Acting on Concerns

Your professional responsibility

The Royal College of Surgeons of England
2013

Contents

Foreword

I am pleased to have been asked to write a foreword to this excellent publication. It seems to me that it provides sound and sensible advice to doctors faced with the unwelcome problem of dealing with some form of shortcoming in a colleague's work or behaviour. I particularly welcome the section on anticipatory clinical governance, which gives advice on setting up systems that will allow members of a team to see a potential problem before it crystallises into a real one.

However, not all problems permit such advance identification. Some may arise from conduct that has been kept secret and gives the discoverer a sense of shock and disbelief. In such unwelcome situations, this publication will provide good practical advice. It stresses that the doctor's first duty must be to the patient rather than to a colleague or to the team. This priority can place great strain on personal friendships and longstanding loyalties. Even in an organisation where senior management is supportive, raising a concern can be deeply upsetting and often requires real bravery. The thing to remember is that, in professional life, we are all our brothers' keepers.

I commend this publication to all medical professionals.

Dame Janet Smith

What this document is about

This document is about how to act on your concerns when you think patients are receiving poor care. Just as importantly, it is about how you and your colleagues collaborate in monitoring the quality of care you provide and how you ready yourselves to deal with problems if they arise.

We start in Part One by looking at how surgical teams can work together to review the quality of care they provide, and what can go wrong when teams do not do this vital work well. Then, in Part Two, we give detailed advice on how to escalate concerns you may have about the quality of care patients receive. In Part Three we consider your responsibilities as a member of The Royal College of Surgeons of England (RCS) when concerns are brought to your attention through your professional networks.

First and foremost this document is about being a member of a professional community that promotes accountability, effective clinical audit, and supportive discussion of risk and failure in surgery. Real excellence in surgery comes from teams managing past failures and future risks well. They build a culture in which the quality of care provided by each individual member of the team is everyone's concern; they support each other through difficulties, and they respond to problems in a timely and constructive fashion. They also recognise the unique contribution that each colleague makes to the profession, take pride in what they do well, and value the care they provide to patients. We discuss in Part One the structures that support such cultures, using evidence from the work of the RCS over recent years.

Practitioners may sometimes need to raise concerns outside of everyday governance forums. In Parts Two and Three we have outlined the avenues available and, drawing on practice wisdom and research evidence, suggest ways in which you can increase the likelihood of achieving a successful outcome. We describe here the

support the College can give to members who are facing difficulty raising, acting upon, or getting a response to their concerns.

Parts Two and Three discuss activity that different bodies have called 'raising concerns', 'speaking up' and 'whistleblowing'. None of these are very precise terms. We have used 'raising concerns' to cover everything from informal conversations with colleagues, to making what are known as 'protected disclosures' under the law that shields 'whistleblowers' from retaliation. The concept of 'whistleblowing' is itself a slippery one. Some people use it just to refer to those who go outside of their organisation (for example to the press), so called 'external whistleblowers'. Others use it more broadly, including those who make use of special procedures within the organisation (so called 'internal whistleblowers'). We have used that broader definition. When we refer to whistleblowing in this document we are discussing taking action to draw attention to perceived wrongdoing, or drawing attention to poor care, using organisational avenues that go beyond standard reporting for clinical governance purposes.

This advice was prepared for The Royal College of Surgeons England's Professional Standards Directorate by Dr Suzanne Shale, University of Oxford and King's College London.

Part One

How not to become a whistleblower: helping to create a safe and just culture

Quick summary for those in a hurry

Good things to do

» Be determined to enjoy quality improvement as a core part of your clinical duties.
» Treat discussion of performance as an opportunity to celebrate the best and to set standards to aspire to, as well as an opportunity to attend promptly to possible problems.
» Use the 'problem checklist' in Part One to assess if your team's quality management activity is up to standard.
» If you believe there are weaknesses in quality management, start discussing them with colleagues *now* - before anything goes wrong.
» Identify how to implement best practice in quality management in ways that fit your situation and the resources available to you.
» However junior you are, be proactive by seeking feedback and sharing your own performance data.
» Rehearse how to talk about performance issues, both individually and as a team.
» If your team is wary of talking about performance, try initiating a team discussion about what it would be like to talk about performance.
» If your team is unaccustomed to talking about performance, consider getting a neutral outsider to help.
» Be clear about what constitutes innovation and ensure that it is appropriately reviewed.
» If you are a junior colleague working in a team where you think quality management is weak, use a coach or mentor to plan how to share your ideas and introduce change.
» Insist on regular appraisal by a trained appraiser.

What not to do

» Don't treat talking about performance as only talking about problems or a way of catching people out. It should be as much about celebrating success, supporting colleagues, seeking new and better ways of doing things, and taking pride in your vocation.
» Don't wait for things to go wrong: strengthen quality management and develop shared understanding with colleagues before any problems become apparent.
» Don't look at individual or team performance in isolation: always benchmark it against the performance of other individuals, teams and organisations.

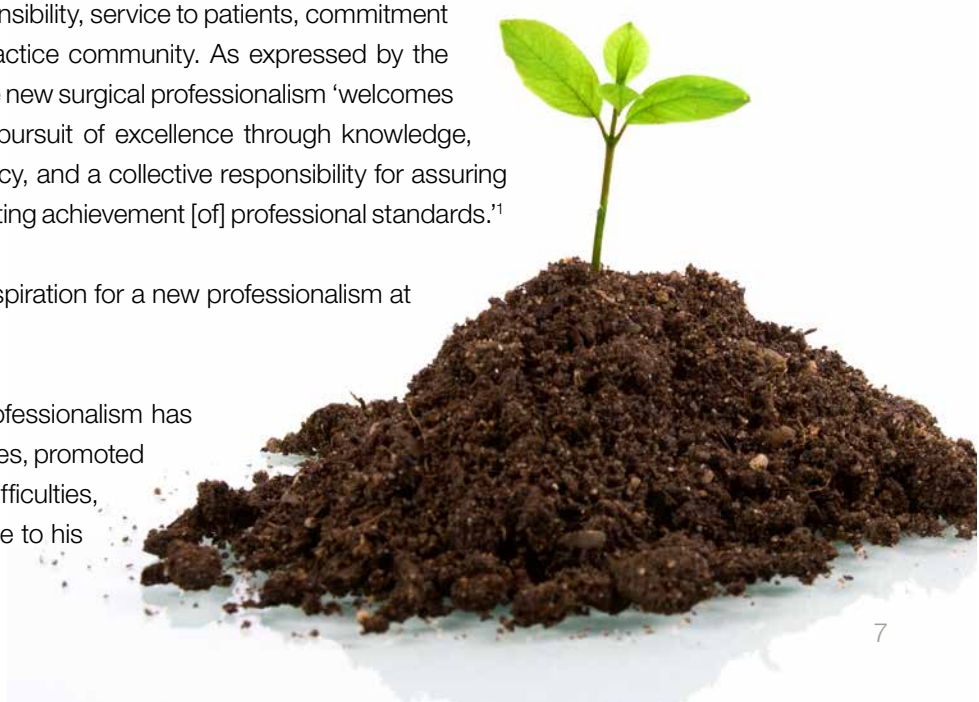
» Don't overlook the reasons why problems may go unrecognised: habituation to low standards, a tendency to explain problems away, making others scapegoats and 'shooting the messenger'.
» Don't fall prey to the temptation to spread unsupported gossip and rumour. If you hear it, ask for the evidence on which it is based and then act if necessary.

Key issues

Patient-centred professionalism and supportive collegiality

No surgeon could fail to be aware of the contemporary debate surrounding the nature of medical professionalism and collegiality. The debate has in part been positively driven from within the profession, with surgeons paving a route to excellence through greater attentiveness to patient safety, more accurate outcome measurement, enhanced clinical audit, more robust clinical governance, concerted action to improve standards in training, and so on. On the negative side, uncomfortable self-examination has been driven by criticism of aspects of the culture of surgery and of medicine more generally. The Bristol Royal Infirmary and Shipman Inquiries marked particular watersheds, and have been followed by the Mid-Staffordshire NHS Foundation Trust Inquiry.

A consensus is emerging that excellence in surgery (and in medicine more broadly) rests on fostering genuine professionalism and collegiality. By 'genuine professionalism', we mean to invoke ideals of personal responsibility, service to patients, commitment to learning, and participation in the practice community. As expressed by the Society of Cardiothoracic Surgeons, the new surgical professionalism 'welcomes patient autonomy, and embraces the pursuit of excellence through knowledge, skill, service, accountability, transparency, and a collective responsibility for assuring patients through setting and demonstrating achievement [of] professional standards.'[1]



There are two reasons to refer to the aspiration for a new professionalism at the beginning of this document.

The first is that, at its best, surgical professionalism has long embraced transparency of outcomes, promoted collegial supportiveness in the face of difficulties, and viewed the surgeon as accountable to his

or her patient above all others. Teams that embrace this ethos become accustomed to open and supportive discussion of routine outcome data and are then better equipped to manage more difficult conversations about worrying outcomes or colleagues in difficulty.

The second reason to call attention to the new professionalism is that it expresses surgeons' overriding duty to take action where patients may be at risk. We discuss the sources of this duty further in Part Two.

'Anticipatory' clinical governance

One of the most important pieces of advice in this document is: do not wait for things to go wrong before you personally attend to the quality of clinical governance in your team or department. If every surgeon treated it as an integral part of their clinical duties to be continuously improving clinical governance, there would be little need to escalate safety concerns outside of local forums.

This does not mean that good clinical governance will always prevent things going wrong. It means that when they do go wrong, teams will know that something is amiss, will deal with matters in a timely and transparent fashion, and will give effective support to both patients and colleagues. Any surgeon or team can encounter a 'bad run', come under pressure from budget constraints or hospital reconfiguration, or experience a serious untoward incident. The difference between an excellent team and a failing team is how well the team anticipates, prevents, mitigates or deals with the aftermath of such events.

There is copious evidence submitted during RCS invited reviews (and other investigations, such as the Bristol Royal Infirmary Inquiry) indicating that routine difficulties experienced by any and every surgical team can spiral out of control when day-to-day quality management is poor. The typical symptoms of quality management that is too weak to support the complexity of modern surgery are listed below. These symptoms may be used as a checklist to review your department's provision.

Clinical leadership

- Leadership roles are not appropriately distributed or shared among the surgical team (eg, all power is concentrated in one or two individuals; leadership roles are allocated either as personal favours or by arbitrary allocation).
- There is resistance to leadership authority, or leadership is weak.

» Junior consultants, senior trainees, and staff grades are not encouraged or supported to take on appropriate leadership responsibilities.

Teamworking and team meetings

» There are insufficient operational meetings bringing together the team, or such meetings suffer from sporadic attendance.
» Team or departmental meetings are run without an agreed agenda, or are not minuted.
» Members of the team exhibit unhelpful behaviour, such as arriving late, discouraging dissent or discounting contributions of junior members.

Multidisciplinary team meetings

» Multidisciplinary team (MDT) meetings are poorly chaired and poorly attended.
» Decision-making processes are unclear or erratically implemented.
» Conflict is not well managed.
» Practitioners do not defer to MDT decisions, or they fail to take steps to have decisions properly reviewed.

Data and information on outcomes

» The department does not gather transparent and robust activity or outcome data.
» There are inadequate patient-experience data, or no patient-reported outcomes.
» The team does not take timely and appropriate action in response to activity and outcome data.

Clinical governance processes

» Audit processes have not been used to support a dispassionate and objective assessment of team and individual performance.
» Morbidity and mortality meetings (M&Ms) do not serve their purpose.
» Significant events are not consistently reported.
» There is a failure to carry out a root-cause analysis (or equivalent) following significant events.
» Learning from significant events is not implemented.
» The team does not systematically review either informal or formal patient complaints.
» Individual appraisal is irregular or inadequate.

Innovation and research governance

- There is weak institutional control of surgical innovation, with unclear processes for approval of new or modified techniques or devices.
- There is poor understanding of the difference between innovation and research, or audit and research, and the reasons for ethical review.

If your own department exhibits one or more of these, working to rectify them now, in collaboration with your colleagues, is probably the best way of ensuring that you never have to raise concerns alone.

Being aware of dangers in the psychology of everyday practice

We discuss in Part Two some of the psychological biases that may get in the way of escalating concerns. Here we consider three reasons why practitioners sometimes fail to recognise poor quality care in the first place. They are: habituation to low standards; 'normalising' or explaining away problems; and scapegoating individuals.

Habituation to low standards

Standards in surgery are, to some degree, relative. Advances in surgery, greater awareness of sources of risk, increased understanding of how to measure outcomes, more emphasis on shared decision making with patients (and so on), all mean that what was once at least adequate practice can start to look old-fashioned, dangerous, ignorant, or paternalistic.

One difficulty for teams or lone practitioners – particularly if they are inclined towards insularity – can be that they fail to recognise where they stand in relation to prevailing best practice. This may explain why it appears to be the case that, relatively speaking, junior doctors raise issues more frequently with the General Medical Council (GMC) than more senior practitioners. Junior doctors change placements often, so are in a good position to compare and make judgements about the standards of practice that they observe.

The answer to the habituation problem is already well recognised: all surgical teams should be receptive to benchmarking and other forms of comparative data, and ensure that members are actively engaged with the professional community through professional networks.

Normalisation in response to worrying events

It is a natural human tendency to seek to explain away data – events or outcomes – that conflict with our preferred version of reality. We respond to dissonant data by trying to re-create our prior mental equilibrium. So we can either tell ourselves that nothing very untoward has happened or we can set out to solve a problem we feel we cannot ignore. Explaining away worrying data, especially where it is ambiguous, may be a tempting option. This is one reason why clinical governance can become just 'ticking the boxes', with poor outcomes viewed in the most optimistic light.

While it is unhelpful to catastrophise, disturbing data need to be given due consideration. This is another area where benchmarking procedures and processes, and comparing the outcomes of individuals or teams, can prove a useful corrective.

Scapegoating individuals

Scapegoating may become a destructive feature of group behaviour when members are under intense psychological pressure. The group takes exception to the actions of one of its number, someone who is exhibiting behaviours that reflect group members' own anxieties. The individual is, in effect, punished by the group for bringing these anxieties to light.

For example, a surgical team that is not effectively managing its collective anxieties about quality, safety or outcomes may target one individual as being 'the problem'. It may be that this individual is indeed an 'outlier', or their behaviour may be questionable. But instead of a supportive and proportionate response, the scapegoated individual becomes the isolated object of ostracism, blame, gossip, disapproval, or outright bullying.

Scapegoating may be difficult to recognise, all the more so where questions about individual performance seem to be justified by assiduous clinical governance. However, one form of scapegoating that is both recognisable and easy to fall prey to is blaming the person who draws attention to problems in a service. 'Shooting the messenger' may be particularly tempting when colleagues of perceived lower status, such as newly fledged managers, raise performance concerns.

Perhaps the best preventive to scapegoating is to ensure that governance is fully evidence based. The same criteria for judgement should apply to the performance of every member of the team;

the performance of all members of a team should be collectively reviewed and individuals should be regularly appraised by a qualified appraiser.

What good practice looks like

Example 1: Findings from the RCS Invited Review Mechanism

It probably goes without saying that our checklist of what can go wrong in clinical governance can also serve as a guide to good practice. A team that can tick every box on the list is likely to have a robust system of review and, moreover, will have ideas about how they can make it even better.

One of the most critical issues for teams that do not regularly hold supportive discussion of performance is that when things go wrong they have no 'shared language' at hand to talk about it. A team that cannot talk about performance when it is in a 'steady state' and confronting only minor complications will find it extremely difficult to talk constructively about performance when it is facing a crisis.

Regularly reviewing performance could be viewed as the governance equivalent of a 'skills drill' or clinical simulation. It allows you to rehearse in relative safety what you may need to do under far more difficult conditions.

Example 2: The Society of Cardiothoracic Surgeons

The Society of Cardiothoracic Surgeons (SCTS) has long championed robust and fair measurement of surgical performance. In *Maintaining Patients' Trust: Modern Medical Professionalism*[1] they set out sound principles for clinical governance in surgery. One overview of the components of good governance proposes that it is essential to use all of the following:

- Clinical guidelines and operational protocols.
- Good systems.
- Good data.
- Good records.
- Focused education and skills training.
- Systematic audit of performance with feedback.
- Regular, formative peer appraisal.
- Critical incident review.
- Risk management methods.[1]

Fit for purpose morbidity and mortality meetings: the evidence

Morbidity and mortality meetings (M&Ms) have a long pedigree and are part of the culture of surgical peer review. There have, however, been questions about their effectiveness.

Australian researchers Travaglia and Debono[2] conducted a comprehensive review of the literature on M&Ms in 2009. In it they noted UK Professor Charles Vincent's critique of the limitations of M&Ms as they are commonly practised.[3] These weaknesses include hindsight and reporting bias, a tendency to focus on diagnostic errors, and infrequent or irregular use: all of these will undermine the efficacy of M&Ms. M&Ms suffer from being retrospective, although arguably retrospective review is important for its own reasons. However, reporting bias, focus and regularity are all capable of improvement.

Travaglia and Debono observed that the strongest claim for the benefits of M&Ms was Antonacci and colleagues' study of implementing their model of M&Ms in a US academic centre.[4] There it resulted in a 40% decrease in gross mortality over four years. However this model featured a range of practices, among which was the introduction of compulsory individual performance reports. The data from these reports could be (and was) used to restrict or revoke surgeons' practising privileges. It is therefore impossible to know which aspect of Antonacci's intervention – report cards or enhanced M&Ms – contributed most to reducing mortality.

The Antonacci M&Ms model included:

- Cases were presented weekly at every site.
- Reporting to M&Ms was mandatory for all adverse outcomes and deaths.
- All presentations were submitted two days before the M&M and then anonymised and shared electronically with the participants before the M&M.
- A standardised case critique methodology was utilised.
- Team presentation times were standardised.
- Residents were required to remain for all the services.
- Root-cause analyses were conducted on major cases.
- Individual and hospital report cards were developed but were kept confidential and delivered personally to each practitioner annually, with a separate report going to the chairperson of the M&M.

In practice, an average of 9.6 cases was reviewed each week. The average time for discussion was two hours per M&M, going up to four hours on occasion.

Governance of research and innovation

We have already noted the importance of sound governance of surgical research and innovation. Surgical research is subject to both NHS and national legal requirements, so we do not need to make the case for robust research governance in this document.

There has, though, been greater diversity of opinion surrounding governance of innovation. Appropriate governance is necessary because new approaches present new risks as well as new benefits to patients. It has proved challenging to define the 'new approaches' in surgery that should be subject to control, as well as to agree on the sorts of control that would be advisable. However, norms for governance of innovation in surgery in the UK changed in the wake of the Bristol Royal Infirmary Inquiry, and are changing internationally with generally increasing levels of scrutiny.[5]

Drawing on a study of Australian surgeons' practice and their perceptions of innovation, Rogers et al argue that it is useful to think about innovation in surgery in terms of both *newness* and the *degree of change*. Hence 'new' can include 'altogether new as well as new to anatomical site, geographical location or surgeon'. To newness and degree of change should be added consideration of *risk* and *impact* on those concerned. These can be used 'to classify surgical innovation to assist with developing appropriate levels of […] oversight.[6]

We would encourage teams to discuss, agree and then periodically review their approach to governance of innovation. Discussion should afford opportunities to align views on what constitutes innovation, the type of case in which institutions such as trusts and universities mandate a formal review of proposed innovation, and cases where peer oversight would be suitable. The range of cases discussed should include:

- surgical improvisation necessitated by the circumstances of an individual case, where this is part and parcel of everyday practise and cannot be prospectively reviewed;
- extension of successful improvisation to further cases, which could be prospectively reviewed;
- variation in instruments, techniques or devices where no risk is apparent to the practitioner (but could potentially be apparent to others);
- innovation that goes beyond being a small variation, may carry risk, could be prospectively reviewed, but may not be research; and
- introduction locally or individually of practices developed elsewhere.

The proposals on governance of surgical innovation published in *The Lancet* during 2009[5] were intended to promote the adoption of good practice throughout the international professional community. Clinical governance leads in teams will no doubt find both the underlying research and its recommendations of value.

Part Two

Raising concerns at work and supporting others to do the same

Quick summary for those in a hurry

Good things to do

» Be aware that many surgeons successfully raise concerns and even earn credit for doing so.
» Maintain an objective and open mind but do not forget that your bias must be towards protecting patients.
» Be aware of the human factors that may inhibit you from raising concerns and ensure that they do not tempt you into neglectful inaction.
» Support others if you share their concerns.
» Work out a plan of action, based on using the internal organisational resources available to you in the first instance and escalating your concerns where necessary.
» Make a note of any evidence you have to support your concerns, remembering that you are only required to have a reasonable belief that something may be amiss and it is not your responsibility to prove your case.
» Be clear about the kind of patient information you can share and with whom.
» Seek the counsel of a trusted colleague on whom to test your perceptions but take responsibility for your own decisions and plans.
» Keep a dated and verifiable record of how you have raised your concerns.

What not to do

» Don't assume either that someone else will take action, or that if you take action your concerns will be ignored.
» Don't conflate raising concerns with raising a personal grievance. If you have to pursue both a concern and a grievance simultaneously, keep them separate and present the evidence for your concerns dispassionately.
» Don't circumvent existing internal processes without reasonable justification, such as that the issue is severe or urgent, or your concerns having been ignored.
» Don't use intemperate language when raising a concern, or over-state your case.
» Don't assume the worst about other individuals (managers or surgical colleagues). This applies whether they are the people you are raising concerns about or the people you are reporting your concerns to. The former may have done nothing wrong. The latter may be responsive and supportive when you raise concerns with them in the right way.

Key issues

Sources of responsibility and how they affect you

Your professional duty

Readers will be aware of the general professional duty to raise concerns. The GMC refers to it in *Good Medical Practice*,[7] and has recently elaborated the duty in a supplementary document *Raising and acting on concerns about patient safety*.[8] In that document, the general duty appears in paragraph seven:

> All doctors have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies and procedures in the organisations in which they work. They must also encourage and support a culture in which staff can raise concerns openly and safely.

In *Raising and acting on concerns about patient safety* the GMC also discusses how this professional duty affects doctors in managerial positions. It stipulates that they must take action when concerns are raised with them:

> Concerns about patient safety can come from a number of sources, such as patients' complaints, colleagues' concerns, critical incident reports and clinical audit. Concerns may be about inadequate premises, equipment, other resources, policies or systems, or the conduct, health or performance of staff or multidisciplinary teams. If you receive this information, you have a responsibility to act on it promptly and professionally. (Paragraph 20.)

It is important to be aware that if you do not raise concerns when you should have done so, your own fitness to practise may be called into question.

The GMC guidance generally refers to a duty to raise and act on concerns within the organisations in which doctors are employed or have practising privileges. However, it is clear that doctors have a more extensive professional and ethical duty to respond when they are made aware of risks to patients elsewhere. We discuss how best to discharge this larger responsibility for patient safety in surgery – wherever patients are being treated – in Part Three.

The terms of your practising privileges

Independent healthcare providers generally incorporate adherence to GMC regulations and guidance into their practising privileges agreement. This accords with the agreement recommended by the Independent Healthcare Advisory Service (IHAS) and the British Medical Association (BMA). This means that even if a provider's internal policies are silent on the obligation to raise concerns, the GMC's *Good Medical Practice* and its associated guidance on concerns forms part of the practising privileges agreement. Providers will also have their own internal policies for clinical governance, and these may well impose higher standards on you.

Consultants providing private care have a collective interest in maintaining the reputation of independent healthcare organisations, and thus in raising concerns about surgeons in private practice. Additionally, the independent sector as a whole views it as being in its interests to align clinical quality assurance activities with those in the NHS. For example, the sector has welcomed the opportunity to contribute to a doctors' appraisal as part of 'whole practice' information gathering.

Independent providers' ultimate sanction is withdrawal of practising privileges. While this is more common when a consultant fails to provide satisfactory care, independent healthcare providers may take similar action for a breach of the GMC duty to raise concerns or for disregard of internal 'whistleblowing policies'.

The NHS constitution

The NHS constitution[9] sets out a duty to raise concerns about matters that include patient care and also go beyond it, such as financial fraud:

> You should aim to raise any genuine concern you may have about a risk, malpractice or wrongdoing at work, (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff, or the organisation itself at the earliest reasonable opportunity. (Section 3b.)

The NHS constitution also refers to a duty on employers in the NHS to support staff that raise concerns.

Distinguishing between 'concerns' and 'grievances'

If you are an employee, it is important to distinguish between the process of raising concerns and the pursuit of an employment grievance. This is so for two very compelling reasons, which we consider after clarifying the difference between concerns and grievances.

This is how the British Standards Institute explains the distinction:

> Whistleblowing is where an employee has a concern about danger or illegality that has a public interest aspect to it: usually because it threatens others (e.g. customers, shareholders or the public). A grievance or private complaint is, by contrast, a dispute about the employee's own employment position and has no additional public interest dimension [...] Inevitably, there can be occasions where a whistleblowing issue will be entangled within a grievance, for example where an employee complains about being made to drive when tired or to use a dangerous vehicle. Another example is where the underlying whistleblowing concern has existed for some time but, as nobody has felt able to raise it, the working environment has degenerated and led to a private complaint.[10]

The first reason to be clear about the difference between escalating a concern and pursuing an employment grievance is a wholly pragmatic one. It tends to weaken whatever case you have if you confound the two. If you try to draw attention to an employment grievance by presenting it as a patient safety concern, it undermines your standing and credibility. And if you do have justifiable concerns about *both* patient care *and* employment matters, muddling them together tends to undermine them both. The *concerns* are liable to be explained away by reference to the on-going grievance ('he's only raising concerns to draw attention to his grievance') and the *grievance* potentially loses legitimacy ('now he's trying to up the ante by raising concerns about patient safety').

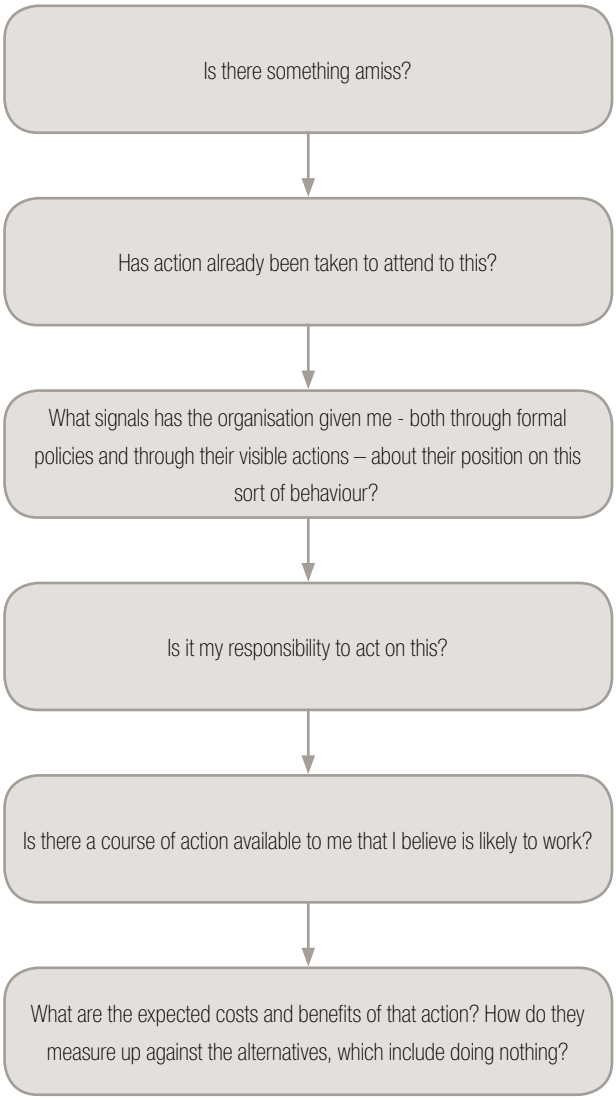
A second reason to be clear about the difference between concerns and grievances is that the legal protection given to an employee raising concerns on behalf of others (the Public Interest Disclosure Act) does not apply to *purely private* employment grievances. In some very exceptional cases, concerns and grievances may overlap, for example if your employer sought to impose a term in your contract that would put patients at risk. But in most situations, a concern and a

grievance will be different things and you should follow the separate routes that your employer provides for pursuing them.

If you believe you have both a patient safety concern to raise and a grievance to pursue, it is particularly important to seek the advice of the RCS, a protection society, or the NHS whistleblowing helpline, all of which can help you to think through how to present your case.

Seeing clearly: a model of the process that leads to concerns being raised

Psychological research into 'prosocial behaviour' (behavior intended to benefit someone else) and whistleblowing in organisations suggests a useful model for understanding the decisions that lead to concerns being raised. The model that generates the questions below is not the only one that researchers have proposed but it does identify some key decision points. It thus helps us to see more clearly some of the difficulties that may have to be faced by those who have concerns about the quality of care and also helps us to see the scope for bringing things to a successful resolution. People who raise concerns will have answered most of the following questions in roughly the order they are set out alongside.



Taking stock: the parts of the process that cause difficulty

Is there something amiss?

You may be troubled by activity that is evidently wrongful, such as treating a capacitous patient without proper consent. However, spotting that something is amiss may require you to make sense of a complex situation, or it may rest on your own judgement. For example you may judge that a colleague is introducing an experimental or innovative procedure without seeking the requisite committee approval or submitting to peer review, while other colleagues think that the procedure in question is merely a minor variant on existing processes. Or it may be that you believe there are insufficient qualified nurses to provide a safe service, while others feel that staffing levels are just about adequate.

Many clinicians ask themselves, when faced with concerns about quality or performance, what they would do if it were members of their own family at risk. A cliché it might be, but the question is of value because it serves to focus attention on two important moral facts. These are: first, that patients and their supporters trust clinicians to take action on their behalf and in their best interest; and second, that when someone is vulnerable to your actions you owe them a special obligation to take care.

In Part One we warned that some habits of thought, familiar in everyday practice, can get in the way of effective clinical governance and recognition that something is going awry. It is worth considering whether any of these are at play when you make your assessment of the situation you are witnessing (see the section Being aware of dangers in the psychology of everyday practice).

There is a further hazard that groups encounter when people suspect that something may be going wrong. Research on prosocial behaviour confirms what common sense tells us, which is that our first inclination when we fear something may be amiss is to look around to see what others are thinking or doing. Unfortunately, if everyone else is reacting as if nothing is out of the ordinary, we can wrongly conclude that nothing is. The result is painfully obvious. Everybody in the group treats everyone else's inactivity as confirmation that nothing is wrong. The way to counter this unfortunate tendency is equally obvious. It only needs one person to ask if something is going wrong for the group to be able to act.

Has action already been taken to attend to this?

It is fair to ask, before taking action, whether it is necessary or will merely be a duplication of effort.

The danger here is a second cause of inertia, for which there is both research and practice evidence: the 'diffusion of responsibility'. Everyone thinks that somebody else has already done whatever needed to be done and, as a result, no one does it. So it is always your responsibility to take steps and check whether action is already being taken.

If another person is taking steps to raise concerns, however, they probably need as much support and evidence as they can get. It is not sufficient to merely note with relief that someone else is doing something. The proper discharge of your responsibility for patient safety entails ensuring that your own knowledge and understanding is put at the service of whoever is leading the response to problems that concern you.

Is it my responsibility to act on this?

As we noted in the introduction to this part, individual surgeons clearly have a responsibility to act on information about treatment of patients who are under the care of their employing or contracting organisation.

We also believe that the scope of professional responsibility extends further than this, and we discuss this expanded responsibility for patient safety in surgery – wherever the patients are being treated – in Part Three.

We noted above that responsibility to act does not stop at the point of discovering that another person is taking action in response to poor care. Where you have evidence of wrongdoing, and others are already pursuing the matter, the evidence should be passed on to them.

Is there a course of action available to me that I believe is likely to work?

The research we have already cited seemed to confirm what common sense would tell us. But there is one aspect of raising concerns where the research confounds the usual expectations. The good news is that clinicians who raise concerns enjoy much more successful resolutions to their situations than is commonly believed to be the case.

The media and the professional rumour mill thrive on stories of failure, so we tend only to hear about whistleblowers who fail to prevent harm and who suffer career-damaging retaliation for their pains. We hear far less about people who successfully raise concerns, using available channels, where prompt action created a safer environment for patients, and whose careers were unaffected or even enhanced by their stand. It is unfortunately the case that among the clinicians who have acted on their concerns many would not relish the accolade of 'successful whistleblower' and they do not advertise their actions. But in one of the very few studies of actual reporting of concerns in the NHS, Firth-Cozens notes 'it is interesting that of those who reported their concerns, most did not have a negative experience and almost all would report again in such circumstances'.[11]

Skilfully raising concerns can accomplish the desired goal of better care and team harmony. We discuss below what is currently known about what works.

What are the expected costs and benefits of that action? How do they measure up against the alternatives, which include doing nothing?

The Medical Protection Society (MPS) reports that over half of respondents to an MPS survey continued to regret a past failure to raise concerns. So: doing nothing may cost both surgeons and patients dearly.

Research into how individual whistleblowers set about weighing the costs and benefits of action suggests that a wide range of situational factors come into play. None of the findings consistently demonstrate a strong correlation but we suggest it is important to be aware of these factors so as not to be unwittingly influenced by them.

- **The gravity of the wrong or the scale of the harm that ensues.** Individuals may be more inclined to report very grave harms. This carries the risk that professionals will not raise concerns about what they perceive to be lesser harms, so that low level wrongdoing continues unhindered.
- **The quality of the evidence.** Where there is clear evidence of wrongdoing, people may be more likely to report it. More often in healthcare there is a dearth of 'evidence' alongside a lot of local 'knowledge'. For example, many nurses will know that a particular surgeon has moods, is a bully or permits inappropriate behaviour but do not report this for fear of retaliation. This evidentiary factor carries the risk that when evidence appears thin,

professionals may not raise concerns. Consequently, no further investigation – which could yield evidence – is mounted.

» **The perceived reasons for the wrongdoing.** It has been argued that the decision whether to raise a concern or not may be affected by broadly 'moral' calculations. Observers may ask themselves if the wrongdoer was responsible for their action, if they intended to do it, if they have done it more than once, and so on. They may also suspect that the doctor's own health is a factor and consider that it would be wrong to 'punish' them for being ill. The clear danger here is that for reasons of perceived 'fairness' to the wrongdoer, concerns will not be reported and patients may be placed at risk.

» **Status of the wrongdoer.** Mixed findings suggest that the status of the wrongdoer may affect a decision to act. Hospital employees seem a little more willing than people working in other settings to raise concerns about a person of high status. However, practice wisdom suggests that there remains continuing reticence to report inappropriate behaviour by a high status peer (consultant to consultant).

What good practice looks like

In this section we identify the resources available to those seeking to raise concerns and consider the approach most likely to achieve a successful outcome.

If it works effectively, the day-to-day clinical governance framework that we discussed in Part One would be the first recourse for exploring concerns as they arise in practice. We noted it should comprise well-attended forums for collegial discussion, regular review of outcomes data, a reporting system such as that supported by Datix®, and adequate personnel with appropriate expertise and influence responding to reported incidents.

Few clinical governance systems work perfectly, and unresolved or urgent problems may require escalation.

It is important to remember that doctors who raise concerns may well earn the approval both of peers and of their organisation. In more controversial cases, the Public Interest Disclosure Act (PIDA)[12] provides a measure of legal protection for individuals who raise genuine concerns about matters such as public or patient safety. The PIDA protects the employment rights of doctors who disclose information in the public interest within their employing organisation, or to an appropriate

healthcare regulator. However, the PIDA does not give protection to 'vexatious' action, or to people who are pursuing employment grievances in the guise of raising concerns (see How the law protects whistleblowers).

We give further details later about how the PIDA works, and what you should do in order to ensure that your interests are protected. You may also wish to draw upon resources such as the RCS Directors of Professional Affairs, your protection society, the BMA or the NHS Whistleblowing Helpline, provided by Mencap, for advice and support. (See Appendix for further information.)

Step 1: Using routine organisational frameworks and resources to raise concerns

All NHS organisations will have a policy on 'whistleblowing' and procedures for escalating concerns. So will most independent healthcare providers. In the NHS these documents are generally sponsored by the human resources department. It is widely recognised that a good employer will provide legitimate ways for staff to bypass their direct management line, so these policies will include provision for doing just that: for example, by referring concerns to a specially designated trust non-executive director.

Independent healthcare organisations are likely to have made reference to a relevant policy in their practising privileges agreement, and such policies may make allowance for concerns to be referred to an independent individual.

The available evidence indicates that those who start out by raising concerns in a measured and appropriate way, through expected organisational routes, may fare best. Moreover, the Care Quality Commission (CQC) and GMC emphasise that they normally expect concerns to have been raised internally before they are referred to regulators.

To whom you escalate your concerns is a matter of judgement, and must to some extent depend upon the severity or urgency of the situation as well as your own organisation's policy and provisions. The BMA guidance[13] recommends referring concerns to your immediate superior, followed by the medical director and then a further referral to the trust's chief executive before referring concerns to a regulatory agency. In an interactive case study on the GMC's website, however, they propose that junior doctors might reasonably refer a concern to the CQC after their medical director had failed to address it within a fortnight. We discuss escalation further in the next section.

While exceptional circumstances may require exceptional steps, you should generally follow the internal avenues prescribed by your own organisation where these remain available to you.

Step 2: Escalating concerns internally or referring them to regulators

In the event that your own organisation fails to respond appropriately and you believe that patients are at risk, it remains your responsibility to pursue your concerns until you are satisfied that they are being resolved. If you are working in the NHS, you have the option of escalating them to the Department of Health (DH) or referring them to a regulator. In the independent sector, your next step will depend upon whether there is a further level to which concerns can be escalated before you take them to an appropriate regulator.

The legislation that protects whistleblowers encourages internal escalation, and in the NHS an 'internal' disclosure can be taken to the most senior level in DH. If you have already escalated your concerns within your own organisation you have the option to write directly to the NHS chief executive, or to the various ministers of state. The alternative is to refer your concern to a regulator. In many cases, referring concerns to the regulator is likely to prove the most effective course of action because they have mechanisms in place to deal with them.

Whether you are working inside the NHS or outside of it in private practice, the GMC's guidance on raising concerns[8] notes that you should contact a regulatory body in the following circumstances:

a. If you cannot raise the issue with the responsible person or body locally because you believe them to be part of the problem.
b. If you have raised your concern through local channels but are not satisfied that the responsible person or body has taken adequate action.
c. If there is an immediate serious risk to patients, and a regulator or other external body has responsibility to act or intervene. (Paragraph 16.)

There is no shortage of healthcare regulatory bodies to whom you could report a concern, and all are seeking ways to cooperate so that legitimate concerns about care do not get lost in the system. To ensure that your action is effective, and to minimise the risk of suffering personal detriment, you need to choose the right regulator.

The CQC is responsible for safeguarding standards of quality and safety within health and social care in England. The CQC deals with quality and safety concerns across all types of organisations, including foundation trusts and independent healthcare providers. If you have a reasonable belief that patients or services are being put at risk, the CQC is the appropriate body to go to in order to escalate your concerns. Importantly, even if your employer does not support your action, where you have acted in good faith in the interests of public safety your position is likely to be protected by the PIDA. This is because the CQC is a 'prescribed regulator' for the purposes of the PIDA (see below).

Where you have a concern that relates to the fitness to practise of an individual doctor, and your organisation is not responsive to your concerns, you should consider raising this yourself with the GMC. Concerns about the fitness to practise of other health professionals (such as nurses) could be referred to a relevant professional regulator (such as the Nursing and Midwifery Council (NMC)).

It is an anomaly that the GMC and other professional regulators are not currently 'prescribed regulators' for the purposes of the PIDA. This means that if you suffer a detriment at work as a result of referring concerns to them, you do not enjoy the same level of legal protection as you would do if you had referred your concerns to CQC. However, you should bear in mind that you have a professional duty to raise concerns with the GMC where this is appropriate. If you do not do so, you may put your own probity and fitness to practise in question. You can contact the GMC in confidence, without having to identify yourself or your organisation, if you need to explore your options.

We discuss below what counts as a 'protected disclosure' under the PIDA. While a 'protected disclosure' requires minimal formality, we strongly advise that you keep a clear, up-to-date record of your actions and any correspondence. This is important in order to demonstrate that you have properly discharged the professional duty set out in *Good Medical Practice*. Your records should be clear, honest and accurate as you may need to produce them in subsequent legal proceedings.

(See Appendix One for contact details of the NHS Whistleblowing Helpline and an outline of how the CQC responds to concerns.)

Step 3: Bringing your concerns to general public attention

Your final recourse, if you believe that neither the NHS nor the regulators have responded appropriately to your concerns, may be to consider making them public through appropriate media channels. The GMC advises[8] that this is justifiable – indeed, is the proper thing to do – where you:

a. have done all you can to deal with any concern by raising it within the organisation in which you work or which you have a contract with, or with the appropriate external body, and
b. have good reason to believe that patients are still at risk of harm, and
c. do not breach patient confidentiality. (Paragraph 17.)

The GMC recommends that you seek advice before going public with your concerns. We would also encourage you to seek advice from an appropriate source before taking further steps because the law in this area is more complex. While the PIDA can apply to disclosures made to the media or to public representatives such as an MP, your case needs to be a little stronger than it does when you raise concerns internally or with the regulator.

The PIDA can afford real protection to those who raise concerns responsibly. However, it affords protection only from maltreatment in employment. In the next section we look at the Act and its remedies in more detail.

How the law protects whistleblowers

The PIDA protects the employment rights of individuals who raise genuine concerns about wrongdoing in their workplace.

The PIDA achieves this by way of special provisions inserted into employment law. It enables you to seek redress if you are dismissed, victimised or suffer detrimental treatment (such as demotion or denial of promotion) as a consequence of raising concerns. Because it operates as part of employment law, the PIDA does *not* protect your interests should you raise concerns about an independent healthcare provider where you hold practising privileges.

While protection of employment rights is welcome, the PIDA may not seem an ideal solution because it places the onus on the whistleblower to initiate legal action if their employer retaliates in the wake of a disclosure, or permits them to become a scapegoat. But the law does have a 'backwash

effect'. Dismissing an employee for making a protected disclosure is deemed an 'automatic' unfair dismissal, and it gives rise to unrestricted levels of compensation. The compensation payable to whistleblowers who suffer victimisation in employment is also uncapped. Given the legal fact that the financial sum payable to maltreated whistleblowers is potentially unlimited, organisations have a real incentive to ensure that those making protected disclosures are not persecuted for their stand.

So how do you go about making a legally protected disclosure? If your disclosure is the sort of disclosure that employment law protects, and you make it to the right person, you are protected automatically.

You are always working under the protective regime of the PIDA, even if you are unaware of the law at the time you make a disclosure and know nothing about its effects. Importantly, your employment rights are protected irrespective of whether you make a disclosure formally or informally, verbally or in writing.

However, you may one day have to provide evidence that your public interest disclosure was the cause of subsequent difficulties at work. So for pragmatic reasons, it is best to have an audit trail that demonstrates what you did, when, and why.

Protection for disclosures made within your employing organisation

To benefit from legal protection when making an internal disclosure, your concern must satisfy the requirements below.[a]

1. **The individual making the disclosure must hold a reasonable belief that what he or she is disclosing tends to evidence a wrongdoing.** The belief has only to be reasonably held, and does not have to be correct. It can therefore be a qualifying disclosure if you reasonably but mistakenly believe that a malpractice was occurring.[b]

2. **The disclosure must be of the public interest category with which the PIDA is concerned.** A breach of the duty of care to patients in primary or secondary care, residents in care homes, or others in a similar position, would satisfy this requirement.[c] Concerns about patient safety undoubtedly qualify as protected disclosures. So too do reports of any attempt to cover up information about patient safety concerns.

[a] Public Concern at Work has published a guide to the Act with detailed commentary on its website http://www.pcaw.org.uk/pida-43a-f

[b] As determined in the case of Darnton v University of Surrey (2003).

[c] In the case of Care First Partnership Ltd v. Chubb & Others (2000) employees in a care home raised wide ranging concerns. The Employment Appeal Tribunal held that allegations of theft and assault came within 43B(1)(a); breach of duty of care within 43B(1)(b); safety risks to residents within 43B(1)(d); and altering care plans within 43B(1)(f).

3. **The disclosure must be made to an appropriate person.** The PIDA has created a 'tiered' disclosure regime that encourages you to raise concerns through your employer or a regulatory body before going public with them. Any disclosures made in accordance with your employer's whistleblowing policy (including disclosures to independent representatives identified in that policy for the purpose of raising concerns) will count as protected disclosures.

So long as you satisfy these three requirements, there is no need to put your disclosure in writing, label a document as a 'protected disclosure', round up witnesses, consult a lawyer or make a sworn affidavit.

It would, however, be prudent to make your disclosure in writing because you then have a record. It would also be prudent to seek advice and assistance when you are raising issues you know are likely to prove contentious or, as we suggested earlier, if you are minded to raise an employment grievance as well as a patient safety concern.

Protection for disclosures to the CQC

If your disclosure to the CQC is to carry protection, the requirements are very similar to those above.

1. **The person must make the disclosure in good faith, with a reasonable belief that it is substantially true.** This is a slightly higher evidentiary burden than is required for internal whistleblowing but still requires only good faith and a reasonable belief.

2. **The disclosure must be of the public interest category with which the PIDA is concerned.** This is no different from the requirement that applies to internal whistleblowing.

3. **The disclosure must be made to a prescribed body.** For the purposes of raising concerns about the quality and safety of care, the CQC is currently the only 'prescribed regulator'. We noted earlier that the professional regulators such as GMC and NMC are not 'prescribed regulators' under PIDA at this time. Notwithstanding, you have a professional duty to raise concerns with the GMC where this is appropriate, and you may put your own registration at risk if you do not do so.

You will be protected when you make a disclosure to the CQC even if you have *not* first raised your concerns internally.

If it is not clear whether the matter should be raised internally or with a regulator, and you are worried about your position, Public Concern at Work (PCAW) advise contacting the regulator informally first. The regulator can then check – without you having to name your employer - that your disclosure is of the protected sort, and give advice about the action the regulator considers appropriate. If you then decide to raise the matter internally, you may wish to point out that you have sought the advice of the regulator without having identified your employer.

Protection for disclosures to the media or others

The PIDA imposes more stringent requirements if your employment rights are to be protected when making disclosures to the media, or to others with a potential interest such as local MPs or campaign groups. The most important difference is that you will probably need to have raised concerns through local channels first.

Disclosures that would satisfy the requirements for protection when raised through internal or regulatory mechanisms may not warrant protection when you go public *unless you have already raised your concerns either internally or with a regulatory body*.

You may be justified in going public first, and therefore qualify for legal protection, if it is an exceptionally serious concern; if you have reason to believe that you will suffer detriment if the matter were raised internally or with a regulator; and if disclosure is reasonable given all the circumstances.

The law in this area is too complex to summarise accurately here. We would urge you to seek appropriate advice before taking action to pursue your concerns with parties *other* than an employer or regulatory body.

Protection for disclosures to legal advisors

Discussions with legal advisors are privileged and any disclosure made in the context of them is automatically protected.

Clarifying confidentiality

Professional ethics, regulatory guidance, and the law, are all clear that patient identifiable information is confidential, and that professionals have responsibility to manage it accordingly. We consider confidentiality briefly here because worries about sharing patient information have in the past prevented NHS staff from raising concerns, with the result that serious abuse has gone unchallenged for considerable periods of time.[d]

[d] See for example *Independent investigation into how the NHS handled allegations about the conduct of William Kerr and Michael Haslam.* CM6640, The Stationery Office, 2005.

It is important to remember that in ordinary circumstances, when you are raising concerns within your organisation, there will be no conflict whatsoever between preserving patient confidentiality and promoting patient safety. In normal circumstances, patients will have given consent to their personal information being used by their care provider for 'healthcare purposes'. These have been defined in the *NHS Code of Practice: Confidentiality*[14] as 'all activities that directly contribute to the diagnosis, care and treatment of an individual and the audit/assurance of the quality of the healthcare provided. They do not include research, teaching, financial audit and other management activities.' Raising concerns within your own organisation falls clearly within the scope of the consent that patients ordinarily give for the use of their personal information.

However, patients may withhold consent to identifying information about them being used. A conflict between patient confidentiality and patient safety may arise if a patient specifically asks you not to disclose information about an incident that could identify them. Patients might ask you not to talk about something that has happened if, for example, they are worried about suffering retaliation for complaining, embarrassed about something that has been done to them, or feel they are themselves to blame for something going wrong.

Any explicit refusal of consent to share personal information carries moral and legal weight. So too does the need to protect patients from harm. If a patient tells you something in confidence and, having been offered encouragement and support, still does not consent to you sharing the information, there are broadly three courses of action open to you.

1. You could approach this as a safeguarding issue, and seek the advice of the safeguarding team in your organisation. They should have up-to-date knowledge of the case law on adult and child protection, including findings about legitimate reasons for sharing information without consent. Importantly, they may also be aware of other abuses arising from the same source.

2. You could consider divulging only such information that does not, and cannot, identify the individual. It would be advisable to seek advice from your Caldicott Guardian or the safeguarding team before proceeding with this course of action.

3. You could consider breaching confidentiality on the basis that there is an overriding public interest in you doing so *and* you cannot achieve the same end without disclosing information that identifies the patient. Only the prospect of very serious harm being done to another is likely to satisfy this public interest requirement. Additionally, you would only be justified in disclosing whatever information it was *absolutely necessary* to disclose in order to protect the public. This is an unusual and challenging situation and you should seek appropriate advice before taking any steps that would result in a breach of confidentiality.

We advise that where any questions arise about the use of patient identifiable information in order to evidence a concern, your first step should be to consult the safeguarding team or Caldicott Guardian within your organisation.

The problem of evidence

The last area to consider is the question of evidence. Your concerns may have arisen out of events that you witnessed, or on the basis of something that you have read, been told or overheard. You may believe this suggests something is amiss but remain unsure if you have sufficient evidence to prove it.

Importantly, it is not your responsibility to prove a wrong or to demonstrate that harm has occurred. You need only hold an honest and reasonable belief that something is amiss. If you are an employee raising genuine concerns reasonably, your disclosure will be protected by PIDA even if you are mistaken.

However, if you consider your evidence to be weak you may be worried about the practical difficulty of getting your concerns taken seriously. How far should you go to gather evidence

yourself? All of the advisory bodies are clear that this course of action is unwise. It may delay a proper inquiry if you set about becoming a private detective before you raise your concerns. You may unwittingly impede a later, official investigation. Perhaps the biggest risk is that you may be thought to be acting in an obsessive or underhand way; neither of these perceptions is likely to advance your cause.

We therefore advise that you raise your concerns strictly on the basis of the evidence you have to hand. You should present it in an objective and dispassionate tone, allowing the facts to speak for themselves and where possible focusing on observed behaviours. Do not exaggerate or over-interpret. If it is not necessary to do so, avoid trawling through years of implicating events. Although it might seem to strengthen your case it may have the opposite effect, inviting speculation about what is prompting you to raise concerns now. Resist the temptation to cast aspersions on people's character or make denigrating statements because, if you do, your concern may appear to be a personal grudge. Lastly, try to avoid a tone of self-justification or self-aggrandisement, which can be perceived as insincerity.

Part Three

Supporting practitioners to raise concerns: what you can do for others and what the RCS can do for you

Quick summary for those in a hurry

Your responsibility

» You should support others to raise concerns within their organisation themselves. However, if after doing so you believe patients remain at risk, you have a responsibility to take further action yourself.

Good things to do

» Demonstrate willingness to hear and discuss concerns.
» Share this document with your advisee.
» If someone seeks your counsel, set an appropriate time and place to have a discussion where you can give the issues proper consideration.
» Make clear that your advisee has a non-transferable obligation to take action themselves if action is necessary.
» Help your advisee to clarify the care quality issues and differentiate them from personal grievances.
» Help your advisee to consider what evidence they have and make an objective assessment of circumstances.
» Help your advisee to identify and appraise the options open to them.
» Ensure your advisee commits to a timely plan of action and agrees with you how you will follow up.
» Encourage your advisee to keep an up-to-date record of their actions.
» Keep a record of your discussion.
» If you believe patients remain at risk, take action yourself.

What not to do

» Do not allow yourself to be manoeuvred into discussing concerns when you cannot give it proper time and attention.
» Do not permit your advisee to feel they have discharged their responsibility by ‘passing the buck’ to you.
» Avoid being drawn into collusion: be aware of the unreliability of second hand information and that your advisee might be seeking your approval for inaction, gossip, scapegoating etc.
» Do not treat the issue as resolved until you have satisfied yourself that your advisee has taken action.

Key issues

RCS's commitment to patient safety and to supporting its members who raise concerns

The RCS exists to develop, support and promote the highest professional standards in surgery. It is committed to enhancing patient safety, and recognises the important role it has in enabling members to review and challenge practices that may place patients at risk.

RCS officers and members provide a range of support for surgeons either responding to or raising concerns.

What are your responsibilities if you are asked to give advice or assistance about concerns arising elsewhere?

Members of the RCS are sometimes approached by surgeons or other healthcare professionals who have concerns about standards of care in other organisations. Our discussion so far has related to escalating concerns within your own organisation, where it is abundantly clear that you have a duty to act. But what are your responsibilities, and what is it right to do, when someone seeks advice about a troubling situation that is arising elsewhere?

Three considerations should guide your action.

1. Collegiality carries an expectation that you support others who find themselves in difficult situations. Membership of a professional 'community of practice' brings both privileges and responsibilities, which include responding to reasonable requests for help.

2. You have an ethical duty that goes beyond just providing safe care to either your own or your organisation's patients. You cannot ignore a risk to patients arising elsewhere in the system once someone alerts you to it.

3. The person raising his or her concerns with you has a duty to raise them within his or her own organisation. Every single healthcare practitioner has a responsibility to raise concerns, and healthcare systems are best served by everybody doing what is required of them.

For these reasons, we advise that your first course of action should be to support the other person to pursue his or her concerns. If this fails, or if the situation is grave and urgent, you must however take appropriate action.

We will now consider what good practice in supporting others looks like.

What good practice looks like

Empowering others to act

Your own professional obligation to protect patients from risk implies that you have a responsibility to support other surgeons who seek your counsel. However, it is neither feasible nor desirable to allow others to simply hand their problem over and hope you will sort it out for them. Your role is to ensure that your advisee, as the person with first-hand knowledge of the situation, deals with it effectively.

People may take an opportunity to raise concerns with you when you have not got time to deal with them, or in what appears to be an inappropriate context such as an informal gathering. If you cannot properly explore their concerns, there is a danger of getting the facts wrong, under- or over-estimating the gravity of a situation, or permitting your advisee to feel they have discharged their responsibility by merely telling you. If the circumstances do not permit a proper discussion, we suggest you make clear your willingness to hear concerns but at an appropriate time and place.

Basic coaching to support action on concerns

In the subsequent discussion you may find it helpful to draw on a widely used coaching model known as 'T-GROW'. This stands for:

- Topic for discussion
- Goal for discussion
- Reality – the circumstances surrounding the person seeking your advice
- Options appraisal
- Ways forward

This model is useful because it helps to focus you and your advisee's attention on why they are seeking a discussion; what they think is happening, together with the evidence they have for this; what their options are; and how they will take things forward after the discussion.

Goal

According to the account we gave of whistleblowing behaviour in Part Two, your advice is most likely to be sought when the person seeking advice is:

- not sure if something is amiss
- not sure if it is his or her responsibility to act
- unaware of what courses of action are available
- worried about the costs and benefits of an action, or the alternative of doing nothing.

Each of the different motivations for seeking advice places different demands upon you, so it is helpful to explore what it is that lies behind the request. Enquiring into your advisee's goal is particularly useful, not least because he or she may not have given much thought to what that goal is. If you offer advice that does not accord with the reason that someone is seeking your counsel, he or she is unlikely to follow it.

Reality

Where a person is uncertain whether or not something is amiss, you can serve as an important sounding board. It could be useful for that person to clarify the reasons for a concern, gauge if the standards he or she is applying are consistent with the community of practice, take stock of the available evidence, and perhaps identify unwarranted anxieties.

It is particularly important to be aware of some of the pitfalls we discussed in Parts One and Two, because your advisee may be seeking an excuse not to act as much as seeking your advice about what to do.

In Part One we pointed out that practitioners can become habituated to low standards, that to some extent we all may be tempted to 'explain away' dissonant or worrying data, and that sometimes individuals who do not comply with group norms become scapegoats. So it is worth exploring the following questions in some depth.

- What standards are they applying and where are these derived from? For example, are there departmental, regional or national performance data indicating both an accepted norm and that an individual or group is an outlier; are there protocols or policies that are being ignored; how do standards compare with departments elsewhere?
- What does the advisee see as the implications of dissonant data? For example, are these being treated as just 'doing the routine' rather than as a source of learning; do they indicate a challenging patient population or, alternatively, a service in trouble?
- If an individual has been identified as a problem, is this appropriate? For example, is the group behaving supportively towards them; is the individual's outcome data being compared fairly with that of other members of the team; is their behaviour a risk to patients or, alternatively, is it really a challenge to the team?

It may also be a part of some practitioners' realities that they have not accepted their own responsibility to raise concerns. Absolute clarity on your part about their obligations, together with an offer of continuing support, may give them the fortitude required. In Part Two, we noted that if others are not taking action this is sometimes taken as proof that nothing is amiss. You should be careful to avoid endorsing inappropriate inaction on the part of your advisee and his or her colleagues.

Options appraisal

Sometimes good people do not do the right thing simply because they do not know how to go about it.

The advice in this document should help you and your advisee to appraise the available options, whether this is to use existing clinical governance forums or to escalate concerns through internal or external avenues. It should become clear, in the course of an options appraisal, how to minimise personal costs and maximise the chances of achieving a successful outcome.

It should also become apparent that where there is genuine cause for concern, there are real costs to the individual surgeon if he or she does nothing. If your advisee is tempted to do nothing and hope the issue blows over, it may be helpful to point to the results of the Medical Protection Society survey to which we referred in Part Two: more than half of respondents still regretted a past failure to raise concerns. Aside from the psychological burden of regret and shame, a failure to raise concerns may raise questions about their own fitness to practise.

Way forward

It is critical both for the advisee and the advisor that a clear plan of action is agreed. This is important for the advisee because making a commitment to you will reinforce their intention to do what they have said they will do. It is equally important for you because, if your advisee does not take effective action, you will have to consider what further action to take yourself. You should therefore elicit a commitment from the advisee to take specific actions within a definite timescale, and agree how and when you will follow up your discussion.

Record keeping

We would advise both you and your advisee to keep a contemporaneous record of your discussion and any subsequent actions. Bear in mind that you may be asked to produce this record in any subsequent legal action.

Your own professional and ethical duty

Where a surgeon seeks your advice, and you believe that patients still remain at risk, you have your own responsibility to act. You may conclude patients are still at risk for a variety of reasons: for example, where you perceive there are significant problems but your advisee does not take action; if the advisee's action appears to have been ineffective; or if you believe that your advisee is placing patients at risk through his or her actions.

If you reach this stage following discussion, how you proceed is a matter for your judgement in the circumstances. Raising your concerns with the trust may be effective. Alternatively, seeking the advice of a regulatory body – CQC, GMC or other – may be the most appropriate action.

Again, it should be remembered that you have a professional duty to protect patients' interests. If you are aware of a serious risk arising in another hospital or trust, and you do not do anything about it, your own probity could be called into question.

Support from the RCS

The RCS is committed to supporting and advising surgeons raising concerns. There are two main sources of advice: the Directors of Professional Affairs (DPAs), and the Professional Standards Directorate. The RCS also provides an important service: the Invited Review Mechanism.

Directors of Professional Affairs

The DPAs are College members appointed to carry out an advisory role within a specific region. The names of the DPAs appear on the RCS website in the regional information pages.

Professional Standards Directorate

The Professional Standards Directorate has a dedicated team that runs the RCS Invited Review service, working closely with a member of the College Council who chairs the Invited Review Mechanism. The team is always happy to discuss any assistance that might be required by fellows and members or other healthcare professionals managing surgical services.

Invited Review Mechanism

The RCS can provide (generally to NHS trusts but also to other providers) invited reviews of individual surgeons or surgical services. Invited reviews are in-depth peer reviews of either an individual surgeon's practice or the delivery of a surgical service.

The RCS will only provide a review if invited by a trust or another organisation. The review is normally requested by a medical director or chief executive, although the process might have been originally instigated by the surgeons themselves. Terms of reference will be agreed between the organisation commissioning the review, the RCS and the review team in advance of any invited review visit. The review team will normally be made up of two surgeons from the specialty concerned (one representing the RCS and the other representing the specialty association) and an experienced non-medical professional. The review team will interview relevant personnel and consider documentation before providing a detailed report addressing the agreed terms of reference.

Invited reviews are carried out on a confidential basis on behalf of the organisation commissioning them, subject to the duty to report any unresolved patient safety concerns to an appropriate regulator. The process is advisory, but the RCS will follow up with the organisation that commissioned a review to ensure that the recommendations made have been considered and addressed.

Appendix

References

1. Bridgewater B, Cooper G, Livesey S, Kinsman R eds. *Maintaining Patients' Trust: Modern Medical Professionalism.* Henley-on-Thames: Dendrite Clinical Systems Ltd; 2011.
2. Travaglia J, Debono D. *Mortality and morbidity reviews: a comprehensive review of the literature.* Sydney: University of New South Wales; 2009.
3. Vincent C. *Patient Safety.* Edinburgh: Elsevier Churchill Livingstone; 2006.
4. Antonacci AC, Lam S, Lavarias V *et al*. A report card system using error profile analysis and concurrent morbidity and mortality review: surgical outcome analysis, part II. *J Surg Res* 2009; **1**: 95–104.
5. McCulloch P, Altman DG, Campbell WB *et al*. No surgical innovation without evaluation: the IDEAL recommendations. Lancet 2009; 374: 1,105–1,112.
6. Rogers W, Lotz M, Hutchison K *et al*. *Identifying surgical innovation: A qualitative study of surgeons' views*. Awaiting publication.
7. Good Medical Practice. General Medical Council. http://www.gmc-uk.org/guidance/good_medical_practice.asp (cited 24 January 2013).
8. Raising and acting on concerns about patient safety. General Medical Council. http://www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp (cited 24 January 2013).
9. The NHS Constitution for England. Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961 (cited 24 January 2013)
10. British Standards Institute. PAS 1998:2008 Whistleblowing Arrangements Code of Practice. London: BSI; 2008.
11. Firth-Cozens J, Firth RA, Booth S. Attitudes to and experiences of reporting poor care. *Clinical Governance* 2003; **8**: 331–336.
12. Public Interest Disclosure Act 1998. legislation.gov.uk. http://www.legislation.gov.uk/ukpga/1998/23/contents (cited 24 January 2013).
13. Whistleblowing. British Medical Association. http://bma.org.uk/practical-support-at-work/whistleblowing (cited 24 January 2013).
14. Confidentiality: NHS Code of Practice. Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253 (cited 24 January 2013).

Resources

RCS Invited Reviews

http://www.rcseng.ac.uk/surgeons/support/employers/irm

The RCS is committed to supporting employers in resolving concerns about the clinical performance of an individual surgeon or surgical unit. Through the Invited Review Mechanism (IRM), the College can provide a fair, independent and professional review process to determine if there is a cause for concern and make recommendations for improvement. The College believes that action should be taken locally at the earliest possible stage with the aim of remedying problems before they affect fitness to practise or impact on patient safety.

Concerns about performance may be highlighted from a number of sources, including local clinical governance process, the appraisal process, other members of the surgical team or through surgical outcome data. The College recommends a staged and proportionate response to investigating concerns, considering both the individual and the environment in which they work. Employers will already have pathways for dealing with performance concerns. The IRM is provided to support, not replace, existing procedures for dealing with such issues.

The IRM provides a service that covers all surgeons working in the NHS and private sector in England, Wales and Northern Ireland.

- Individual reviews assist hospitals in identifying whether there is a case to be answered with regard to alleged inappropriate or unsatisfactory surgical performance of a surgeon.
- Service reviews provide an independent expert opinion in relation to concerns about a specific surgical department/unit.

The review mechanism is flexible and the College will work with the commissioning hospital to develop the appropriate terms of reference to address the concerns that have been highlighted.

NHS and Social Care Whistleblowing Helpline

0800 724 725
www.wbhelpline.org.uk

The NHS and Social Care Whistleblowing Helpline provides free, independent, legally compliant advice. It is run by the charity Mencap. The website provides updates, guidance and information as well as a range of materials and resources.

The telephone helpline is operated by legally trained advisors on weekdays from 9am to 6pm. A voicemail service operates out of hours, and messages will receive a response to the next working day. There is also an email facility that operates a 24-hours service.

The helpline is not a disclosure line and therefore does not replace the need to refer your concerns in due course to your employing organisation or a relevant external body. However, it can help you think through how to act to achieve the best outcome.

What happens when you call the helpline?

The helpline advisors provide first-line triage services. They can help by outlining the process and your legal rights, discussing your options, raising other considerations or signposting other departments or organisations that can provide additional support or information. Where complex concerns are raised, the advisor may feel it appropriate to refer the matter to the Mencap legal team or the whistleblowing policy manager, who will call back at an agreed time.

Callers are requested to provide as much information as possible about the concern and some basic details about themselves such as location, sector, gender etc. However, it is recognised that you may not want to divulge personal details such as your name or location, and if this is the case the call will be logged as anonymous. Calls are not recorded but details are logged on a secure database so the progress of the call can be tracked for service improvement and training purposes.

Unless you have given express permission, all calls are held in strict confidence. In rare circumstances the helpline has a legal obligation to disclose details of calls to the authorities, for example where a serious crime is occurring or is about to take place.

Care Quality Commission

03000 616161
www.cqc.org.uk/contact-us

The CQC can be contacted between 8.30am and 5.30pm. It has produced a detailed account of how it responds when concerns are raised. This can be downloaded via the 'Whistleblowing' tab on the contact section of the CQC's website

It is recommended that you look at the document titled *Whistleblowing: Guidance for Workers*, which is more informative than the Quick Guide on the same page.

General Medical Council

0161 923 6402
www.gmc-uk.org/concerns/making_a_complaint/a_guide_for_health_professionals.asp

Full information on raising concerns about a doctor with the GMC may be found on their website. Further guidance on raising concerns can also be found here:
www.gmc-uk.org/guidance/ethical_guidance/decision_tool.asp#slide_intro

Produced by RCS Publications

The Royal College of Surgeons of England
35–43 Lincoln's Inn Fields
London
WC2A 3PE

The Royal College of Surgeons of England
35–43 Lincoln's Inn Fields | London | WC2A 3PE
www.rcseng.ac.uk
Registered charity no 212808