THE PRICE OF SILENCE

Despite government outlawing of gagging clauses in NHS contracts, **Jonathan Gornall** reports a new case that shows at least one trust has continued to use them

A nurse is struck off (later reduced to suspension on appeal) for assisting a secret BBC exposé of care standards[1]; an NHS trust seeking foundation status is accused of putting financial interests first and ignoring staff concerns about inadequate staffing levels and patient safety.[2 3] Both of these recent episodes have reinforced concerns that, despite the repeated assurances of politicians, whistleblowers in the NHS remain an endangered species.

Launching the BMA's whistleblowing guidance and helpline for hospital staff at the organisation's annual representative meeting earlier this year,[4] chairman Hamish Meldrum said that such cases "send out completely the wrong message to those health professionals who might want to speak out about unacceptable conditions."[5]

Now evidence has emerged that, almost a decade after the Public Interest Disclosure Act was passed, a foundation trust went to remarkable lengths to ensure that a senior consultant did not go public with his concerns about management and patient safety.

Rarely do such cases see the light of day—disagreements between consultants and their trusts generally end in a parting of the ways shrouded in the mutual secrecy of a compromise agreement. However, thanks to a related disciplinary hearing before the Bar Standards Board, documentation relating to a dispute between Liverpool Women's NHS Foundation Trust and Peter Bousfield, a long serving consultant—including the compromise agreement that gagged him from commenting publicly about his concerns—has now come to light.

Peter Bousfield tried to raise patient safety concerns

The hearing arose after Peter Bousfield's son, a non-practising barrister who works in the media, attempted to represent his father in correspondence. The trust refused to deal with him and authorised its solicitors to lodge a complaint about his activities with his professional regulator. In May a disciplinary tribunal of the Bar Standards Board reprimanded Andrew Bousfield for "holding himself out to be a barrister . . . in correspondence with Mace and Jones solicitors" and, by sending "abrasive, intemperate" correspondence, for engaging in conduct discreditable to a barrister "and/or likely to diminish public confidence in the legal profession."[6]

In his defence statement, submitted to the hearing, Andrew Bousfield claimed his father thought that "the gag clause was sprung upon him, late in the day, when his early retirement had already been agreed . . . to cover up [his] whistleblowing claims. As a former Medical Director of a large hospital site, his voice has been silenced."

However, Andrew Bousfield told the *BMJ* he was appealing. "Backed by eminent QCs, I am appealing the findings arguing that the complaint was used by the Trust at public expense as a vindictive measure to silence legitimate patient safety concerns. Liverpool Women's Hospital has spent nearly £40 000 of public money instructing lawyers to prevent the release of information and to bring a personal complaint against me in my professional body," he said.

The documents also show that not only was a non-disclosure clause incorporated into the compromise agreement at the behest of the trust, contrary to NHS guidance, but the trust's solicitors also threatened Mr Bousfield with a court injunction if he tried to bring matters to the attention of local members of parliament.

Cause for concern

Mr Bousfield, a senior consultant gynaecologist at Liverpool Women's Hospital, was offered early retirement and a termination payment in April 2007 after he had raised a series of concerns about patient safety at the trust's Aintree University Hospital site, where he had worked since 1981 and, before reorganisation in 2000, had been medical director for four years.

Operations, he said, were being conducted with insufficient staff, particularly theatre assistants and registrars. He also raised safety concerns related to Liverpool Women's Hospital, which in his view lacked the back-up facilities of a general hospital; as a result, he claimed, operations were often delayed while specialists had to be called in from the Royal Liverpool Hospital.

On 26 May 2006, he wrote to the then chief


STEVE BELL/REX

"We will not tolerate management that bullies or discourages whistleblowers."
Former health minister, Ben Bradshaw


DAVID JONES/PA

"The reality is that devices are being employed by certain hospitals and hospital authorities to bypass the 1998 Act."
William Cash MP

"The Trust does not accept that the contents of that agreement conflict with the Trust's whistleblowing policy."
Liverpool Women's Hospital

"Regulated health professionals . . . are under a professional obligation to raise concerns about patient safety."
David Grantham

executive, Louise Shepherd, outlining his concerns and referring to the case of a patient found moribund and whose life threatening condition, he said, had almost been overlooked. "The experience of the patient," he wrote, "is I believe by no means unusual." A staff nurse had commented to him that "being on duty at LWH over a bank holiday weekend was . . . like being on the Marie Celeste."

In a statement to the *BMJ*, Kathryn Thomson, who succeeded Ms Shepherd as chief executive in April this year, said the trust "did not accept that in 2006 its staffing levels were inadequate" and that responses addressing Mr Bousfield's concerns had been sent by the medical director on 9 June and by the chief executive on 16 June.

The documents show that on 26 June Mr Bousfield was invited to a meeting with the trust's chairman, Ken Morris, to discuss "the issues you describe, in particular the concerns you have around Junior Doctor allocation." In a letter to Mr Bousfield written later that day, Mr Morris wrote that "given the significant personal concerns you expressed in our meeting," he had asked the chief executive to "look at the option of helping you personally to move on by facilitating early release from your contract of employment, if these concerns cannot be satisfied by the Trust."

The letter took Mr Bousfield by surprise. It was, he wrote back on 3 July, "unusual wording" that seemed to imply a threat of either dismissal or redundancy.

There was another surprise in store for him. Just three days later, the head of midwifery and women's health submitted a formal complaint, alleging that, according to a student midwife mentor, Mr Bousfield had "verbally humiliated" a student midwife in the antenatal clinic in the Aintree Centre for Women's Health and "physically assaulted" her by hitting her on the head three times.

Though clearly serious, and denied by Mr Bousfield, the allegation was never formally investigated. It was, however, used by Ms Shepherd, the trust's chief executive, as a threat. On 4 September 2006, she wrote to Mr Bousfield to say "should we not be able to agree a suitable arrangement regarding your early retirement within the next few weeks, I will have a duty to formally investigate those claims further."

In the light of the findings from the Healthcare Commission's 2007 national NHS survey that in 12 months 20% of staff at Liverpool Women's Foundation Trust had suffered harassment, bullying, or abuse from colleagues or managers, the fact that a serious complaint was not formally investigated is an uncomfortable revelation.[7]

On 18 September, Mr Bousfield replied to Ms Shepherd's letter: "I was under the impression that I was to see this complaint and be given the opportunity to respond to it regardless of my employment intention . . . To attempt to use this sort of information as a 'bargaining chip' confers no credit."

Peter Bousfield told me that "As the story unfolded it became evident that there was no formal written complaint. There's a formal complaints procedure and stage one is that there has to be a complaint from the person who is aggrieved."

Asked why such a potentially serious allegation had not been dealt with formally, Ms Thomson said only: "The complaint was considered on an informal basis and remained unresolved at the time of Mr Bousfield's departure from the Trust," which was almost a year later.

Mr Bousfield retired on 1 April 2007, although, because of a disagreement over pension entitlement he did not sign the trust's compromise agreement until 19 September. He received £166 200.98 (€196 236; $282 489)—a contribution to his pension scheme of £103 100.98 and £63 100 in compensation for termination of employment.

By then, he says, "I felt that I had done everything I possibly could within the trust to correct the wrongs as I saw them. I threatened to go outwith the trust and at that point the trust made it perfectly plain that my long-term future with them was non-existent, but they were prepared to offer a sum of money by way of compensation.

"I had had it, to use the phrase, up to my neck and I felt that after years of fighting I didn't want any more. I have to say I was rather ashamed at myself and still do occasionally think that, but I'd done everything I possibly could."

He still tried to do more, though by now the threat of losing his severance package hung over him. On 5 November 2007, after he had finally received the money, Mr Bousfield wrote to the chief executive. During the

course of the meeting he had had with her and the chairman in June, he wrote, "it was evident there was little interest in resolving [the] medical issues" he had raised. "I cannot and will not let these issues rest," he continued, and outlined plans to write to the Secretary of State for Health and the members of parliament who represented the constituencies served by Aintree University Hospital.

He gave the trust a deadline of 26 November by which it should respond. On 23 November, the trust's solicitors, Mace and Jones, wrote back to say that, although they did not consider that the compromise agreement "affects any communication between you and the Trust Board or the Secretary of State for Health . . . any wider communication would be in breach of . . . the compromise agreement." Mace and Jones warned him that, unless he confirmed by 30 November that he would abide by the terms of the compromise agreement and promised not to copy his letter of 5 November to "anyone other than the members of the Trust Board and the Secretary of State," the trust reserved its right to apply for a court order to restrain him from so doing.

It was a threat in which the trust itself had little confidence. In a confidential briefing produced for the Healthcare Commission in January 2008, the chief executive and chairman of the trust noted: "The Trust has considered taking an injunction should Peter Bousfield breach the confidentiality clause . . . but believes that is not in the best interests of either the Trust as a public body or the wider NHS."

Gagging clauses

Whether or not such an injunction was in the best interests of the trust, the effect of the gagging clause it had insisted on did not seem to be consistent with section 43 (J) of the Public Interest Disclosure Act 1998, which states: "Any provision in an agreement to which this section applies is void in so far as it purports to preclude the worker from making a protected disclosure." As well as protecting disclosures to employers and "prescribed persons," the act protects any worker who, having already made the disclosure to his employer, remains concerned and elects to tell another person or body, provided he does so in good faith, "reasonably believes" the allegations are true, and does not make the disclosure for personal gain.

Furthermore, gagging clauses have been specifically prohibited in NHS employment contracts since before the act was passed. In a letter to chief executives of NHS trusts and health authorities issued in September 1997, the health secretary wrote: "Confidentiality ('gag- ging') clauses

FALLING FOUL OF GAGGING CLAUSES

Doctors who leave trusts "under a cloud" can also have gagging clauses made in their favour, making it difficult for future employers to find out what went wrong and leaving them free to repeat their behaviour. These legal restrictions make it difficult to raise concerns about a doctor's competence. The *BMJ* has uncovered a case of one consultant currently working as a locum who has left two trusts with gagging clauses concealing the reasons for the departures. Jane Cassidy hears how a concerned medical colleague who tried to report the consultant to the General Medical Council got into trouble for breaching the gagging clause

"My problem was with my recently appointed consultant colleague. I had concerns about the consultant's competence, and nurses witnessed shortcomings and informed me of them. My managers said I must do what I thought right. I submitted my complaint, and the individual was swiftly removed from clinical practice. An excellent start.

There were more detailed reports from me and various meetings, although I was kept in the dark about meetings with my colleague. Then things seemed to deteriorate. The consultant's previous trust had agreed a gagging clause and seemingly had been keen to be relieved of the doctor's services whatever happened in future.

We found out when my medical director contacted their opposite number at the doctor's last employer, in response to my complaint, and was told nothing could be discussed because of the gagging clause.

When the doctor finally left my trust, another gagging clause was imposed. Before this happened, I felt my employers found it tedious that we could not reach resolution. I was advised the consultant must return to duties because of legal pressures.

I felt nothing had changed, the consultant's clinical practice had not been assessed by someone in the specialty and I would not agree to reinstatement. I was solidly supported by the senior nurse. Management backed down, but we were told later that we were nearly disciplined.

I understand the accused will usually counter claim. A letter was sent to the medical director, which suggested that the consultant had accused me before I raised concerns. I was obliged to respond to the charges. Fortunately, there was no case to answer. However, since none of us is perfect, it is easy to see how tables could be turned.

The trust took the view that both whistleblower and accused should be judged equally, as if a whistleblower is likely to have base motives. When I was told the doctor had resigned hours before a trust disciplinary hearing, I wrote to the GMC.

I felt incensed that another trust had allowed this to happen and that even when two trusts were aware of repetitive behaviour they did not, or could not, join forces to save a third from employing this person.

I knew I must refer any inquiries from potential employers to the trust and say nothing. However, I still fell into a legal trap. I told the GMC in my letter that I could not recommend this individual to a consultant asking for a reference. When this information was passed on to the consultant by the GMC, which I accept is normal policy, the individual complained, and I was subject to a trust disciplinary inquiry for breaching the gagging clause.

I was cleared but still feel unhappy that this doctor could be employed by someone unaware of their past. There were no recommendations for retraining, special supervision, non-consultant grading, for instance, so this person could strike again.

Although my trust did fairly well compared with others, the system for raising concerns is unclear and does not serve patients and decent staff well. The legal status of gagging clauses also seems very unclear. Releasing information in these circumstances seems to be very complicated, and no one seems to know how to do it. I recommend any whistleblower to try to find strong, loyal colleagues equally committed to good practice and willing to expose bad."

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BMA VIEW ON WHISTLEBLOWING

The question "What are doctors for?" has been considered in the *BMJ* on more than one occasion. The straightforward answer is that our fundamental responsibility is to provide care of the highest possible quality to our patients and do all we can to guarantee their safety—no matter what obligations we have to any other parties, including our employers. The BMA's guidance on whistleblowing recognises the huge courage that is often required to act as an advocate for patients.[1] It also identifies raising concerns as a professional duty that needs to be fulfilled in a professional way. Internal mechanisms should be respected and adhered to from the start—we would not argue for the right of staff to bring personal vendettas to the media before employers have had an opportunity to deal with the concerns.

BMA NEWS

Mark Porter: employers must promote a culture of openness

Some behaviour by senior managers is, however, unacceptable. A recent BMA survey showed the extent of the poor treatment of those brave enough to put their heads above the parapet. A significant proportion (15.5%) of hospital doctors in England and Wales who reported concerns said that their trusts had indicated that speaking up could negatively affect their employment.[2] And although public disclosure of a specific issue may not always be appropriate—for example, when it would jeopardise patient confidentiality—the option to go outside must always be open. To say there are no circumstances in which a concern for patient safety can be raised outside the organisation, or to attempt to enforce silence through a contractual mechanism, is appalling.

The NHS is, and must be, a learning organisation. Processes need to be in place to allow staff to raise their concerns, to reflect on any failings, and to make changes if necessary. Employers who do not promote a culture of openness are failing in their duties to staff and patients alike. The contract doctors have with their patients collapses if they are unable to take their concerns to someone who will listen.

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on NHS employment contracts contravene NHS Executive policy. I believe that such clauses discriminate against staff's rights and responsibilities to bring unacceptable practices into the open and that there is no place for them in the NHS."[8]

This position was reinforced in August 1999, when the Department of Health issued guidance on whistleblowing: "Ministers expect a climate of openness and dialogue in the NHS," it said. "Every trust and authority should have in place policies and procedures that complied with the new Act, and such policies should prohibit confidentiality 'gagging' clauses in contracts of employment and compromise agreements which seek to prevent the disclosure of information in the public interest . . . Confidentiality clauses have no place in NHS employment contracts. Any settlement on termination must be available for proper public scrutiny . . . Gagging clauses in employment contracts and severance agreements which conflict with the protection afforded by the [Public Interest Disclosure] Act [1998] will be void."[9]

A spokesman for Monitor, the regulator of foundation trusts, said there was no question that "NHS foundation trusts should not include within compromise agreements or contracts of employments any gagging clauses which seek to prevent the disclosure of information in the public interest. Gagging clauses which conflict with the protection afforded by the Public Interest Disclosure Act 1998 (the Act) will be void."

All NHS trusts, said a spokesman for the Department of Health, were required "to prohibit the inclusion of confidentiality 'gagging' clauses in contracts of employment, and compromise agreements which seek to prevent the disclosure of information in the public interest."

I asked Liverpool Women's Hospital if it was aware of the guidance prohibiting the use of gagging clauses, how it justified the use of such a clause, and whether it considered its actions towards Mr Bousfield were in keeping with the spirit of the statement by Ben Bradshaw, the then health minister, this May. The government, he said, fully supported whistleblowing. "We will not tolerate management that bullies or discourages whistleblowers. Listening to and acting on the concerns of staff are vital ways to drive up standards and help ensure against poor or unacceptable quality care."[10]

The answer began factually, if evasively: "Each of the provisions of the compromise agreement entered into by the Trust and its employee were settled and agreed by lawyers acting on behalf of each party" and concluded by answering a charge that had not been put: "The Trust does not accept that the contents of that agreement conflict with the Trust's whistle blowing policy."

Isolated case?

Despite the difficulty in determining the frequency with which such clauses are used in NHS termination agreements, there is some suggestion that what happened in Mr Bousfield's case in Liverpool might not be an isolated incident.

In July, after a long struggle for access under the Freedom of Information Act, Andrew Bousfield succeeded in getting Liverpool Women's Hospital to release details of all compromise agreements it had entered into with doctors between 1998 and 2009. The 11 other compromise agreements released included termination payments ranging from £1216 to £63 077; five were over £25 000.

All of the agreements featured gagging clauses; three of the largest payments came with clauses specifically banning the doctor from speaking to the media. Five agreements included a penalty clause threatening recovery of the full amount in the event of a breach of the contract by the employee.

And Liverpool may not be alone. "We are hearing anecdotally that these compromise agreements are being done with quite blatant clauses in them, whereby people are being paid a specific amount extra not to say anything," said a spokesman for Public Concern at Work (www.pcaw.co.uk), the charity that has worked with the Department of Health since the birth of the act and operates a whistleblowing helpline for NHS staff.

A review of patient safety published by the House of Commons Health Committee on 3 July concluded: "The NHS remains largely unsupportive of whistleblowing, with many staff fearful about the consequences of going outside official channels to bring unsafe care to light." How a trust treated whistleblowing, it added, was "an important measure of an organisation's safety culture."

The question of why—despite government reassurances and the supposed protection of the Public Interest Disclosure Act—no whistleblowers had stepped forward to expose the failings at Mid Staffordshire General Hospitals NHS Trust, where patients may have died because the concerns of medical staff were not taken seriously, was addressed during a House of Commons debate on 12 May. William Cash, MP for Stone, said "there are whistleblowers, but they are terrified to come forward. The reality is that devices are being employed by certain hospitals and hospital authorities to bypass the 1998 Act."[11]

He also brought it up in Parliament again on 12 October this year, saying that a lot of problems that arise "relate to gagging clauses".

"The trouble with the Act that enables whistleblowing—the Public Interest Disclosure Act 1998—is that it's not working. Gagging clauses should be banned by law," he said.

"Great ingenuity is being used by certain trusts—not just Mid Staffordshire but other trusts of which I am aware—that are using their lawyers and their medical establishment effectively to bypass and shut out consultants—in some cases, as many as 20-odd. I am concerned about that. It is no good having good intentions in an Act if the provisions can be bypassed in the way that they are being bypassed at the moment," he added.

"I'm not painting myself as a saintly paragon of virtue, but as somebody who was well intentioned, hard working, with a second to none clinical record who became a nuisance because I was unwilling to accept the drop in standards that was blatantly obviously there."
Peter Bousfield

Obligation to speak

Not blowing the whistle could leave a doctor in a dangerous position. David Grantham, head of programmes at NHS Employers, points out that failing to speak up is never a safe and acceptable option for doctors: "Regulated health professionals, including doctors, are under a professional obligation to raise concerns about patient safety. Entering into a legal agreement not to pursue genuine concerns where they exist in exchange for financial settlement could be a breach of that obligation."

Mr Bousfield says he is happy for his case to be used as an example of the dilemma that may face others in his position and speaks frankly about his decision to take the money and walk away: "I would have to accept that that is a weakness in the position in which I then and now find myself. But one has to accept that there are commercial considerations in this world and to finish work early left me with a huge amount of unpaid mortgage. The lump sum was used to pay off the mortgage, in the way that my salary, had it continued for another two or three years, would have been used. That's part of the position that many people find themselves in.

"The judgment I had to make was 'Do I want to continue working with these people for another three years under the circumstances as they are, because I have tried to change them and failed, or if they're offering me a sufficient lump sum to pay off a mortgage, do I cut my losses and run and save my own coronary arteries?'"

He remains, he says, "very sad that I am no longer working. Had there never been this horrendous merger with the Liverpool Women's Hospital then I think I would now still be working and very happily so."

For doctors who find themselves in Mr Bousfield's position, the final word on whistleblowing can be found in paragraph six of the General Medical Council's *Good Medical Practice*.[12] "The GMC expects doctors to put patients' interests first," a spokeswoman said. "Doctors have a duty to protect patients from risk of harm and our guidance says that doctors must put the matter right or raise concerns where they have good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies, or systems. Where the employer or contracting body does not take adequate action after concerns have been raised, doctors should take independent advice on how to take the matter further."

But fear of falling foul of the GMC, says Mr Bousfield, "was never a consideration . . . I would like to think that my strength of character and professionalism were sufficient to counter any accusations that might be made in that direction.

"I'm not painting myself as a saintly paragon of virtue, but as somebody who was well intentioned, hard working, with a second to none clinical record who became a nuisance because I was unwilling to accept the drop in standards that was blatantly obviously there."

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If you have signed a gagging clause or are concerned that they're being implemented at your hospital, please contact Deborah Cohen, features editor, in confidence: dcohen@bmj.com