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RESPONSE

Whistleblowers: heroes or traitors

John Garrow*

University of London, UK

John Garrow worked for the Medical Research Council in Jamaica and the UK for 33 years. He was professor of human nutrition, based in St Bartholomew's Hospital, until he retired in 1994, and spent a decade editing the European Journal of Clinical Nutrition*. John Garrow has been chairman of the charity HealthWatch for the past nine years.*

Yesterday I spent the day at the Royal College of Physicians. The banner on the College letterhead is 'Setting higher medical standards', in particular, evidence-based medicine (EBM). I listened to a brilliant set of experts talking about fraud and misconduct in medical research. If medical journals report false information about the safety or efficacy of a therapy, this is bad evidence, which will generate bad medicine. All the speakers agreed that fraud and misconduct are a serious threat to EBM, but there was no consensus about how often they occur, who is most to blame, and what is to be done.

The chairman was Richard Tiner, president of the Faculty of Pharmaceutical Medicine (FPM). The first speaker was Frank Wells, a retired pharmaceutical physician, famous for his work on the strict regulation of clinical trials of drugs and healthcare products. Both emphasised the importance of transparency. In an ideal world, the sponsors of such trials would reveal the results of all the trials performed on the product. All the trials would be registered, so that those giving less favourable results could not just disappear without trace. Both speakers insisted that fraud and misconduct in medical research are rare, Wells suggesting its prevalence to be about 1%. He described how the FPM had developed ways to detect and prevent fraud and misconduct, and declared that whistleblowers should be supported, not penalised.

I take a keen interest in whistleblowers. Their value is acknowledged by Wells and Farthing (2008) as 'an essential element of any detection strategy'. Sabine Kleinert (a senior editor of *The Lancet*) is more forthright still: 'Almost every case of research misconduct that comes to light is exposed by some form of whistleblowing …' (Kleinert, 2008). It was Peter Wilmshurst who first raised my concern about the relation of whistleblowers to misconduct in medical research, and the speaker at the end of the morning session was none other than Peter Wilmshurst. Iain Chalmers, the *eminence grise* of EBM, speaks of Wilmshurst as one of his heroes, and he is also one of mine. Not everyone shares this opinion.

In 2003, I was chairman of the registered charity HealthWatch. It promotes EBM, and annually gives an award to the person who (in the opinion of the Committee) has made the greatest contribution towards this EBM. Peter Wilmshurst was the front

*Email: johngarrow@aol.com

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runner for the 2003 award. He had exposed fraud in the research done in prestigious London medical schools, despite advice that such behaviour would not impress the academic elite or increase his promotion prospects. It is understandable that he was not a hero to those individuals whose misconduct he had exposed, but I was surprised that even their colleagues, people who had done no wrong, despised him as a traitor for sullying the name of their institution. A decade later, not much has changed: Wilmshurst (2007) has continued his good work of exposing misconduct, but his profession has offered him no esteem or gratitude.

So, what does the evidence tell us about misconduct in medical research? How common is it? Why do those who regulate the ethics of medical practice have so much contempt, and little use, for whistleblowers? What can be done to improve the situation? It is not really possible to calculate the prevalence of misconduct in medical research because it depends how you define misconduct. The Wells estimate of 1% may be achieved if only major fraud is counted, and many of the 'inaccurate' data are ascribed to carelessness, accident or innocent mistake. Surveys of medical academics in the UK have found that half were aware of cases of research fraud, but very few had reported this to the regulatory bodies, such as the GMC.

Some whistleblowers are not deserving of respect because they are themselves fraudulent. An example is the scandal about the NMR vaccine. It arose because Andrew Wakefield submitted a fraudulent paper to the *Lancet* claiming that the NMR vaccine was linked to neurological disorders in children. His version was enthusiastically supported by some newspapers, despite denials by the Department of Health. Vaccine uptake fell and prevalence of the relevant diseases increased.

Another example is parents accused of abusing their children. They brought many complaints of misconduct against the paediatricians who made these diagnoses in order to discredit them, and the GMC showed gross incompetence in dealing with these complaints. The careers of distinguished clinicians were ruined because the GMC accepted the false accounts from vengeful parents.

Kleinert notes that even whistleblowers with truthful complaints are given little respect. In the US they are often referred to as 'complainants' rather than whistleblowers. A survey of 68 whistleblowers conducted for the Office of Research Integrity (Research Triangle Institute, 1995) in the US reported that eight had been sacked, eight had had their position not renewed, 19 were denied promotion, 29 were pressured to drop their allegations, and 27 were subjected to counter-allegations.

Wilmshurst is being sued for libel because he would not withdraw the statement that the publication of a report on a trial failed to mention serious complications. He was a chief investigator in the trial, but not an author of the report (Dowson *et al*., 2008). The journal published a long correction and apology for mistakes in the original version (Dowson *et al*., 2009).

So, what can be done to improve the situation? The guidelines issued by the FPM are well intentioned, but not very effective. It is one thing to recommend transparency, but there is no way in which it can be enforced. Pharma will not reveal data that are commercially confidential. The advice to support whistleblowers, not penalise them, is charming, but ignored.

It will be evident from the above that I believe that progress against misconduct in medical research requires better treatment of whistleblowers. At present, any young researcher will probably take the advice of his mentors to remain silent if he or she knows about misconduct in research. The threat to promotion, or even employment, is real, so silence is the safer option.

I am so old that I am not risking anything, either socially or financially, by suggesting that a heavy responsibility rests on the RCP to enforce better treatment for whistleblowers – as long as their complaint is true and in the public interest. The idea that concealing misconduct preserves the good name of any medical school or research unit is poisonous.

Who can and should bring about this change in attitude towards whistleblowers? Who better to lead the change than the Royal College of Physicians? In the discussion period of the meeting at which Wilmshurst spoke, I had the cheek to ask what steps our College had taken to support whistleblowers? There were plans to do something, sometime.

References

Dowson, A., Mullen, M., Peatfield, R., Muir, K., Khan, A., Wells, C., Lipscombe, S., Rees, T., De Giovanni, J., Morrison, W., Hildick-Smith, D., Elrington, G., Hillis, W., Malik, I. and Rickards, A. (2008) 'Migraine intervention with STARFlex Technology (MIST) Trial: a prospective, multicenter, double-blind, sham-controlled trial to evaluate the effectiveness of patent foramen ovale closure with STARFlex septal repair implant to resolve refractory migraine headache', *Circulation,* 117, pp.1397–404. Data supplement available from http://circ.ahajournals.org/cgi/data/CIRCULATIONAHA.107.727271/DC1/1; clinical perspective available from http://circ.ahajournals.org/cgi/content/full/117/11/1397#response.

Dowson, A., Mullen, M., Peatfield, R., Muir, K., Khan, A., Wells, C., Lipscombe, S., Rees, T., De Giovanni, J., Morrison, W., Hildick-Smith, D., Elrington, G., Hillis, W., Malik, I. and Rickards, A. (2009) 'Correction', *Circulation,* 120, pp.e71–e72, available from http://circ.ahajournals.org/cgi/content/full/circulationaha;120/9/e71.

Kleinert, S. (2008) 'The role of the whistleblower' in Wells, F. and Farthing, M. (eds) *Fraud and Misconduct in Biomedical Research,* Royal Society of Medicine, London.

Research Triangle Institute (1995) *Consequences of Whistleblowing for the Whistleblower in Misconduct in Science Cases,* Report to the Office of Research Integrity, Rockville, MD.

Wells, F. and Farthing, M. (eds) (2008) *Fraud and Misconduct in Biomedical Research,* Royal Society of Medicine, London.

Wilmshurst, P. (2007) 'Dishonesty in medical research', *Medico-legal Journal,* 75, 1, pp.3–12.