 Feb 2013).
14. Department of Health. Compromise Agreements and the Public Interest Disclosure Act 1998. http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_132261 (accessed 15 Feb 2013).