When things go wrong

BY RAY CLARKE

The new-age, Paediatrc Surgeon, **Ray Clarke**, (fear uasal, íseal), eloquently demands throwing off the shackles of the past and welcomes the dawning of an era of openness, transparency and candour, preferably suffused with compassion for both the patient and the doctor.

"A just and learning culture in healthcare, where professionals are able to raise concerns and reflect openly on their mistakes but where those who are responsible for providing unacceptable standards of care are held to account."
Sir Norman Williams, June 2018

Sir Norman Williams's aspiration [1] seems a world away from the mess we have got ourselves in to. I remember fondly one of the last lectures we had just prior to graduation in the early 'eighties. Proud, apprehensive but joyful, and about to be unleashed into the world of real patient care we listened attentively to an avuncular and much-loved professor of medicine as he dispensed nuggets of wisdom to us bright young things. When he came to professional behaviour, ethics, conduct and how we might escape the attention of regulatory bodies he was curt and pragmatic. Avoid embezzling patients' money, never embark on any kind of emotional relationship with patients or their families, and most of all don't upset your colleagues by over-enthusiastic self-promotion. Such gentle, innocent times! Patients were told very little, still less when there was a medical error. There was an apocryphal story of a celebrated surgeon who, having opened the wrong side to repair an inguinal hernia, silently completed the surgery on the correct side and triumphantly told the grateful patient that things had gone so well he didn't need to operate on the middle bit. Nobody dared contradict him.

Good riddance to the arrogance and paternalism that encouraged such obfuscation and deceit. Openness, transparency, and candour are the very welcome new norms, as per the 2013 Francis report. When things go wrong patients and their loved ones are entitled to know why. They should expect a fulsome apology if appropriate, and an assurance that miscreants – if there are such – are identified and held to account, according to guidelines from the GMC. They are also entitled to know what steps have been taken to minimise the prospect of a similar event being visited upon another patient. Yet how the world of professional regulation has changed! As I advance toward retirement my circle of friends and acquaintances now numbers many who have been through gruelling and destructive investigations, often with long periods out of clinical work, expensive legal bills, reputational, personal, and health damage and an overwhelming feeling that a calling to which they have devoted the greater part of their lives has betrayed them. Some have suffered sanction; many have been exonerated but left wounded and bitter following an honest mistake, or in some cases an allegation found to be without any substance. Several doctors are known to have died by suicide when under investigation by the General Medical Council (GMC).

Doctors subject to disciplinary hearings at the hands of the Medical Practitioner's Tribunal Service (MPTS) – a sub-committee of the GMC – speak of bizarre Kafka-esque experiences. In true pantomime fashion, a barrister for the GMC paints them as warped, malevolent and without a scintilla of compassion or remorse. The barrister assumes guilt, and proceeds on the basis of establishing not guilt or innocence but degree of guilt. A barrister acting on the doctor's behalf (at enormous expense) pleads his or her innocence and asks for clemency. A tribunal listens to the often-fractious exchanges and retires to make judgement. The doctor who protests his innocence is characterised as having poor insight and given an even stiffer sanction. The local press then photographs the hapless doctor, usually in an unflattering pose, and the tabloid sub-editor generates lurid headlines about 'another bungling doctor'. Disquiet has been rumbling within the profession for some years but was brought into sharp relief by what was widely perceived as the gross injustice meted out to Dr Hadiza Bawa Garba [2]. A trainee paediatrician, recently returned from a long period of maternity leave, Dr Bawa Garba was pitched in to a busy duty shift in an understaffed Accident and Emergency unit with what sounds like questionable supervision. A sorry sequence of events ensued leading to the tragic death of a young boy. Dr Bawa Garba was ultimately convicted of 'medical manslaughter' and given a suspended jail sentence. The GMC imposed its sanction – suspension from the medical register for a year – but appealed essentially its own decision by application to the High Court. Dr Bawa Garba's name was then erased from the medical register. Doctors who studied details of the case were outraged; it was only the senior leaders at the GMC that seemed perplexed by the degree of unease. This smacks of a lack of insight on the part of senior GMC figures as to what goes on in hospital coffee shops, staff rooms, canteens, doctors' messes, at grand rounds and in breaks from medical lectures and teaching events. Dr Bawa Garba's fate alone didn't spark the outrage; it was the tipping point for a profession that has essentially lost faith in the regulatory processes. In football parlance a manager is said to be in real trouble when he has 'lost the dressing room', and the GMC truly has 'lost the dressing room'.

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DEFINITIONS FROM THE 'FRANCIS REPORT' [4]

- Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

GMC ADVICE TO DOCTORS REGARDING 'DUTY OF CANDOUR'

- Tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong.
- Apologise to the patient (or, where appropriate, the patient's advocate, carer or family).
- Offer an appropriate remedy or support to put matters right (if possible).
- Explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long-term effects of what has happened.

From GMC homepage www.gmc-uk.org

So how does the GMC restore the confidence of the profession? How do we deal with medical mishaps in a way that acknowledges, humanely and compassionately, both the enormous sense of hurt and betrayal felt by aggrieved patients and their loved one, and the reality of human failures? Medicine is complex. Decisions, especially in the white heat of an emergency scenario, are often made with incomplete background information, limited by resource constraints and in situations where the very nature of the scenario makes pressure to complete the task in hand immense. The stakes may be very high indeed. A wrong decision, or series of wrong decisions, can have devastating consequences. Patients get hurt; in some tragic situations patients die. Families and loved ones are entitled to know why. Sometimes, decisions made and acted on are seen, in hindsight and when subject to cold and careful analysis in less fraught circumstances, to have been questionable or even clearly wrong. That is why we have morbidity and mortality meetings, clinical audit, and why we encourage honest reflective practice in our trainees. So we can get better and deliver better care.

One way forward may be to look at a highly unusual grand round that recently took place in the University Medical Centre Utrecht (UMCU), in the Netherlands. A packed lecture theatre heard the account of a woman, Adrienne Cullen, with a now-terminal cancer whose biopsy result, several years earlier showed a cancer but was not followed up. A series of human errors – including some by senior medical staff who acknowledged their mistakes – led to a scenario whereby her cancer progressed from a treatable early stage to being incurable. The exchanges were uncomfortable in the extreme for the doctors and of course the outcome is catastrophic for the patient. "It's too late for me", she says, "I'd like to think this is the beginning of a new chapter in openness and transparency at UMCU, but there's still a very long way to go" [3].

The hope is that such a public forum will promote the sort of 'learning culture' that Sir Robert Francis's report into the devastating failures at an NHS hospital encouraged [4]. We have to move away from the inquisitorial, pugilistic and punitive approach that characterises current hearings and decisions. We need to re-evaluate whether an adversarial, gladiatorial contest between opposing barristers, played out in a theatrical forum before a tribunal, is really the best way to determine the facts when cases come before the MPTS. Fraudsters, reckless practitioners, and the 'truly exceptionally bad' [1] clearly can be offered no hiding place within the profession. They should be roundly denounced, sanctioned, and in the most egregious cases struck off. And no, doctors are not above the law and are quite properly subject to criminal proceedings like anyone else when they engage in criminal behaviour, in or out of work. But demonising doctors who make honest mistakes is neither just nor compatible with a culture where we can learn from honest reflection. It is counterproductive, promotes a climate of fear and suspicion among doctors, and harms patients.

Compassion for patients who have suffered mishaps, or even death, is not incompatible with treating doctors decently and humanely.

Despite having 'lost the dressing room' the GMC doesn't deserve the fate of errant football managers. It has done sterling work to modernise medical education. It has made substantial and progressive contributions to many ethical and professional issues and helped lead us out of the dark days where omnipotent doctors could ride roughshod over patients and their wishes; but it needs a long and probably uncomfortable period of reflection and engagement with the profession and the general public about how we move forward collectively on dealing with doctors who are alleged to have harmed patients. Looking after doctors and looking after patients are not mutually incompatible.

References

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3. A medical failure, a terminal illness, and a public examination of conscience. *The Irish Times* April 2018.
4. *The Mid Staffordshire NHS Foundation Trust Public Inquiry*. 2013; available at www.midstaffspublicinquiry.com Last accessed 13 July 2018.

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