Authors' Information

Dental Update invites submission of articles pertinent to general dental practice. Articles should be well-written, authoritative and fully illustrated. Manuscripts should be prepared following the Guidelines for Authors published in the April 2005 issue *(additional copies are available from the Editor on request)*. Authors are advised to submit a synopsis before writing an article. The opinions expressed in this publication are those of the authors and are not necessarily those of the editorial staff or the members of the Editorial Board. The journal is listed in *Index to Dental Literature*, *Current Opinion in Dentistry* & other databases.

Subscription Information

Full UK £158 | NON UK £202
Retired GDP £93
Student UK Full £51 | Foundation Year £95
11 issues per year
Single copies £24 (NON UK £35)
Subscriptions cannot be refunded.

For all changes of address and subscription enquiries please contact:

Dental Update Subscriptions
Mark Allen Group, Unit A 1–5, Dinton Business Park, Catherine Ford Road, Dinton, Salisbury SP3 5HZ
FREEPHONE: 0800 137201
Main telephone (inc. overseas): 01722 716997
E: subscriptions@markallengroup.com

Managing Director: Stuart Thompson
Design/Production: Lisa Dunbar
Design Creative: Georgia Critoph-Evans

Dental Update is published by: George Warman Publications (UK) Ltd, which is part of the Mark Allen Group.

MARK ALLEN GROUP
www.markallengroup.com

GEORGE WARMAN PUBLICATIONS (UK) LTD
Unit 2, Riverview Business Park, Walnut Tree Close, Guildford, Surrey GU1 4UX
Tel: 01483 304944, Fax: 01483 303191
email: **astroud@georgewarman.co.uk**
website: **www.dental-update.co.uk**

Please read our privacy policy, by visiting **http://privacypolicy.markallengroup.com**. This will explain how we process, use & safeguard your data.

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW
DENTISTRY

The Dental Faculty of the Royal College of Physicians and Surgeons of Glasgow offers its Fellows and Members *Dental Update* as an exclusive membership benefit.

abc

DU ISSN 0305-5000

Trevor Burke

Is whistle-blowing working?

Whistle-blowing is in the news. The recent release of the film Official Secrets (with a powerful performance by Keira Knightley) is based upon the true story of Katharine Gun, a British intelligence specialist working at GCHQ, whose job involved handling of classified information. In 2003, she received a memo from the US National Security Agency containing a directive, namely, that the United States was enlisting Britain's help in collecting compromising information on United Nations Security Council members in order to blackmail them into voting in favour of an invasion of Iraq. Ms Gun was outraged by this email, as she considered (correctly) that this would lead to war in Iraq. She made a copy of the email, took it home, deliberated for several days, then made the decision to leak the memo to the press. This whistle-blowing act did not end well. Following the publication of the leaked memo, Ms Gun was arrested and charged under Section 1 of the Official Secrets Act. She was initially held in custody, spending several nights in a police cell, and the case eventually came to court in February 2004, giving Ms Gun almost a year of torture: however, the case was dropped within half an hour of its opening because the prosecution declined to offer evidence, the reasons for this being unclear.

At the time of writing, the world's press (in the West at least) are awaiting the trial relating to the impeachment of President Trump. Central to the proceedings is a report by a whistle-blower who asserted that the President abused his powers by pressurizing Ukraine's President Zelensky to investigate the family of Joe Biden. It remains to be seen how that will end for the whistle-blower and the President, mired as it is in the politics of an US election year.

In dentistry, as in medicine, we have been encouraged to report failings in care when we witness actions which are sufficient to raise concerns. While this should always have been the duty of a healthcare professional, it was given renewed vigour by the so-called Francis Report into the problems at mid-Staffordshire Hospital.[1] Among the many recommendations in the report, a principal finding was that everyone must ensure that patients are *always* put first, as opposed to meeting targets and the like. It added that staff should agree on what is good care for patients, and make a note of when this does not happen, so that care can be improved. The report stressed that there should be openness and honesty if things do not look right, in other words, staff should be able to tell someone if they are worried about deficiencies in patient care. The report also stressed that all those who provide care for patients should be accountable for what they do, and ensure that the public is protected from those not fit to provide such a service. I will remind readers that the report stressed the need for:

- Openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered;
- Transparency: allowing true information about performance and outcomes to be shared with staff, patients and the public;

■ Candour: ensuring that patients harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made.

As a result, a statutory obligation is now in place, ensuring that there is zero tolerance of any service that does not comply with fundamental standards of service. In summary, the report stressed the need to be honest, open and truthful in all dealings with patients, putting the patient first, with standards formulated to promote the service being delivered safely and effectively. It also set out guidelines for complaints handling, with the investigation of a complaint being initiated by the provider Trust and recommending that, where meetings are held between complainants and Trust representatives as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.

So, taking all of the above into consideration, we can ask the question – is whistle-blowing (something that we have been encouraged to do) working? I sadly report a couple of similar instances of which I am aware, in which a dentist spotted what he/she considered to be a blatant affront on patient care. As per the recommendations that I have outlined, the dentist reported these to the appropriate authority, bearing in mind the need to put patients first. The dentists involved were both suspended and the persons about whom the complaint was made countered by claiming bullying and harassment by the complainant, denying any wrongdoing. This made it untenable for the complainant to continue working in this environment until the complaint was settled. However, despite the fact that the first priority for any organization should be ensuring that patient safety and quality standards are being met, the complained-against person is continuing to operate without any change, while the whistle-blower has been severely disadvantaged. These are examples of a poorly managed complaint and appear to be a serious failing on behalf of those investigating the incident: as a result, the whistle-blowers have suffered, which is not in the spirit of the concept. In this regard, the Royal College of General Practitioners (RCGP) have published a document on whistle-blowing in the NHS.[2] In this they state that some individuals who have blown the whistle, and taken their concerns to individuals and bodies outside normal channels, have suffered severely in relation to their career prospects and their working environment, adding that they (the RCGP) find this unacceptable. This echoes the cases that I have outlined.

I am also aware of an anomaly in which (in England at least), FD1 educational supervisors can cancel their contract as a trainer at short notice, leaving the trainee high and dry. This is exactly what has occurred when FD1 dentists raised complaints about their trainers. I am aware of two such cases, but those circumstances make raising a complaint as an FD1 a matter of being employed or unemployed at a critical part of the trainee's career. Again, it is my view that these cases have been inadequately managed and there is obviously something wrong here which needs addressing.

A new type of whistle-blowing has recently appeared. These are the so-called 'blue on blue' complaints, the term having arisen, I believe, from the book *Blue on Blue: An Insider's Story of Good Cops Catching Bad Cops*.[3] In the context of this editorial, this relates to dentists raising concerns about their business dealings with another dentist or dentists: readers will be aware that this is something that has been happening for as long as dentists have had dental practices. However, once the complaint suggests that the concern spills over into problems with patient care, as well as the business of dentistry, it falls into the remit of the General Dental Council (GDC). I recently listened to an excellent lecture given by Catherine Rutland, Clinical Director at Denplan (Simply Health), in which she described the politics of UK dentistry and advised the audience that her information from the General Dental Council indicated that 'blue on blue' reporting/whistle-blowing was on the rise.

Also on the rise are Non-Disclosure Agreements (NDAs). This is a catch-all term for agreements which include confidentiality clauses, which could also colloquially be termed gagging orders. In these, the NDA seeks to prevent employees from talking about the terms, facts and circumstances leading to the settlement of a claim by a complainant. In industry, these may also relate to an employee being paid not to divulge a new discovery or the like. However, this is not applicable to healthcare, in which it would appear some payments are made to quieten employees who complain. I have not been able to find exhaustive details of the extent of these, but can give readers an example: The South-East Coast Ambulance Service paid out, for NDAs, just under £300,000 from three financial years to 2017. By the way, whistle-blowing is not confined to the NHS. The BBC has revealed that UK universities have spent around £87 million on payoffs to staff that come with NDAs since 2017. More of this in another *Comment*.

In healthcare, the term 'raising concerns' is probably more appropriate than whistle-blowing, given that whistle-blowing has, in the past, had negative connotations.[4] The term 'speaking up' has also been suggested and, indeed, NHS Trusts should have a 'speak up guardian'. Whatever the term, whistle-blowers do not take their actions without great thought, given that they will have had an honest belief that wrongdoing has occurred or is occurring. To blow the whistle is, in my view, a brave and honourable decision. Different dentists will have differing views on how serious a wrongdoing might be. In this regard, it would seem that there is a need for a comprehensive list of unacceptable practices, classified according to their seriousness, for example:

■ Deficiencies which may lead to patient harm. This might include

regular failure to collect a medical history;
- Deficiencies which may lead to inadequate treatment of a patient's dentition: this might include a regular failure to produce a cavity which will adequately retain a (non-adhesive) restoration or formulate a treatment plan;
- A combination of both might, for example, include routine failure actually to write up patient notes.

The Francis report[1] indicated that whistle-blowers were often treated poorly, many being forced out of their jobs as a result of speaking out. Has anything been done to change this? In dentistry, we need to move away from poor management of concerns which are raised. And, as Holden has written[4] '*whistle-blowing must be viewed in the frame of altruism, as an activity that is undertaken in the best interests of patients*'. Adding, '*that the dental profession should reflect upon how those who raise concerns and whistle-blow are perceived*'.

Perhaps it is worth mentioning the Daughter Test[5] in this context. This stated that, when a clinician conceives a treatment plan, the clinician should ask oneself if (s)he would carry out that treatment plan on his/her daughter, and, if not, change the treatment plan. Similarly, if treatment which is viewed by a clinician falls short of accepted standards, and if this is seen time and time again, then the environment should be appropriate for the clinician to raise concerns. At the time of writing, it seems questionable whether whistle-blowing is working as it was intended.

Postscript: The Editor encourages readers to send in their experiences of whistle-blowing/raising concerns. These could then be published (anonymously, if requested) in a future 'Letters to the Editor' feature.

References

1. Francis R. Freedom to speak up: an independent review into creating an open and honest reporting culture in the NHS. 2015. Available at: **http// webarchive.org.uk**
2. Royal College of General Practitioners. Whistle Blowing in the NHS. **https.// www.rcgp.org.uk/policy-areas/ whistle-blowing-in-the-nhs.aspx**
3. Campisi C, Dillow GL. *Blue on Blue: an Insider's View of Good Cops Catching Bad Cops*. New York: Scribner, an imprint of Simon and Schuster, 2017.
4. Holden ACL. "Blowing the whistle": the ethical, professional and legal implications of raising concerns and self-regulation within dentistry. *Aust Dent J* 2018; **63**: 150–155.
5. Burke FJT, Kelleher MJD. The "daughter" test in elective esthetic dentistry. *J Esthet Restor Dent* 2009; **21**: 143–145.