

FEATURE

WHISTLEBLOWING

Name and shame

When health workers raise the alarm about standards of care, they can end up feeling as guilty as the organisations they expose, **Jane Cassidy** reports

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Steve Bolsin is one of the best known whistleblowers in UK medical history. The consultant anaesthetist experienced career damage and professional isolation after raising concerns about death rates in paediatric heart surgery at the Bristol Royal Infirmary in the 1990s.

Nearly 20 years on, he says he is “a modern day exile from the NHS,” indelibly marked by the process of exposing the problems at the United Bristol Healthcare Trust.^{1 2} Professor Bolsin wrote his first letter of concern to the then trust chief executive in 1990, five years before the death of Joshua Loveday, the last of 29 babies and toddlers who died after having complex open heart surgery at the hospital. A further four were left brain damaged.

He says he couldn't take “another day of knowing that a child was being sacrificed once more on the altar of surgical pride, institutional indifference, and professional impotence.”

It was five years before he met the makers of a *Dispatches* documentary broadcast in 1996 that finally led to a public inquiry in 1999. In the interim he approached not only clinical colleagues and senior managers but a host of outside individuals and organisations including MPs, the Department of Health, and the Royal College of Surgeons.

“It was an isolating and depressing experience. Nobody was doing anything and it was also very time consuming. I spent a lot of time thinking about who I could go to next, what more I could do,” he said.

Meanwhile his attempts at finding a job elsewhere in the UK proved fruitless. “I didn't want to stay at Bristol. I was made to feel that I was the problem rather than the service. I was shortlisted for various interviews but never got the jobs. Finally, I was given advice by one panel member, who said that my reputation preceded me.”

He waited until he had a full employment contract in Australia before he felt comfortable enough to contact the GMC about what was going on in Bristol, and he was the only doctor to do so. He has described this lack of action by others as “a stain on the medical profession.”

He has had a successful career as director of perioperative medicine, anaesthesia, and pain medicine at Geelong Hospital, Victoria. But there have been times, he says, when he and his partner were not sure they'd done the right thing by moving overseas and struggled to justify what had happened.

He still thinks, though, that if he had stayed in the UK it would have been impossible to achieve the investigation that was needed. “If I'd been a registrar I might have been the messenger that was shot. I was lucky that I was able to get publicity and leave the country.”

No support

He believes that the vindication of his actions from the ensuing public inquiry and from the GMC was crucial in staving off any long term psychological effects of the actions he took. He remains disappointed at the UK's failure to tackle discrimination against whistleblowers.

“What I find sad is that I don't think anything's changed in the UK. It wouldn't be any easier to speak out now than it was in 1990.”

He is still contacted by UK whistleblowers and knows of junior doctors who have not been recognised, acknowledged, or in any way supported for their contribution to improved patient safety. “In fact they continue to be hounded by the organisations that insist that [health professionals] should have done what they did,” he says.

Despite regulators producing written guidelines stating that doctors must report poor care, in many cases when this is done, the regulators then punish the reporters with no real justification, according to Professor Bolsin. “Sadly I never see examples of reporters of poor care being praised by the regulators or inspectors, even when their findings have confirmed the poor practice,” he says.

Doctors contemplating raising concerns need an officer in every trust who they can turn to anonymously. This puts the onus on hospitals to do something about complaints, he says.

An investigation can be taken out of an individual's hands so that a single healthcare professional doesn't have to take responsibility for difficult tasks such as compiling detailed data to support concerns or tackling the individual they are concerned about.

He believes doctors in Australia are offered more support and protection when speaking out, and wonders why similar measures can't be introduced in Britain. A combination of hospital administrators keen to act swiftly when alerted to problems and a strictly enforced public interest disclosure law, help provide an environment that encourages rather than punishes those who raise concerns.

Evidence from a recent unpublished survey by Professor Bolsin and his colleagues, suggests Australian junior doctors may be much more likely to report poor care or medical errors than their UK counterparts. The team used the same methods as those in a UK 2000-1 study that asked medical students whether they would be prepared to report a senior colleague for wrongdoing.³ The question was posed at the beginning and end of trainees' five years at medical school.

The UK results showed 87% of trainees unwilling to report at the start of their studies and 95% unwilling to do so by the end.³ In stark contrast in Australia, more than 60% of trainees in their first three years said they would be willing to report a senior colleague.

Professor Bolsin's team also studied what happened when they gave trainee doctors working in his department handheld computers so they could accurately collect data at the point of care.^{4,5} Results showed critical incident and near miss reporting rates of 98% among junior doctors using the technology. He believes this type of routine monitoring would have detected and prevented many of the deaths attributed to poor surgical standards in the Bristol scandal.

"There are solutions out there. With an encouraging environment and the right technology, we've seen that junior doctors will become the strongest advocates for monitoring their performance and will want to do it for the rest of their careers.

"I changed my department here in two months. Change can happen very easily. The big question is whether you want it."

Current concerns

Professor Bolsin's pessimistic observations are echoed in the findings of a BMA survey published last month. Three quarters of 565 doctors surveyed said they had concerns about issues relating to patient care, malpractice, or bullying at some time in their careers.⁶ Seven out of ten said they had raised a concern in their trust. Many found the experience negative. Nearly half said they were unaware that anything had happened as a result. A considerable proportion (15.5%) said their trusts indicated that speaking could negatively affect their employment.

The survey results informed newly published BMA guidance on whistleblowing (box).⁷ Specialist registrar in anaesthesia Tom Dolphin, who is vicechairman of the BMA Junior Doctors' Committee, put forward the idea of producing guidance after his experiences trying to help a fellow junior doctor. The doctor concerned, also a trainee anaesthetist, was met with a "wall of apathy and disinterest" when he tried to raise concerns about outdated equipment. "It took us ages to work out who to go to and where to take the concerns," said Dr Dolphin.

The doctors finally resolved the issue with the help of the BMA and the Postgraduate Medical Education and Training Board.

Dr Dolphin thinks the guidance may be needed more than ever in the run up to the implementation of the European Working Time Directive in August, which could have serious implications for medical staffing levels in some hospitals. "We want doctors of all grades to be able to say: 'This isn't going to work,' and know where to take their concerns rather than just muttering among themselves," he said.

Greater statutory protection, more support from regulatory bodies, and a culture change to encourage speaking out are all required to transform the face of whistleblowing, according to an editorial by Peter Gooderham, a tutor at Cardiff Law School.⁸ He says whistleblowing is still hazardous to whistleblowers, as the recent case of Margaret Haywood shows. She was struck off in April by the Nursing and Midwifery Council after her covert filming of poor standards of care at Brighton and Sussex University Hospitals NHS Trust was screened on a BBC *Panorama* programme.⁹

At around the same time, Mid-Staffordshire NHS Foundation Trust hit the headlines for poor patient care that is being blamed for hundreds of unnecessary deaths.¹⁰ In its report, the Healthcare Commission indicated that there had been warnings about some of Mid-Staffordshire's problems for years before they became publicly known and that clinical governance was inadequate.¹¹ Mr Gooderham asks, "Why should staff accept the risks of whistleblowing if warnings are ignored?"⁸

Better protection of whistleblowers is not an issue confined to the UK. US President Barack Obama has identified transparency and accountability as priorities for his administration. He has expressed a commitment to strengthen whistleblower laws to protect federal workers who expose waste, fraud, and abuse of authority in government.¹²

Media's role

General practitioner and columnist at *Private Eye* magazine Phil Hammond was the first journalist to write about the Bristol heart scandal and has just highlighted new concerns at the same trust, this time about misdiagnosis of biopsy samples.¹³ When he first wrote about the heart case in 1992, it took seven years to get a public inquiry. The Bristol pathology concerns have prompted the announcement of an external inquiry in seven days, a sign of some progress, he said.¹⁴

The latest Bristol case offers a vision of how speaking up can work, said Dr Hammond—through constructive use of the media, with patients and staff working together to raise concerns. However, some worried staff have been lobbying for five years for the action that may now take place as the result of the *Private Eye* story.

Dr Hammond finds it depressing that little has changed to encourage speaking out in the interests of patient safety since the Bristol heart scandal.

"It's still the same now. No-one wants to go public; everyone is scared for their jobs; and those who do go public are still vilified," he said.

When contacted, Dr Hammond tries to get to the bottom of the concerns raised and passes them on in anonymised form to the relevant national and local authorities. More often than not the first reaction from a trust will be: "Let's get the bastard who's leaked this," he said.

One stick used to beat whistleblowers is that they go to the media rather than try to resolve problems internally. Yet people with urgent concerns often really don't know what the internal mechanisms for complaint are, said Hammond.

BMA's guidance on whistleblowing⁷

- Raise initial concerns within your team or with your manager or immediate superior. If you feel uncomfortable doing this, speak to the designated officer. Your employer's policy should have a formal and confidential procedure for raising concerns. Some issues such as bullying should be raised as a grievance
- If your concerns are not dealt with, take them to the medical director
- If they are still not addressed satisfactorily, go to the chief executive, but make sure your medical director is aware you have done this
- Only once you have exhausted all local workplace policies and procedures should you consider raising your concerns externally. The BMA, the Care Quality Commission, and National Patient Safety Agency can help. Also your local strategic health authority, health board, NHS board, or health and social care trust, depending on where you live
- Going directly to your local elected representative or the media is advisable only if your employer has a record of ignoring, discouraging, or suppressing concerns even after they have been raised at the highest level. Consult the BMA or a defence body before taking this step

"They may go to a medical director. But if the director doesn't think it's a problem or is not interested, they could approach a royal college, which more often than not will say clinical governance is an internal matter.

"You may be told you have to provide evidence which you may not have access to, or that your concerns are too statistically insignificant. It's very difficult raising concerns internally unless you work for the kind of trust which encourages it."

He condemns the "absolute absurdity" of the decision to bar Margaret Haywood from nursing. "It provides a clear disincentive to anyone else to raise concerns. Here is someone who has exposed seriously bad nursing practice and they've struck her off."

Hammond agrees with Professor Bolsin that an opportunity was missed following the Bristol inquiry to rebuild the NHS around transparency, trust, and openness. "The vision after Bristol was to build a health service where whistleblowing was not needed and clinical governance issues were addressed quickly," he said. The introduction of the internal market soon destroyed this ideal and meant everything disappeared into secrecy and competition, he said.

While there has been huge progress in certain areas of patient safety, time and again the interests of the patient are submerged by conflicting interests, often involving compliance with government targets, he said.

Some sort of regional independent inspectorate is needed to investigate complaints as they happen, otherwise scandals such as Mid-Staffordshire "just go on and on."

"We need a resource allowing for an external expert's view, otherwise problems fester for years and the balloon only goes up when the deaths can't be covered up anymore."

He also believes current public interest disclosure legislation is full of loopholes, often making it impossible to reassure those coming to him with concerns that they will be protected if their identities are discovered.

Only the brave

Consultant cardiologist Peter Wilmshurst has spent most of his professional life exposing research misconduct. Having reported more than 20 doctors to the GMC in as many years, he has reflected on what makes whistleblowers tick. "Some may seem to be self confident, difficult, a bit different, maybe even odd. The pressure whistleblowers experience makes their lives very difficult and can make them odd.

"Many whistleblowers I know have been forced out of medicine. They give up because the medical establishment makes their life so difficult or tries to 'get them' by suggesting they're the problem.

"I know of cases when whistleblowers were falsely accused of dishonesty, said to be mentally ill, unfairly dismissed, or had their working conditions changed so badly that they resigned.

"Perhaps the most remarkable thing about me is that, unlike most whistleblowers, I'm still working as a doctor in this country." Despite a highly successful start to his career, he found it difficult to get a consultant job as he began to build a reputation for exposing research fraud. Doctors who were less experienced than him, and some he had helped to train, were getting jobs that he applied for: "I stopped counting rejections after the 42nd," he said. "It was clear to me that loyalty, no matter how misplaced, was valued more highly in medicine than integrity.

"I guess I'm outspoken, one of those people who says what they think, and so I'm not very politically correct. I just happen to think that as a doctor my first priority is my patients, not the protection of institutions or colleagues.

"I don't know where my resilience comes from. I've got a family and they share much of the burden, but it takes its toll on them," he said.

Defending a legal claim by a medical device company also takes a financial toll. Dr Wilmshurst is currently facing libel action over comments he made to a US based medical website about a trial in which he was the joint principal investigator.¹⁵

He first experienced misconduct while working as a research registrar on amrinone, a promising new drug for heart failure. His research showed that the drug, developed by Sterling-Winthorp, did not have the cardiac effects claimed but had serious side effects.¹⁶ He took his findings to the *Guardian* newspaper after medical and pharmaceutical regulators refused to take action.

"I don't know why I haven't gone completely mad. I'm different in that most whistleblowers do it once and never again. Some end up very damaged and very poor, much poorer than if they'd kept their heads down. I cannot imagine that one could get a clinical excellence award for being a whistleblower, even if it results in improved patient care."

He draws on his experience to give talks and advise fellow whistleblowers. He believes self regulation doesn't work because of inevitable conflicts of interest. The regulatory role of the General Medical Council should be replaced by a body similar to the Independent Police Complaints Authority, which regulates the police force.

A robust checking system needs to be put in place that allows random inspection of raw data, similar in approach to drug testing in sport. Whistleblowing would then be welcomed by institutions keen to protect their research ratings.

Joe Collier is a rare example of a whistleblower who was ultimately thanked for his actions in drawing attention to racist

and sexist admission procedures at the medical school where he worked. The acknowledgment came years after he wrote a letter to the Commission for Racial Equality about what he discovered at St George's Medical School in 1986.

The commission's inquiry into the case and media coverage that followed helped pave the way for fairer admissions procedures.¹⁷ Denied a professorship for a decade after he was eligible for promotion, he was told several times that the school had decided he would never get it. Many colleagues ostracised him, angry that, in their eyes, he had damaged the institution's reputation and finances.

Those who thanked him tended to do so "in hushed tones in quiet corners" while he recalls others said loudly and more publicly that his actions would attract poor quality students to the school.

Having discovered a computer software system rigged to discriminate against women and those with non-European sounding names, he felt there was only one moral course of action. He and Aggrey Burke had already published a paper documenting systematic illegal racism and sexism taking place in the selection procedures at other medical schools.¹⁸ "I'd made a statement saying other schools were sexist and racist, if I didn't say ours was I would be colluding, so I had no choice but to go public."

Describing himself as a "toughy," he stayed at St George's and was finally made professor of medicines policy but was to learn that the scars of his whistleblowing experience ran deep. It was only when he was thanked for his actions from a public platform at St George's several years later, that the strain of braving vilification for so long finally overwhelmed him. He recalls that this occasion was the first time he had allowed himself to let down his guard: "Obviously all the anxiety and hurt I felt welled up. I found it hard not to be tearful. It was a very strong feeling," he said.

Competing interests: None declared.

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Cite this as: *BMJ* 2009;339:b2693

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