

The handling by the General Medical Council of cases involving whistleblowers

Report by the Right Honourable Sir Anthony Hooper¹ to the General Medical Council presented on the 19th March 2015

Introduction

1. I was asked by the General Medical Council (GMC) on 5 September 2014 to conduct an independent review of how the GMC engage with individuals who regard themselves as whistleblowers. My terms of reference are:

“To conduct a review of how the General Medical Council handles cases involving individuals who regard themselves as whistleblowers and who have appropriately raised concerns in the public interest. These are individuals:

- whose fitness to practise is being investigated or determined under the General Medical Council (Fitness to Practise) Rules 2004; or
- who have reported such a concern to the GMC.”

2. I have communicated orally or in writing with a number of doctors about their experience as whistleblowers. I have taken into account their views and experiences in formulating my recommendations. I have made clear to all with whom I have communicated that I would not examine the merits of any individual case,² and that what they have told me is confidential, unless they wish otherwise. I have spoken to employers and I have received the help of many staff members of the GMC, for which I am very grateful. In particular I express my thanks to Ms Natasha Ricioppo whose administrative assistance to me has been invaluable.

3. Whistleblowing is the raising of a concern, either within the workplace or externally, about a danger, risk, malpractice or wrongdoing which affects others.³

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² Where a doctor is subject to an ongoing fitness to practise investigation, I have not asked the GMC for any details about the case. Where such an investigation has been concluded, then, with the consent of the doctor, I have been provided by the GMC in some cases with further details.

³ The PCaW Report of the Whistleblowing Commission on the effectiveness of existing arrangements for workplace whistleblowing in the UK (PCaW Report), para. 2. <http://www.pcaw.org.uk/files/WBC%20Report%20Final.pdf>

4. In his Report on the Freedom to Speak Up review (“the Report”) published on 11 February 2015, Sir Robert Francis QC defines a whistleblower, in the context of the NHS, as:

“a person who raises concerns in the public interest. For the purpose of concerns relating to the NHS, and in particular patient safety concerns, the term ‘whistleblower’ is used in this report to apply to those who speak up when they see something wrong usually relating to patient safety but also to the integrity of the system.”⁴

5. In the Introduction, Sir Robert explains what he means by “the integrity of the system”:

“1.6 ...NHS workers are all in a position to contribute to protecting the integrity of the service. Every time money or equipment are wasted or stolen the resources to treat patients are reduced. Every time a patient or a colleague is deceived, intentionally or otherwise, public confidence in the service can be threatened.”

6. It is sometimes said that a whistleblower is a person who raises concerns externally, that is with persons other than his or her employer. This is not right.

7. Many persons who raise concerns do not necessarily, at the time of raising the concerns, see themselves as whistleblowers. They may, at that time, be ignorant of the protections⁵ afforded to persons who raise such concerns. They are likely to come to regard themselves as whistleblowers if they suffer detriment as a result of raising the concerns or if no action is taken on their concerns.

Patient safety, the duty to raise concerns and the duty of candour

8. The goal of patient safety is much more likely to be achieved if healthcare professionals raise concerns about those acts or omissions of other healthcare professionals or systemic failures which, in their view, detrimentally affect patient safety.⁶

9. In the words of Dame Janet Smith:

“I believe that the willingness of one healthcare professional to take responsibility for raising concerns about the conduct, performance or health of another could make a greater potential contribution to patient safety than any other single factor.”⁷

⁴ In the Glossary at page 221 of the report.

See also: http://www.gmc-uk.org/DC5900_Whistleblowing_guidance_for_publication.pdf 57107304.pdf

⁵ For example under the Public Interest Disclosure Act 1998 or under a contract of employment.

⁶ The value of encouraging persons in the workplace to raise concerns is recognised in many fields: see PCAW Report, paras. 33-35 and 37.

⁷ Fifth Report of the Shipman Inquiry – Safeguarding Patients: Lessons from the Past – Proposals for the Future, Dame Janet Smith, 9 December 2004.

10. The GMC, in fulfilling its main objective of “protecting, promoting and maintaining the health and safety of the public”,⁸ recognises the vital importance of raising concerns.

11. Paragraphs 24 and 25 of “Good Medical Practice”⁹ provide:

“Respond to risks to safety

24. You must promote and encourage a culture that allows all staff to raise concerns openly and safely.

25. You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.

a. If a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away.

b. If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy. You should also make a record of the steps you have taken.

c. If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken.”

12. Failure to comply with paragraphs 24 or 25 may amount to “misconduct” and a finding that a doctor’s fitness to practise is impaired. “Good Medical Practice” states in paragraph 6 that: “Serious or persistent failure to follow this guidance will put your registration at risk”.

13. The October 2014 “Joint statement from the Chief Executives of statutory regulators of healthcare professionals”¹⁰ states:

“The Professional Duty of Candour

Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.

This means that healthcare professionals must:

- tell the patient (or, where appropriate, the patient’s advocate, carer or family) when something has gone wrong;

⁸ Section 1(1A) of the Medical Act 1983, as amended.

⁹ http://www.gmc-uk.org/static/documents/content/Good_medical_practice_-_English_0914.pdf

¹⁰ http://www.gmc-uk.org/Joint_statement_on_the_professional_duty_of_candour_FINAL.pdf_58140142.pdf

- apologise to the patient (or, where appropriate, the patient’s advocate, carer or family);
- offer an appropriate remedy or support to put matters right (if possible); and
- explain fully to the patient (or, where appropriate, the patient’s advocate, carer or family) the short and long term effects of what has happened.

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested.

Health and care professionals must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest and not stop someone from raising concerns.”

14. This requirement on healthcare professionals “to be open and honest with their regulators, raising concerns where appropriate” and the requirement to “support and encourage each other to be open and honest and not stop someone from raising concerns” complement and reinforce paragraphs 24 and 25 of “Good Medical Practice”.

15. When the Joint Statement was published the Chief Executive of the GMC, Mr Niall Dickson, said:

“We know that many front line staff can feel under enormous pressures and that the culture of the institutions in which they work is vital in creating the conditions for openness and honesty - not a blame culture but a learning culture. And that means everyone in the healthcare team feeling able to raise concerns. *The feedback we have received suggests there is some way to go in this - some doctors are not confident they would be supported if they raised a concern, while others need to know where to take their concerns.* [Emphasis added.]

The awful reality that emerged from Mid Staffs and indeed other inquiries was that doctors knew about our guidance but were not empowered by it. They felt it was acceptable to ‘walk by the other side of the ward’ knowing that there was unsafe and unacceptable practice going on. We must all do what we can to make sure that does not happen again. The joint statement we have signed, is an important milestone and makes it clear that the professional duty of candour sits with every healthcare professional, regardless of their field of practice.”¹¹

¹¹ <http://www.gmc-uk.org/news/25605.asp>

Reprisals against those who raise concerns

16. There is considerable evidence that, in the workplace, persons who raise concerns about a danger, risk, malpractice or wrongdoing that affects others, may well suffer, or believe that they will suffer, reprisals at the hands of an employer or fellow workers.¹²

17. Employers and fellow workers may resort to reprisals against those who raise concerns in order to protect the reputation of the organisation or of a fellow (often senior) worker.¹³

18. Persuasive evidence that healthcare professionals who raise concerns risk reprisal and fear the risk of reprisal is to be found in the Submission by Patients First to “The Freedom to Speak Up review”.¹⁴ Others to whom I have spoken confirm this, including Dr Clare Gerada of the NHS Practitioner Health Programme and Dr Kim Holt.

19. In the Introduction to his Report, Sir Robert paints a bleak picture:

“The number of people who wrote to the Review who reported victimisation or fear of speaking up has no place in a well-run, humane and patient centred service. In our trust survey, over 30% of those who raised a concern felt unsafe afterwards. Of those who had not raised a concern, 18% expressed a lack of trust in the system as a reason, and 15% blamed fear of victimisation. This is unacceptable. Each time someone is deterred from speaking up, an opportunity to improve patient safety is missed.”¹⁵

20. Sir Robert continued:

“The effect of the experiences has in some cases been truly shocking. We heard all too frequently of jobs being lost, but also of serious psychological damage, even to the extent of suicidal depression. In some, sad, cases, it is clear that the toll of continual battles has been to consume lives and cause dedicated people to behave out of character. Just as patients whose complaints are ignored can become mistrustful of all, even those trying to help them, staff who have been badly treated can become isolated, and disadvantaged in their ability to obtain appropriate alternative employment. In short, lives can be ruined by poor handling of staff who have raised concerns.

The consistency in the stories told to us by students and trainees about the detriments they could face was alarming. These were mainly young people at the start of their careers who

¹² It was to discourage the taking of retaliatory action against workers that, in 1998, the Public Interest Disclosure Act was enacted. This is a worldwide phenomenon. See the American studies referred to in “Telling Tales and Saving Lives- the Role of Professional Colleagues in Protecting Patients from Dangerous Doctors”, Medical Law Review, 9, Summer 2001, pages 111-112.

¹³ Failure to conduct an independent investigation into the validity of the concerns raised may well indicate an unwillingness to take the concern seriously.

¹⁴ http://www.nursingtimes.net/Journals/2014/09/22/c/b/u/Patients_First_Submission_to_the_Freedom_to_Speak_Up_Review.pdf

¹⁵ Page 5 of the report.

genuinely believed they should raise issues for the benefit of patients. Of none of them could it be said that they had axes to grind. Their overwhelming sense was one of bemusement that anyone would want to treat them badly for doing the right thing. Yet we heard far too many stories from them of being bullied, and of their assessments suddenly becoming negative.”

21. The GMC has recognised that the bullying of those who raise concerns may make persons reluctant to do so. A GMC survey (published in November 2014) of the 50,000 doctors in training found nearly one in ten reporting that they had been bullied, while nearly one in seven said they had witnessed it in the workplace.¹⁶ At the time of the publication Mr Niall Dickson said:

“There is a need to create a culture where bullying of any kind is simply not tolerated. Apart from the damage it can do to individual self-confidence, it is likely to make these doctors much more reluctant to raise concerns. They need to feel able to raise the alarm and know that they will be listened to and action taken.”¹⁷

22. Reprisals may take many forms. The employer (and I use that word in the widest possible sense) may look for some reason to take disciplinary action against the person in the context of his or her employment: for example, written warning, suspension, dismissal, demotion or non-renewal of a contract of employment.

23. In my conversations with those who answer the GMC confidential hotline to help doctors report patient safety concerns,¹⁸ I was told that a significant number of doctors using the helpline express their concerns about being bullied.

24. The effect of the reprisals on individuals at work and at home is likely to be devastating. Doctors who have devoted their lives to the care of others face the prospect of their careers being brought to an end. One of the consequences may be that the doctor against whom the retaliatory measures are being taken becomes clinically depressed. His or her depression may then be used as justification for further action against the doctor.

25. It is self-evident that the fear of suffering reprisals acts as a powerful disincentive to raising concerns, as does also a belief that the concern will be ignored. The attainment of the objective of patient safety therefore requires that the risk of reprisals is reduced or eliminated, and that concerns are not ignored.

¹⁶ http://www.gmc-uk.org/NTS_bullying_and_undermining_report_2014_FINAL.pdf 58648010.pdf

¹⁷ <http://www.gmc-uk.org/news/25945.asp>

¹⁸ See below para. 91.

26. In the context of this review, my concern is that employers may use the process of making an allegation to the GMC about a doctor's fitness to practise as an act of retaliation against a doctor because he or she has raised concerns or, simply, as an inappropriate alternative to dealing with the matter in-house. If that happens, the GMC unwittingly becomes the instrument of the employer in its campaign against the doctor. If the doctor is then subject to an interim suspension order and, as it later turns out, he or she ought not to have been, the damage to the doctor can be lifelong.¹⁹

27. I accept, of course, that even if the GMC knows that an employer has made a retaliatory or inappropriate allegation against a doctor, the GMC remains obliged to exercise its statutory functions. But it would be both cruel and counterproductive to require doctors to speak up and then unfairly or inappropriately damage or destroy their careers when they do so. Whilst it is well established that the GMC procedures must focus on a doctor's current and future fitness to practise and not on disciplining him or her for past misconduct,²⁰ it must not be overlooked that any interference with or deprivation of a doctor's career has all the hallmarks and effects of harsh punishment for the individual and his or her family.

28. In a written submission to me a senior legal officer in the GMC wrote: "a medical practitioner can properly be criticised for not raising a concern, particularly where not doing so may compromise patient safety, even if doing so may lead to their being referred by their employer to the GMC for investigation and where the appropriate exercise by the GMC of its powers, including its powers to seek the imposition of interim orders, may have an adverse impact upon them." Whilst this may be right in law, doctors are not likely to raise concerns if they do not believe that they will be treated fairly by the GMC should an employer refer their fitness to practise to the GMC as a result of raising those concerns.

29. The key to minimising the risk that the GMC unwittingly becomes the instrument of the employer in a campaign against a doctor is an understanding of the background to the allegation. In the words of Sir Robert in paragraph 80 of the Executive Summary to his Report:

¹⁹ A consultant described to me how, following the making of complaints to the GMC, an investigation was opened by the GMC into his fitness to practise based upon material emanating from his employer which the consultant had himself disclosed. He was made subject to an interim order. Twenty months later a judge refused to extend the interim order saying that the delay had been deplorable. Over two years after the investigation had been opened, case examiners closed the case. The interim order, so the consultant told me, "made it impossible to find any jobs, even on an honorary basis.... The GMC process has damaged my reputation and it will take a long time to recover from this gratuitous infliction". The GMC tells me that unreasonable/unjustifiable delays are not the norm.

²⁰ At page 13 of http://www.gmc-uk.org/FTP_reforms_consultation_paper.pdf_38085201.pdf

“It is important that professional regulators are aware of the context in which a referral for investigation of a medical professional is made, to ascertain whether there is any risk that it is a retaliatory referral. I am not suggesting that there should be no investigation because someone has been a whistleblower: there may be a perfectly good justification for doing so. But the regulators need to assure themselves that the referral is fair.”

30. The evidence from Patients First to Sir Robert’s review offers support for the proposition that some employers use referral to punish healthcare professionals who raise concerns. Paragraph 83 of Annex 3 of the submission refers to “retaliation by referral” and in paragraph 84 regulators are called upon to screen employer referrals where there is a *prima facie* case that the referral follows the raising of a concern.²¹

31. A consultant wrote to me:

“...there is a widespread and in my opinion accurate view that employers use referral to the GMC as a way to persecute and intimidate whistleblowers. ... it is too easy for a vindictive employer to make a GMC referral with no come-back.”

32. Another consultant described how, after he had unsuccessfully raised concerns locally about a colleague, he reported the colleague to the GMC. According to the GMC records, the consultant felt he was being bullied and targeted by his employer for having raised concerns. Shortly afterwards the employer referred the consultant to the GMC in respect of a clinical incident. The investigation by the GMC took three years, at the end of which time the case examiners closed the case (which by then included further allegations from the employer) with no further action.

33. A Professor described his referral to the GMC as “an instance where it can reasonably be inferred that the GMC was used as a tool of harassment”.

34. In my opinion the GMC can take a number of steps to enhance its ability to recognise when referral is being used by organisations as a reprisal against a doctor who has raised concerns, or as an inappropriate alternative to dealing with the matter in-house.

Legal framework

35. I set out here the legislative provisions relevant to the issues with which I am concerned. I have simplified them where necessary.

36. By virtue of section 1(1A) of the Medical Act 1983, as amended:

²¹ See footnote 14 above.

“The main objective of the General [Medical] Council in exercising their functions is to protect, promote and maintain the health and safety of the public.”

37. Section 35C, headed “Functions of the Investigation Committee”, applies where:
- a. an allegation is made to the GMC that a doctor’s fitness to practise is impaired and also,
 - b. when an allegation is deemed to have been made in circumstances where it has come to the attention of the GMC that a doctor’s fitness to practise is impaired.²²

38. By virtue of section 35C(4): “The Investigation Committee shall investigate the allegation and decide whether it should be considered by a Fitness to Practise Panel”.

39. By virtue of section 35C(2) fitness to practise shall be regarded as “impaired” for one or more of *only* six reasons. For the purposes of this review, the likely relevant reasons are: “misconduct”; “deficient professional performance” or “adverse physical or mental health”. Impairment of fitness to practise has been the subject of much judicial interpretation and those investigating allegations are given guidance in: “The meaning of fitness to practise”.²³ In paragraph 5 the guidance repeats that which is stated in “Good Medical Practice”, namely: “Serious or persistent failures to follow this guidance will put your registration at risk”.

40. In paragraph 14 of a GMC document headed: “Making decisions on cases at the end of the investigation stage: Guidance for the Investigation Committee and case examiners”²⁴, it is stated that those investigating:

“must have in mind the GMC’s duty to act in the public interest which includes the protection of patients and maintaining public confidence in the profession, in considering whether there is a realistic prospect of establishing that a doctor’s fitness to practise is impaired to a degree justifying action on registration.”

41. Further guidance for investigators is to be found in a document entitled: “The Realistic Prospect Test”²⁵ which states:

“1. The “realistic prospect” test will apply to both the factual allegations and the question whether, if established, the facts would demonstrate that the practitioner’s fitness to practise

²² See sections 29C and 35CC(3).

²³ http://www.gmc-uk.org/the_meaning_of_fitness_to_practise.pdf_25416562.pdf

²⁴ http://www.gmc-uk.org/DC4599_CE_Decision_Guidance_Making_decisions_on_cases_at_the_end_of_the_investigation_stage.pdf_58070536.pdf

²⁵ http://www.gmc-uk.org/The_Realistic_Prospect_Test.pdf_25416411.pdf

is impaired to a degree justifying action on registration. It will reflect a genuine (not remote or fanciful) possibility. It is in no-one's interest for cases to be referred to a FTP [Fitness to Practise] panel when they are bound to fail. On the other hand, cases which raise a genuine issue of impaired fitness to practise justifying action on registration are for the FTP panel to decide.

2. In performing their task, the case examiners and members of the Investigation Committee:

a. should bear in mind that the FTP Panel is required to be persuaded that the facts are more likely than not to be true: the facts need to be proven 'on the balance of probabilities'. The standard of proof applicable in any proceedings is that applicable to civil proceedings.

b. are entitled to assess the weight of the evidence;

c. should not, however, normally seek to resolve substantial conflicts of evidence;

d. should proceed with caution (given that, among other considerations, the case examiners are working from documents alone and the evidence before them may be untested);

e. should proceed with particular caution in reaching a decision to halt a complaint where the decision may be perceived as inconsistent with a decision made by another public body with medical personnel or input (for instance, an NHS body, a Coroner or an Ombudsman) in relation to the same or substantially the same facts and, if the case examiners/ Investigation Committee does reach such a decision, should give reasons for any apparent inconsistency;

f. should be slower to halt a complaint against a practitioner who continues to practise than against one who does not;

g. if in doubt, should consider whether any further investigation is appropriate and in any event should lean in favour of allowing the complaint to proceed to a FTP panel;

h. should bear in mind that whilst there is a public interest in medical practitioners not being harassed by unfounded complaints, there is also a public interest in the ventilation before a FTP panel in public of complaints which do have a realistic prospect of establishing impaired fitness to practise;

i. in considering whether to issue a warning should bear in mind that the standard of proof is that applicable to civil proceedings."

42. The Act includes detailed provisions relating to the powers and duties of the Registrar, the Investigation Committee and the Fitness to Practise panel. The Act gives the power to make interim orders, including interim suspension orders.

43. The General Medical Council (Fitness to Practise) Rules 2004 (No 2608) as amended lay down detailed procedural rules for the investigation of allegations that a doctor's fitness to practise

is impaired and for the hearing by a Fitness to Practise panel of allegations referred to them for determination.

44. Allegations are initially considered by the Registrar, who is authorised to exercise the functions of the Investigation Committee. This stage is known as the “triage stage” or “Rule 4 stage”. Where the Registrar considers that the allegation falls within section 35C(2) he must refer the matter to a medical and lay Case Examiner. They, like the Registrar, are also authorised to exercise the functions of the Investigation Committee. The Case Examiners may refer the allegation for determination by a Fitness to Practise panel. In the event of disagreement between the two case examiners, the allegation is referred to the Investigation Committee.²⁶

45. At the triage stage the Registrar may carry out any investigations as are in in the Registrar’s opinion appropriate to the consideration of whether or not the allegation falls within section 35C(2) of the 1983 Act or of the doctor’s fitness to practise.²⁷

46. Section 35A of the Act gives wide powers to require the disclosure of information, backed up, where necessary, by a court order.

Recommendations on the handling of referrals in circumstances where the doctor has raised concerns

47. This brief analysis of the legal framework shows:

- a. an allegation of unfitness to practise may be based on (amongst other things) one or more of the following: “misconduct”; “deficient professional performance” and “adverse physical or mental health”;
- b. the GMC has a “duty to act in the public interest which includes the protection of patients and maintaining public confidence in the profession”; and
- c. there should be no referral to a Fitness to Practise panel in the absence of a realistic prospect of establishing that the doctor’s fitness to practise is impaired to a degree justifying action on registration.

²⁶ Rule 8(5).

²⁷ Rule 4(4).

48. If, at the conclusion of the investigation, there is a realistic prospect of establishing that the doctor's fitness to practise is impaired to a degree justifying action on registration, then the fact that the doctor has raised a concern will not prevent the case being referred to a Fitness to Practise panel. But the fact that the doctor has raised a concern may be material, and sometimes highly material, during the investigation stage.

49. During the investigation, those responsible for the investigation will normally need to reach a conclusion about the facts. In reaching that conclusion the investigator will be answering the question: "Is there a realistic prospect of the panel being satisfied on the balance of probabilities of those facts necessary for a finding of impaired fitness to practise?"

50. If the answer to this question is: "Yes", then the investigator has to ask the second question: "Is there a realistic prospect that the facts, if established, would demonstrate that the practitioner's fitness to practise is impaired to a degree justifying action on registration, namely erasure, suspension or conditional registration?"²⁸

51. The fact that the doctor has raised a concern may be material, if not highly material, when examining these two questions.

52. In assessing issues of fact for the purpose of answering the first question, it will be helpful for the investigator to know about the background to the allegation, including what steps, if any, have been taken to deal with the concerns raised.

53. In answering the second question, it will be helpful, for example, for the investigator to know whether the alleged impairment of the doctor's fitness to practise is related to the fact that he or she has raised concerns and has suffered detriment for having done so. Sir Robert Francis summarised the evidence in this way: "We heard all too frequently ... of serious psychological damage, even to the extent of suicidal depression."²⁹ I have received similar accounts. In determining whether there is a realistic prospect that the facts, if established, would demonstrate that the practitioner's fitness to practise is impaired to a degree justifying action on registration, the fact that the organisation making the allegation is or may be responsible for the "adverse physical or mental health" of the doctor and that the issues are now being properly investigated, could well be material to the assessment of the future health of the doctor.

²⁸ Section 35D(2) of the Act. See also "Making decisions on cases at the end of the investigation stage: Guidance for the Investigation Committee and case examiners", paras. 67 and following under the heading: "Whether the failing is easily remediable and has been remedied."

²⁹ See para. 20 above.

54. My recommendations are in large part aimed at ensuring that the investigators, preferably at the triage stage, have as much information as reasonably possible to enable them accurately to predict the likely outcome at the conclusion of a panel hearing of an allegation against a doctor who has raised a concern. To put it another way, my recommendations are designed to assist investigators, in applying the realistic prospect test, to assess the merits of the allegation and the consequences of a finding of impairment.

55. It is my understanding that the Registrar takes the view that, under the Act, there is no power to require an allegation to take any particular form. It is said that this follows from the provisions set out in paragraphs 37-38 above. An absence of formal requirements may well be desirable in the case of allegations from individuals, known as complaints. It seems to me that an absence of formal requirements is much less justifiable in the case of allegations from organisations, known as referrals. I shall, however, assume that the view taken by the Registrar is correct. I shall therefore express my recommendations in terms of encouraging change and of adopting a cautious approach when organisations do not comply.

56. Although the risk of taking retaliatory action against a doctor who has raised concerns may arise in the context of a complaint, it is much more likely that it will arise in the context of a referral from an organisation. I shall therefore concentrate on referrals from an organisation.

57. My recommendations are designed to enable the GMC to recognise that a referral is being used by an organisation as a reprisal against a doctor who has raised concerns or as an inappropriate alternative to dealing with the matter in-house.

58. My recommendations are largely drafted in broad terms and, if accepted, would need to be worked out in detail. It would probably be desirable to develop a referral form which organisations would be encouraged to use.

59. I understand that the introduction of the Employer Liaison Advisers has done much to improve the quality of the material designed to support a referral. I would expect Employer Liaison Advisers to play a significant role in implementing my recommendations if accepted.

60. I understand that referrals are invariably made in writing and I shall assume that any referral will be made in writing.

61. Any procedures designed to enable the GMC to recognise that referral is being used by organisations as a reprisal against a doctor who has raised concerns or as an alternative to dealing with the matter in-house, must first identify whether the doctor, against whom an allegation is being made, has raised concerns.

62. I recommend therefore that:

1. Organisations referring a doctor's fitness to practise to the GMC should be encouraged to answer a written question the effect of which is to ascertain whether the doctor being referred has raised concerns about patient safety or the integrity of the system³⁰.

63. There will be circumstances in which such a question is not apposite - for example when the organisation informs the GMC that a doctor has been convicted of a serious offence resulting in a custodial sentence.³¹

64. The fact that the organisation answers "Yes" to this question is not of course dispositive of the issue of fitness to practise.³² What it does do is to assist those investigating the allegation to see it in context. To put it another way, knowing that the doctor against whom the allegation is being made has raised concerns, gives the investigator an understanding of the background against which the allegation has been made and may well assist him or her when assessing the credibility of the allegation.

65. There are other circumstances in which the Registrar may approach an employer when considering an allegation.³³ In these circumstances it may also be desirable to ask a similar question when the employer provides adverse information about a doctor whose fitness to practise is being investigated.

66. Complaint has been made to me that those making an allegation on behalf of, or in the context of, an organisation may not be subject to GMC procedures should the allegation turn out to have been made maliciously. Encouraging registered doctors, who are subject to GMC fitness to practise procedures, to sign and be responsible for the truth of any allegation made in the context of

³⁰ See para. 5 above.

³¹ See Rule 5.

³² See para 27 above.

³³ Sections 35A and 35B of the Medical Act 1983 and http://www.gmc-uk.org/DC4599_CE_Decision_Guidance_Making_decisions_on_cases_at_the_end_of_the_investigation_stage.pdf 58070536.pdf, para.11.

a referral will make it more likely that an allegation is genuine and not merely a reprisal against a doctor for having raised a concern.

67. I therefore recommend that:

2. Organisations referring a doctor's fitness to practise to the GMC should be encouraged to have the document containing the allegation signed by a registered doctor and to contain a statement by the doctor to the effect that: "I believe that the facts stated in this document are true".

68. Failure to answer the question truthfully would no doubt lead to the signing doctor's fitness to practise being investigated and, if discovered during the course of the investigation, would be an important factor in assessing the credibility of the allegation.

69. As a corollary of these recommendations, I recommend:

3. If the written document containing the allegation is not signed by a registered doctor and/or does not contain a statement to the effect that "I believe that the facts stated in this document are true", organisations should be encouraged to explain why this has not been done.

70. The failure to comply with these recommendations would not, of course, be dispositive of the issue of fitness to practise but should assist those investigating the allegation to see it in context.

71. If the doctor being referred to the GMC has raised concerns with the organisation making the referral, then it will be very important for the investigator to have a copy of the file relating to the raising of the concern by the doctor including the date or dates when the concern was raised and a copy of any report investigating the concerns raised by the doctor. A lack of transparency on the part of the organisation may well cause the investigator to be additionally cautious.

72. I therefore recommend:

4. If a doctor being referred to the GMC has raised concerns about patient safety or the integrity of the system with the organisation making the referral, then the necessary steps should be taken to obtain from the organisation material which is relevant to an understanding of the context in which the referral is made.

73. Some of those who have written to me have raised the issue of non-disclosure of reports by an employer on the grounds of legal professional privilege or a related privilege. Section 35A(6) provides that the power to require information or a document does not apply in relation to the supplying of information or the production of a document that a person could not be compelled to supply or produce in civil proceedings before the relevant court. I would invite the Registrar to

test any such claim to privilege carefully. Failure to produce such reports when available may well be a factor that the investigator wishes to take into account in assessing the credibility of the allegation.

74. Sir Robert Francis refers in paragraph 6 of his Introduction to whistleblowers having:

“provided convincing evidence that they raised serious concerns which were not only rejected but were met with a response which focused on disciplinary action against them rather than any effective attempt to address the issue they raised.”

75. He also writes in the preceding paragraph:

“Suggestions of ulterior purposes have for too long been used as an excuse for avoiding a rigorous examination of safety and other public interest concerns raised by NHS staff.”

76. An organisation’s failure to investigate the concerns raised before making an allegation to the GMC may be indicative that the referral is being used to take retaliatory action against a doctor for having raised concerns. It may also be indicative that referral is being used as an improper alternative to dealing with the matter in-house. The absence within the organisation of recommended procedures³⁴ for encouraging the raising of concerns and the absence of recommended procedures for handling concerns may also indicate that referral is being used improperly. I therefore recommend:

5. Investigators assessing the credibility of an allegation made by an organisation against a doctor who has raised a concern should take into account, in assessing the merits of the allegation, any failure on the part of an organisation to investigate the concern raised and/or have proper procedures in place to encourage and handle the raising of concerns.

77. I turn to another possible indicator that an organisation is using the referral process to take retaliatory action against a doctor for having raised concerns or simply as an alternative to dealing with the matter in-house. Assume that an organisation referring a doctor to the GMC claims that an examination of a number of cases in which the doctor was involved has demonstrated that in one or two cases the doctor failed to meet the necessary professional standards. If there has been no similar examination of the cases of other doctors working alongside the doctor, that may indicate that the doctor who has been referred has been picked out because he or she has raised a concern. The investigator, faced with such a case, should inquire of the organisation whether the cases of other doctors have been the subject matter of a similar examination and, if not, ask why.

³⁴ See e.g. Annex A to Sir Robert’s Report.

78. In his Report, Sir Robert pinpoints the problem of delay:

“3.2.32 Cases could be long running and remain unresolved for months and even years. Delays in the process for handling and investigating concerns had a huge impact on individuals, particularly if they were suspended or on special or sick leave. This included an increased sense of isolation, stress and in some cases mental health issues. Delays also reduced the possibility of establishing the facts of the case.”

79. In paragraph 80, Sir Robert urges the professional regulators to consider what they can do to speed up their investigations into fitness to practise.

80. Many of those who have communicated with me have complained in similar terms of the length of time that it has taken for the GMC to resolve allegations of unfitness to practise made by their employer organisations. Consistent with the recommendations of Sir Robert, allegations against doctors who have raised concerns must be investigated as quickly as possible. The quicker the investigation is concluded, the less damage will be done to the doctor if the allegation is unjustified.

81. Delay could be reduced in such cases if the Registrar exercised his powers under rule 4(4) of the GMC Fitness to Practise Rules to carry out a fuller examination than he might otherwise do at the triage stage. I understand that a fast track procedure under rule 4(4) procedure is already being used increasingly to deal with some allegations. When carrying out the examination at the triage stage, it may well be very helpful, in addition to obtaining the information referred to above, to ask the doctor against whom the allegation is being made whether he or she wishes to comment on the allegation. His or her comments with any supporting documentation may provide valuable insight into the background of the allegation and may help the investigator when assessing its merits.

82. I therefore recommend:

6. In those cases where an allegation is made by an organisation against a doctor who has raised concerns, the Registrar should, where it is appropriate to do so, exercise his powers under rule 4(4) to conduct an examination into that allegation, including taking the steps outlined in my earlier recommendations and asking the doctor for his or her comments on the allegation and the circumstances in which the allegation came to be made.

83. Sir Robert devotes part of his recent Report to the role of mediation and other alternate dispute resolution. He recommends³⁵:

³⁵ Page 135 of the report.

“• NHS organisations make full use of mediation, reconciliation and ADR expertise, whether internal or external, at an early stage with the agreement of all parties involved in a dispute or disagreement. It is particularly used:

- where relationships are poor, to support remedial action to resolve issues before they break down irretrievably
 - where relations have broken down, to try to repair them
 - to build or rebuild trust in a team or a relationship where there has been a difficult issue
 - to support staff involved in a difficult case to prevent or support recovery from stress and mental illness.
- Mediation and similar techniques are undertaken with the agreement of those involved, respecting their confidentiality. Refusal to consent is never considered as a cause in itself for disciplinary action.
 - Expert support of this type is also considered prior to, or instead of, disciplinary action where there are concerns about an individual’s behaviours or their oppressive management style, in line with the concept of a just culture described in 5.2, although repeated infringements of a type likely to undermine an open and honest culture are not be tolerated.”

84. Sir Robert recommends the following action:

“All NHS organisations must have access to resources to deploy alternative dispute resolution techniques, including mediation and reconciliation to:

- address unresolved disputes between staff or between staff and management as a result of or associated with a report raising a concern
- repair trust and build constructive relationships.”

85. I have asked myself whether mediation or alternate dispute resolution has a role to play in preventing employers from using referral to the GMC to retaliate against a doctor because he has raised concerns or simply as an inappropriate alternative to dealing with the matter in-house. Section 35C(4) of the Medical Act 1983 requires an allegation to be investigated and it could be said that mediation can therefore have no role, at least until the investigation has completed with no action being taken against the doctor. There is nothing in the Act or Rules which specifically gives the investigator a power to adjourn the investigation pending mediation. Even if an allegation were to be formally withdrawn, the allegation would still have to be investigated. It can therefore be said, that any mediation would be inappropriate at least until the investigation has been concluded in the doctor’s favour. On the other hand, investigations into allegations may in practice be put on hold, in the sense that further work on the allegation is unlikely to be undertaken until, for example, a report is ready or a request answered. If an investigation can in this sense be put on hold, why can it not

also be put on hold pending a mediation or other alternate dispute resolution? A mediation might result in an allegation being withdrawn which might also result in a speedier determination by the GMC of the now withdrawn allegation.

86. Given the importance that Sir Robert rightly places on the role of mediation in achieving patient safety and given the GMC's main objective of "protecting, promoting and maintaining the health and safety of the public", I believe that there could be, in a few cases, a role for mediation. One example could be a case where the preliminary investigation tends to show that the organisation is using a referral to the GMC as an inappropriate alternative to dealing with the matter in-house. Another example could be a case where, underlying the referral, is a dispute between two doctors one or both of whom have raised concerns against the other. The GMC could only *recommend* mediation and mediation could not take place in the absence of the consent of the doctor and the organisation.

87. The three Law Commissions of the United Kingdom and Northern Ireland considered the issue of mediation in the context of fitness to practise and stated that they remained unconvinced that it was an appropriate process.³⁶ They did so albeit that a large majority of those consulted agreed that all the regulators should have powers to mediate, and a majority felt that mediation was appropriate in the context of fitness to practise procedures.³⁷ Notwithstanding their concerns, the Commissions recommended that the Government's regulation-making powers should include the power to introduce mediation for one or more of the regulators. The recommendation was not accepted by the Government.³⁸

88. Although I would have been minded to recommend that mediation does have a role to play, I shall not do so in light of the history of the issue.

89. If my six recommendations are accepted, then it will be important to train investigators handling allegations against doctors who have raised concerns to understand "whistleblowing". Sir Robert's Report would, no doubt, form an important part of that training. I recommend:

7. Those who investigate allegations made against doctors who have raised concerns must be fully trained to understand "whistleblowing", particularly in the context of the GMC and the NHS.

³⁶ Law Com No 345 / Scot Law Com No 237 / NILC 18 (2014), pages 141-142.

³⁷ The GMC opposed the use of mediation in the context of fitness to practise procedures: see para. 8.213 of Joint Consultation Paper LCCP 202 / SLCDP 153 / NILC 12 (2012) (Consultation Analysis).

³⁸ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399020/Response_Cm_8995.pdf See para. 5.27.

The handling of cases involving those who have reported concerns to the GMC

90. The second part of my terms of reference asks me to review how the GMC handles cases involving individuals who regard themselves as whistleblowers and who have appropriately raised concerns in the public interest and who have reported such a concern to the GMC.

91. In December 2012 the GMC launched a helpline. The accompanying announcement³⁹ stated:

“The helpline will enable doctors to seek advice on any issues they may be dealing with and to raise serious concerns about patient safety when they feel unable to do this at local level.

Today the GMC has also launched a new online decision aid to help doctors report patient safety concerns.

The new services are part of the GMC’s on-going commitment to support doctors who raise concerns around patient safety and to foster a more open and transparent working culture in which all staff feel empowered to speak up.

The launch of both services follows the publication of new GMC guidance for doctors, Raising and Acting on Concerns about patient safety, which was sent to every doctor in the UK earlier this year.

The helpline will be staffed by specially trained advisors who will be able to take forward information about individual doctors or organisations that can be investigated by the GMC. Callers can also be directed to other appropriate organisations, such as the Care Quality Commission (CQC).”

92. At the time of the launch Mr Dickson said:

“The eyes and ears of health professionals are often the most valuable means of protecting patients and ensuring high quality care.”

93. I spent some time watching the work of those who operate the helpline. I was very impressed with their professionalism, courtesy and patience.

94. If a doctor raises a concern via the helpline, a summary of what he or she has said is sent electronically to the triage department to take such action as is appropriate.

95. If the consequence of making a call to the helpline carries with it a significant risk of an investigation into the caller’s fitness to practise, this could deter would-be callers. One doctor told me that, having used the helpline to raise a concern, her own fitness to practise then became the

³⁹ <http://www.gmc-uk.org/news/14222.asp>

subject of an investigation. This may be unavoidable in a few exceptional cases. I hope the implementation of the recommendations which I have made above will make sure that, if the caller's fitness to practise becomes an issue, the necessary information will be available to the investigators.

96. If a person raises a concern about a doctor, then it is important that the person is kept informed of the progress of the investigation. This is particularly important if the doctor is still working alongside the colleagues about whom they have complained. I have received complaints about the way that the GMC handles complaints from both doctors and lay persons, many of those complaints being concerned with the fact that the GMC closed them with no action. I am unable to evaluate those complaints. That said, I stress the importance of both having and implementing the necessary procedures to handle complaints fairly, transparently and effectively.

97. One of the perennial disputed issues of fact in whistleblowing cases is whether the employee has or has not raised a concern. If the employee has kept a record of raising the concern and its authenticity cannot sensibly be questioned, that record will provide some protection to the employee against the employer.

98. Organisations which implement recommended good practice to encourage and handle concerns will have procedures designed to record the raising of concerns and the subsequent monitoring of those concerns. Hopefully those organisations which have in place and follow proper procedures will not make referrals to the GMC in order to punish those who have raised concerns or as an improper alternative to dealing with the matter in-house.

99. The publication: "Raising and acting on concerns about patient safety"⁴⁰ tells the doctor raising a concern: "You should also keep a record of your concern and any steps that you have taken to deal with it."⁴¹

100. If the doctor does record the concern and the steps taken by the doctor to deal with it, there remains the risk that the authenticity of the record may be challenged.

101. Although a doctor could call the GMC helpline he or she may rightly feel that the concern will be properly dealt with locally and that it is premature to get the GMC involved.

⁴⁰ http://www.gmc-uk.org/Raising_and_acting_on_concerns_about_patient_safety_English_0914.pdf_48902813.pdf

⁴¹ Para 15. See also "Good Medical Practice", para, 25(c).

102. There should be some way that any doctor can confidentially make a record of the fact that he or she has raised concerns with his employer and the steps which the doctor has taken to deal with it. Such a record would then provide the doctor with evidence upon which he or she could rely, should the employer deny that a concern was raised.

103. If, however, the record is made with the GMC or other regulator, then statutory obligations may impose a duty to investigate even though any such investigation could be premature and do more harm than good.

104. In the GMC publication “Who can help if you're not sure what to do?”⁴², doctors are given the following information about the charity Public Concern at Work (PCaW):

“this charity provides free, confidential legal advice to people who are concerned about wrongdoing at work and aren’t sure whether, or how, to raise concerns (www.pcaaw.co.uk, 020 7404 6609).”

105. I understand that PCaW is sometimes called upon by employees to provide evidence that the employee has contacted it with a concern and PCaW will do so. However issues of legal professional privilege can cause difficulties.

106. To solve this problem I recommend:

8. The GMC, together with healthcare regulators, professional organisations, unions and defence bodies, set up a simple, confidential and voluntary online system, run by an organisation independent of the regulators. The system would enable healthcare professionals to record electronically the fact that they have raised a concern with their employers, what steps they have taken to deal with the concerns, including details of when and with whom the concerns were raised. The date and time at which the healthcare professional made the entries would be recorded. Access to the record would be restricted to the professional or another person with his or her consent.

Revalidation

107. Revalidation is not within my terms of reference. The revalidation process carries with it the risk that the responsible officer can use the revalidation process to punish a doctor who has raised concerns or to “persuade” the doctor to withdraw concerns which he or she has raised earlier. A senior consultant told me in confidence that she was told that, unless she withdrew her allegations against another doctor, she would not receive a positive recommendation that she should be

⁴² <http://www.gmc-uk.org/publications/11880.asp>

revalidated. At the time her revalidation had already been deferred. She withdrew the allegation. I invite the GMC to consider this issue.