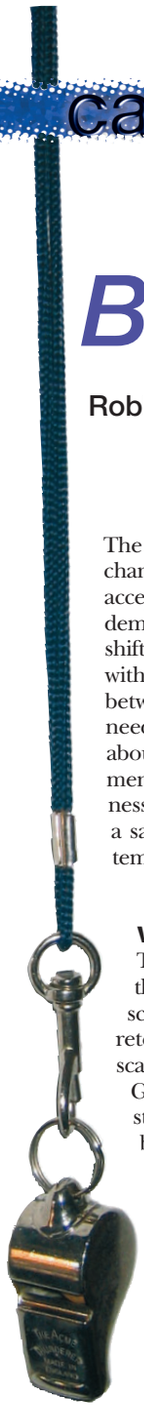
# Blowing the whistle

**Robbie Coull** is brave enough to talk straight



The ethical canvas of our society is changing, and patients, who in the past accepted paternalistic care, now demand fully informed consent. This shift in attitudes is producing tension within the NHS. A gap is opening up between those who think that the public needs to be protected from the truth about medical errors and poor management, and those who believe that openness and transparency are vital parts of a safe and fair modern healthcare system.

## Whistleblowing in the NHS

The most high profile examples of this shift are the Bristol baby heart scandal[1 2] and the Alder Hey organ retention scandal.[3] The effect of these scandals has been so profound that the General Medical Council (GMC) has strengthened its guidance on whistleblowing.[4 5] Another key sign of the change in attitudes is the introduction by the UK government of legislation designed to protect whistleblowers.[6]

It is my belief that these examples are only the tip of the iceberg, and that throughout the United Kingdom there are health professionals who have serious concerns about aspects of local health care. However, most are too afraid to do anything about their concerns. And they are afraid for good reason. The NHS has a long history of treating whistleblowers badly. Many whistleblowers find that their career, physical health, and mental health all suffer.[7 8]

## How to whistleblow and live to tell the tale

My involvement in whistleblowing started when I was 5 years old. Two older Swedish boys lived next door to us in Copenhagen, and they were frightening a local 3 year old boy by hiding one of their friends inside a wardrobe and telling him there was a ghost. I opened the wardrobe, exposed the deception, and told the terrified child what they had done. My neighbours would not talk to me after that and, having failed to learn my lesson, I have been opening wardrobe doors that others would prefer to have kept closed ever since.

What I have learnt is that, firstly, whistleblowing is rarely welcome; secondly, there are several ways that the whistleblower can be "got at"; and, thirdly, there are various tactics you can use to protect yourself in this situation. Here are a few.

### *Record everything*

Detailed records of events are vital if you are going to survive as a whistleblower. Write down all relevant events with dates, times, and people present. Record whom you have spoken to and what was discussed. Keep copies of all letters sent and received. Make sure this record is stored securely. You may want to make a voice recording of important meetings or telephone calls. If so, use a standard portable tape recorder, not a Dictaphone. Forget what you have seen in the movies—a standard medical Dictaphone is useless for this task. It was designed to record speech from a distance of 5-8 cm, not a few metres, and the tape lasts only a few minutes. Be open about the fact that you are making a recording.

### *Check local policies and lines of responsibility*

All units should have a formal whistleblower's policy in place and named managers who are responsible for ensuring safe practice. Find out what this policy is and follow it. A common error is to report concerns at too low a level, where they are buried before more senior management can find out about it (see gambit 5 below). Find out if there are any external regulatory bodies that you could approach for help or advice.

### *Take advice from professional bodies*

Read the GMC's advice on dealing with poorly performing colleagues[4] (although whistleblowing often involves concerns about system failures or non-medical staff, rather than individual doctors). It's also important to contact a defence union, lawyer, or the BMA for advice. However, be prepared for the fact that they will often advise you not to take any action. This is because their job is to limit your exposure to risk, and whistleblowing always has risks. You have to decide how great those risks are, and if you can live with yourself if you do nothing.

### *Never report serious concerns informally*

If you have serious concerns, put them in writing at the earliest possible opportunity. This can be in the form of a critical incident report (see below) or a letter to the clinical director concerned. If the managers are honest, they will respect your integrity. If they are not, they will try to undermine you. I would qualify the GMC's advice that "informal confidential advice from senior colleagues may be helpful in deciding what action to take" by saying that you should seek such informal advice only from *independent* senior colleagues whom you know and trust. You are far less vulnerable to attack once you have raised the issues formally (see gambits 1 and 5 below).

### *Be non-judgmental and stick to the facts*

Write balanced, factual, and problem based reports and letters. Most serious problems are system failures and are rarely the fault of just one person. Point out your safety concerns, but avoid directing blame. To limit the risk of libel or slander, stick to facts or events that you have witnessed yourself or know to be true. If you have obtained information second hand, consider keeping it in reserve or at least qualify it strongly. Be clear about areas where you do not have access to the full facts.

### *Dealing with informants*

You may be approached by other members of staff, or the public, who have important information but who do not wish to be named publicly. If you do agree to keep their identities secret, warn them that there are circumstances when this will not be possible (for example, legal proceedings). Be extremely careful about acting on information that comes from only one source, no matter how convincing they are. You could be being manipulated.

### *Dealing with the press*

"Going public" is the whistleblower equivalent of a weapon of mass destruction. The threat of going to the press is a powerful one, but actually doing so can be dangerous to all concerned. It is difficult to control a story after the press has become involved, so passing information to the press is usually a last resort. Check your employment contract and the whistleblower policy in your unit to minimise the risk of disciplinary action. And, of course, be careful not to divulge patient sensitive information without explicit consent.

### *Critical incident report forms*

These are an ideal way of documenting problems in a factual and non-pejorative manner. They minimise blame while fostering the implementation of change. They can have various formats, of which this is just one example:

- Date of report
- Reporting team member
- Date and time of incident
- Location of incident

- Other team members involved
- Description of incident
- Management of incident/recovery
- Consequences and potential consequences
- Was the incident preventable?
- Suggested changes to prevent recurrence
- Planned follow up to monitor whether changes have been successfully implemented.

## Common anti-whistleblower techniques

It sometimes seems that there is a secret "How to Silence Whistleblowers" manual in the NHS. Here are the most common tactics that I have experienced and seen used, along with my suggested defences.

### *(1) The "discredit the messenger" gambit*

**Technique**—Trawl the whistleblower's caseload for errors and attempt to discredit them with spurious complaints. In more serious cases, false allegations of sexual impropriety, financial irregularities, drug abuse, or other criminal activity can be made against the whistleblower. This may lead to the "Mexican stand-off" gambit, which entails suggesting that both sides then drop their complaints and forget about the whole thing.

**Defence**—Put your concerns in writing as soon as possible, before they have a chance to ambush you with this technique. Avoid any actions or behaviour that could be misconstrued or misrepresented.

### *(2) The "stall for six months gambit" (or "here we go round the mulberry bush")*

**Technique**—Since junior staff rotate on a regular basis, you need to avoid dealing with an issue only until the next rotation arrives. First SHO: I think xyz is dangerous. Consultant: Thank you for raising this important issue. We will have a meeting about it next month. (Stalling tactics with promises of action to come.)

Six months later: Next SHO: I think xyz is dangerous. Consultant: Thank you for raising this important issue. We will have a meeting about it next month. (Stalling tactics with promises of action to come.)

Six months later… ad infinitum.

**Defence**—Raise your concerns formally as early as possible during your rotation. Set a deadline for change or follow up your concerns after you have left to make sure they have been dealt with.

### *(3) The "no one has ever raised this before" gambit*

**Technique**—Make the whistleblower feel isolated and foolish by insisting that they are the only one to perceive a problem.

**Defence**—Firstly, always verify comments like this independently. Ask for contact details of the previous incumbents and speak to them yourself. There is a good chance that this has been raised by several other doctors in the past but has been buried every time. Secondly, this kind of comment is of no importance even if it is true. Either your concerns are justified or they are not. Whether anyone has raised them before or not makes no difference.

### *(4) The "transference of blame" gambit (or "it's your fault now if the hospital closes")*

**Technique**—Suggest to the whistleblower that if this information becomes public it will do more harm to patients by causing the unit to close, etc—for example, "a poor service is better than none at all."

**Defence**—This is false logic. Patients' interests are almost never served by hiding the truth from them. Defuse this by separating the problems from the personalities—for example, "I don't think talk of blame is helpful at this stage; I think what is important is focusing on how the problem can be resolved".


### *(5) The "see no evil, hear no evil" gambit*

**Technique**—Attempt to dissuade the whistleblower from formalising their concerns, and avoid responding to allegations in writing. This allows "credible denial" in the future if things go wrong. This also facilitates the use of a scapegoat. If senior management is being kept in the dark, take steps to avoid the whistleblower contacting them.

**Defence**—To avoid denial that some or all of your conversations took place, put your concerns in writing and make sure you receive a written response. Make sure that you have copied letters to managers above the level that this gambit originates from. Consider recording conversations and using recorded delivery for letters.

### *(6) The "you don't understand the issues involved" gambit*

**Technique**—Try to convince the whistleblower that the issues involved are more complex than they realise. Ask them to leave these issues to people who understand them better.

**Defence**—Usually, if you are raising the issues, it means you understand them all too well. Don't let them discourage you. Ignore these comments and focus on the key issues.

### *(7) The "make the messenger the problem" gambit (or "wouldn't you be happier somewhere else?")*

**Technique**—Arrange a meeting with the whistleblower to discuss the issues they have raised. When they arrive tell them that the meeting is only to discuss their future with the unit, their lack of team skills, and so on. Concentrate on criticising their attitude towards problems in the unit, but avoid discussing their concerns.

**Defence**—Defuse this by separating the problems from the personalities. If this does not work, refuse to discuss your handling of the issues until after your concerns have been fully resolved. If they persist, disengage and obtain union or legal advice.

### *(8) The "you'll never work again" gambit*

**Technique**—Make it clear to the whistleblower that there is no place in the NHS for people who are not team players. Imply that you will see to it that they are blacklisted from working again in your area or specialty, and that they will not get a reference for their current post. Avoid making this threat openly if possible, but make sure that the subject understands.

**Defence**—This is the most widely known technique, largely because of its lack of subtlety. The shortage of doctors in the NHS, coupled with changes to whistleblower legislation, have made this less of a threat than it once was. However, it remains one of the greatest threats to those who have their hearts set on a particular career path.

## Playing dirty

Fortunately, real dirty tricks against whistleblowers are less common in the NHS. However, they are a serious threat. They can include bullying, sexual harassment, removal or replacement of supportive staff members, deliberate increases in workload to "burn out" the whistleblower, and even the threat of (or actual) bodily violence. If you encounter any of these tactics obtain urgent legal advice. In extreme cases, where you suspect a criminal offence has occurred, you may need to inform the police.

Over the years, whistleblowers have improved the care that NHS patients receive immeasurably, but often at great cost to themselves. That needs to change so that the NHS becomes somewhere that staff can raise legitimate concerns without fear of retaliation. In the meantime, be careful.

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References are on studentbmj.com

### Further reading

- Baguley P. *Teach yourself negotiating*. London: Hodder and Stoughton, 2003
- Fisher R, Ury W. *Getting to yes*. New York: Random House, 1991