MORE THAN DEFENCE

Medical Protection

PROFESSIONALISM
A MEDICAL PROTECTION GUIDE

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PROFESSIONALISM – A MEDICAL PROTECTION GUIDE

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ABOUT MPS

MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members around the world. Membership provides access to expert advice and support as well as the right to request indemnity for any complaints or claims arising from professional practice. Highly qualified advisers are on hand to talk through a question or concern at any time.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This includes clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.

INTRODUCTION

Welcome to MPS's guide to professionalism, a publication that takes a closer look at what it means to be a professional.

Increasingly we hear from members whose experience is that patient expectations are growing: the patient is encouraged to see themselves as a consumer of health services, and this has led to a change in approach and ethos. But a lasting constant in these times of great change is your professionalism – the core values, beliefs and behaviours around duty, integrity, honesty and clinical competence that are as important as ever. With higher expectations, patients are more likely to be disappointed and then complain about their care; certainly, we hear concerns from members that the gap between expectations and what they can realistically deliver is widening. In such times your professional attributes can really come to the fore and make all the difference when under pressure.

This booklet is designed to get you thinking about what it means to be professional; in particular the characteristics and behaviours that uphold professional qualities. We also take a look through history to place modern expectations in the context of changing societal attitudes to the definition of professionalism, and our timeline on page 34 makes for interesting reading. The GMC's expectations are summarised in the second chapter, and we look at how they should be applied in scenarios, through a number of anonymised case studies from our own files.

We hope you find this booklet a thought-provoking read but also one that offers useful practical advice.

1 MEDICAL PROFESSIONALISM – WHAT DO WE MEAN

> A professional is someone who can do his best work when he doesn't feel like it
>
> Alistair Cook, American journalist (1908-2004)

As a collective whole, doctors are regarded as "professionals" both by the public and by their peers. They remain the most trusted profession among the public, which has been the case for many years. Individually, some doctors may fall short of the mark. But what do we mean by professionalism? And how much bearing does this definition have on the behaviours expected of a doctor? Firstly, we need to be clear about exactly what a profession is.

HOW DO YOU DEFINE A PROFESSION?

A profession can be defined as a vocation or 'calling', especially one involving a degree of skill, learning or science. Another helpful description is that of "a trade or occupation pursued for higher motives, to a proper standard".

The distinction is usually drawn between a professional (ie, someone who earns a living from their trade or occupation), and an amateur (ie, someone who might do the same or a similar thing, but without remuneration). But the difference is not simply that one is paid and the other is not, because a 'professional' performance is one which is good, polished and of a high quality, whereas an 'amateurish' performance is the opposite – however much or little payment might have been received.

A logical conclusion is that if a person intends to rely upon a certain trade or occupation as their main source of income, then they would need to be proficient at it, and be recognised as being so.

HOW DOES THIS APPLY TO MEDICINE?

> All professions are a conspiracy against the laity
>
> George Bernard Shaw, The Doctor's Dilemma (1911)[1]

Bernard Shaw's cynicism may well be anachronistic given the patient-centred and shared decision-making approach favoured in medicine today. Modern medical professionalism includes the ability to communicate specialist knowledge, diagnosis and treatment options in an easy-to-understand way, rather than seeking to use specialist knowledge as a means to create distance from, and a dependency of, the public. Professionalism also involves confidentiality, continuity, trust, honesty and compassion.

Older definitions of professionalism pitched the doctor in an exclusive group, defined through specialist knowledge and expertise. Today, information about health and disease is available to anyone with access to a computer, and the definition of professionalism has had to adapt and change in an increasingly consumerist healthcare sphere.

Dame Janet Smith stated that: "Professionalism is a basket of qualities that enables us to trust our advisors."[2] A patient's trust in a doctor is no longer assumed; it is reached through a display of appropriate professional qualities: expertise, probity, integrity, and so on.

In 2005, the Royal College of Physicians (RCP) produced a report, Doctors in Society: Medical Professionalism in a Changing World, to seek to redefine the nature and role of medical professionalism in a modern society. The report agreed that medical professionalism is:

> "A set of values, behaviours, and relationships that underpins the trust the public has in doctors."

Furthermore, the RCP working group concluded that in their day-to-day practice, doctors are committed to:

- integrity
- compassion
- altruism
- continuous improvement
- excellence
- working in partnership with members of the wider healthcare team.[3]

Following on from the older definitions of "lofty professionalism", as discussed above, is the assumption that professional qualities are automatically inherited upon qualifying. As medicine is a profession, such thinking follows that all doctors are automatically professionals. However, this booklet serves to show this is not the case. Modern medical professionalism is something that can, and indeed should, be learnt. Being aware of the expectations of a professional can help to improve patient care. It is important to continually develop communication skills, clinical knowledge and team-working skills in order to help improve standards.

OTHER PROFESSIONAL STANDARDS

In other professions, too, similar qualities of trust, responsibility and integrity apply. The Solicitor Regulation Authority's *Code of Conduct* states that: "Those involved in providing legal advice and representation have long held the role of trusted adviser." The mandatory principles that apply to all legal professionals include: acting with integrity; not allowing independence to be compromised; acting in the best interests of each client; and behaving in a way that maintains the trust the public places in the individual solicitor and in the provision of legal services.[4] The Teaching Agency is responsible for the regulation of professional conduct; if standards of an individual teacher fall below the expected levels, sanctions are imposed and, in serious instances of professional misconduct, they may be barred from teaching. The onus on standards and regulation is not solely on the medical profession.

DOES PROFESSIONALISM EQUAL PERFECTIONISM?

There is a flip side to the pressures of striving to be professional in the medical profession. Perfectionism is a common trait amongst doctors. People who are perfectionists strive for flawlessness, set excessively high standards of performance, and tend to be overly critical of their behaviour.[5] Far from bringing the profession into disrepute, many doctors strive for extremely high standards, and can be at risk of burnout in their quest to ensure high-quality healthcare and safeguard patient safety.

It is important to remember that doctors are human too; mistakes will be made, and sometimes doctors will fall short of the high ideals that the public, and they themselves, expect. Adverse outcomes can result from care in the most experienced hands – it is not necessarily a sign of poor care or lack of commitment. True professionalism comes into play when mistakes are made. Knowing what to do when things go wrong and how to react appropriately can make all the difference in ensuring high standards of patient care are maintained and a speedy resolution is reached. More can be found on what to do when things go wrong in Chapter 4, on page 42.

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PROFESSIONALISM –WHAT DOES IT LOOK LIKE

PART 1 – THE CHARACTERISTICS OF A PROFESSIONAL

In Chapter 1, we tried to define professionalism; in particular, how it relates to the concept of a "profession". Here we look at some of the characteristics commonly associated with a professional person; as a doctor, these are perhaps the minimum expectations patients have of you. Ultimately these characteristics together create the foundation stone of the doctor–patient relationship: trust.

Expertise

A professional person is expected to have a particular set of skills in their chosen field, at a level that can be considered expert. This will have been acquired through learning, knowledge, training and practice of the relevant skills and, in most cases, this can be demonstrated by qualifications or accreditation of some kind. The validity of this expertise is maintained by ongoing training throughout the course of a medical career.

Standards

A professional person is expected to have the ability and dedication to achieving a set of standards in their duties that their peers find acceptable.

Respectability

There are expectations that a professional will work and behave in a manner that is appropriate to the nature of their particular profession. In medicine, these expectations are unique: good standards of personal appearance and dress, appropriate standards of speech and personal conduct – such attributes will confirm to a patient an acceptable standard of respectability.

Responsibility and reliability

Honouring commitments and keeping promises are key aspects of a professional person's sense of responsibility and reliability. Ensuring that tasks and duties are completed and addressed, by taking the initiative and leading by example, are imperative in medicine, where a lack of immediate attention to your duties can be the difference between life and death.

Probity

The word "probity" is taken from the Latin for good, honest and upright. A professional person should be all these things, as well as fair, law-abiding and of general good character. Probity is central to the public trust placed in the medical profession and a professional person should, through their actions, uphold this reputation. We will look in more detail at the GMC's expectations around probity later in this chapter.

Conduct

The actions of a professional person will be seen by both the public and their fellow professionals as being appropriate and proper. Again, the GMC has clear expectations of the correct behaviour and conduct of a medical professional, and this will be explored later in this chapter.

Respect

Respect for authority and the rule of law are traits of a professional person, and this respect should be maintained when managing or employing others. A professional person should aim to be courteous and should at the very least respect the rights, dignity and autonomy of others.

Professional vs unprofessional

A professional person will:

- Take pride in doing a job well and pay attention to detail
- Take personal responsibility for their actions and the consequences
- Seek to develop and improve their skills
- Not be satisfied with a substandard result, and will seek to put things right
- Be prepared to acknowledge mistakes, learn from them and take appropriate steps to prevent recurrence
- Show respect for those who consult them in a professional capacity.

In medicine, some examples of unprofessional behaviour may include:

- Any criminal behaviour or conviction
- Behaviour that suggests a disregard for the wellbeing of patients, or members of the public, and/or their dignity and rights
- Failing to honour clinical commitments
- Rude, abusive or disrespectful behaviour
- An irresponsible or apathetic attitude
- Showing a disregard for the time and effort of those who are relying on them – for example, by consistently bad timekeeping
- Dishonest business/financial dealings
- Any abuse of the doctor–patient relationship
- Anything that undermines public confidence in the profession
- Anything that undermines the reputation or standing of the profession
- Selfishness: putting one's own financial or personal interests above all other considerations
- Accepting unsatisfactory clinical standards
- Gratuitous criticism of colleagues and others
- Inappropriate relationship with patients, employees, etc
- Treating patients when not fit to do so
- Agreeing to undertake a procedure for which the person lacks the necessary training, expertise or competence
- Being resistant to feedback or maintaining one's continuing professional development
- Laziness, sloppiness or a lack of attention to detail.

Social responsibility

Many of the characteristics listed at the beginning of this chapter relate to those directly linked to a person's professional role, and are generally concerned with the individual's ability to carry out their duties. But in medicine, this is not enough; the caring nature of the profession means that a healthcare professional must possess a strong sense of empathy, a desire to do good – and this can be broadly described as having a social responsibility.

This might include:

- Compassion for those suffering pain and hardship
- A proper and responsible role in society
- A responsible attitude to the environment (especially in relation to the management of clinical and hazardous waste, the use of energy and raw materials)
- Good employment practices (in the case of self-employed GPs or doctors working in private practice)
- An awareness of social issues where the medical profession is in a position to play an important or central role (eg, physical abuse in all its forms, discrimination, etc)
- Humanity in both professional and personal matters (eg, proving assistance in an emergency situation, a Good Samaritan act)
- Adherence to the law (eg, in relation to substance abuse, driving while unfit to do so).

Summary

Doing what is right – when the law requires it, as well as for ethical or moral reasons – should be a matter of personal pride for the professional person.

Persisting in doing what is right, on those occasions when it is much easier, quicker and cheaper or more convenient to do otherwise, is a greater test.

Some will no doubt maintain that the ethos of professionalism, and the instinct that tells us what a professional person would do in a given situation, can only develop with experience. Others will argue that professionalism is simply about making the right choices, for the right reasons, no matter what stage in your professional career these decisions arise. There may be some truth in both perspectives, but it can never be too soon to think these issues through. Professional integrity is a precious attribute that needs to be cultivated and protected from the very start of a professional career, including entry to medical school.

PART 2 – THE GMC EXPECTS

The GMC's role in safeguarding professionalism in medicine stems from its founding in 1858, when it was set up to expunge so-called "quacks" from practising and to ensure uniformity of qualifications. The GMC harvested representative self-governance and took on a disciplinary function for any medical professional guilty of "infamous conduct in a professional respect" – a term first defined in the 1894 case of *Allinson v General Medical Council*.

In that case, Lord Justice Lopes said: "If a medical man in the pursuit of his profession has done something with regard to it which will be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the General Medical Council, if that be shown, to say that he has been guilty of infamous conduct in a professional respect."[6]

The phrase was then enshrined in law in the consolidated Medical Act of 1956:

"If any fully registered person –

(a) is convicted by any court in the United Kingdom or the Republic of Ireland of any felony, misdemeanour, crime or offence, or

(b) after due inquiry is judged by the Disciplinary Committee to have been guilty of infamous conduct in any professional respect, the Committee may if they think fit direct his name to be erased from the register."[7]

Today, the GMC looks for evidence of impaired fitness-to-practise before it can take action to stop or limit a doctor's right to practise. According to the GMC website, this evidence may be that doctors:

- "have not kept their medical knowledge and skills up to date and are not competent;
- have taken advantage of their role as a doctor or have done something wrong;
- are too ill, or have not adequately managed a health problem, to work safely."[8]

Such evidence leads the GMC to direct the Medical Practitioners Tribunal Service to hold a fitness-to-practise hearing. Alternatively, any significant departure from the principles of the GMC guidance *Good Medical Practice* may also lead to a fitness-to-practise hearing. Originally published in 2006 and revised in 2013, *Good Medical Practice* set out the most comprehensive set of standards of conduct and care ever compiled in the UK. This core guidance sets out the standards by which doctors are judged and, therefore, can be viewed as the tenets of what it is to uphold professionalism in the healthcare industry.

This section will look at some common categories of allegation heard at fitness-to-practise hearings. We will explore the GMC's expectations around each one and how they relate to the concept of being a good professional. These are:

Probity

Honesty and integrity are central to probity and define how any professional person should act: being upstanding and law-abiding, and respectful of the trust placed in you by others. This is vital in healthcare as trust is the fulcrum on which the doctor–patient relationship is balanced. Patients confide in you a great deal of personal and private information, exposing a degree of intimate information usually only reserved for those close to them, such as family. A good consultation is an open one and this requires a patient's complete and justified faith in your professionalism.

Your duty to be honest and open covers all aspects of your professional practice. This includes:

- Writing your CV
- Preparing medical reports
- Record-keeping – medical records should be contemporaneous and not retrospectively altered in the event of a complaint or claim
- Any other documents or forms you are asked to sign or complete – they must be comprehensive and include all relevant information

- Giving evidence or acting as a witness – as well as being truthful when giving a spoken or written statement, you must be honest about the limitations of your knowledge and competence
- Co-operating fully with any complaint or investigation related to your treatment of patients, including disclosing any relevant information with appropriate consent
- Assisting the coroner or procurator fiscal with inquests or inquiries into a patient's death.

Research is another area of clinical work that you may become involved in. It is essential in improving the standard of healthcare and for exploring new possibilities, ensuring clinical care continues to develop now and in the future. In recognition of its importance, the GMC has produced supplementary guidance on the good practice principles of working in research: *Good practice in research and Consent to research* (2010).

Avoiding conflicts of interests is another important aspect of probity and can be complex, and even innocently committed. Any financial interests or commitments you may have in a healthcare, pharmaceutical or biomedical organisation must play no part in the treatment decisions you make for your patients. If it is in the patient's best interests that their treatment utilise the services of such an organisation, then you must disclose this to the patient. This is particularly pertinent in the new arena of clinical commissioning groups – and the GMC has produced specific explanatory guidance on this topic – *Financial and commerical arrangements and conflicts of interest* (2013).

Overall it is the patient's best interests that are the deciding factor in any decision made about their treatment, and this must not be affected by any inducements offered to you or by you. The Bribery Act, introduced in 2010, carries severe punishments of up to ten years in jail for anyone who improperly carries out a "function or activity" for financial or other advantage.

CASE STUDY

FIGHT NIGHT

The GMC is not just interested in how doctors practise in a clinical setting. The GMC is interested in any aspect of the conduct of a doctor, which could raise a question about their fitness to practise, and undermine the public's trust in the medical profession. What many students and junior doctors fail to grasp is that a serious mistake in your personal life could harm your prospects before you've even qualified.

Dr Hassan was out celebrating the completion of her F1 year, and her impending full registration with the GMC, when she got embroiled in a fight in the city centre. During the fight the police arrived and arrested all those who appeared to be involved. After this, Dr Hassan subsequently accepted a caution for assault.

When she came to apply for full registration with the GMC, Dr Hassan completed the declaration on fitness to practise. She didn't think that the caution was relevant, since it did not arise from her professional conduct, and was embarrassed, so filled in the forms without disclosing the caution.

A few months into Dr Hassan's first job as an F2, a CRB check highlighted the issue. Dr Hassan's trust referred the matter to the GMC. The GMC soon instigated fitness to practise proceedings on the basis of dishonest failure to disclose, which led to her being dismissed from her post.

MPS advice: The GMC takes dishonest and inappropriate behaviour very seriously. Probity in the eyes of the GMC means being honest, trustworthy and acting with integrity, which is at the heart of medical professionalism.

The GMC requires full and prompt disclosure of cautions and convictions. If you do find yourself in difficulty, take advice from your MDO, trainer or deanery – don't be tempted to cover it up; if such attempts are discovered, it can do serious harm to your medical career. Hospital trusts will generally take a hard line on dishonest applications, and can treat it as gross misconduct, leading to immediate dismissal.

Examples of other things that may concern the GMC include: alcohol misuse affecting clinical work, misuse of drugs (even if there are no legal proceedings), drunk driving, bullying and physical violence.

Be aware that your behaviour outside the clinical environment, including in your personal life, may have an impact on your fitness to practise.

Clinical care

According to *Good Medical Practice*, when providing clinical care you must:

(a) prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs

(b) provide effective treatments based on the best available evidence

(c) take all possible steps to alleviate pain and distress whether or not a cure may be possible

(d) consult colleagues where appropriate

(e) respect the patient's right to seek a second opinion

(f) check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications

(g) wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.[9]

Delivering good clinical care depends, of course, on your expertise, your knowledge and your competency to carry out the relevant treatment or procedure. It depends on your diligence in keeping legible, contemporaneous medical records, and your precision in prescribing safely.

However, clinical care goes beyond your skill in diagnosing and treating a patient's illness. The professional approach is to be fair and equitable in your treatment of each and every patient – which is why you should avoid treating those close to you.

As already discussed, a professional can acknowledge mistakes and act on them, taking care to learn from the error in the process. In medicine, you should also be prepared to seek and accept assistance, and consult colleagues for advice if you are unsure of what course of action to take. Do not be afraid to question and revisit your own diagnosis – it is not an admission of failure to question whether your own original diagnosis was wrong. Numerous studies have highlighted common cognitive errors in the diagnostic process and it is important not to ignore your own potential for making such mistakes.[10]

If you suspect that patient safety is threatened by underperforming colleagues, poor resources or inadequate systems or policies, you must take appropriate action. The GMC's guidance on *Raising and acting on concerns about patient safety* (2012) provides extensive guidance on how to report your concerns, and why it is important to overcome barriers and obstacles. The GMC is clear that your duty of care extends to raising concerns about patient safety, and it is simply not an option to turn a blind eye. Even though it may be hard to do, and many doctors fear the personal consequences, the GMC is clear about the professional responsibility to put patient safety first. MPS can give advice by discussing specific issues around this.

Whom you report your concerns to will depend on your own circumstances. It may be your supervisor, trainer, a senior colleague or a director of risk or clinical governance. It is wise to document your concerns and the actions you have taken. Your MDO can help with areas of uncertainty.

CASE STUDY

A QUESTION OF COMPETENCY

Working outside the limits of your competence has a clear potential for patient harm, and an associated impact on your team arising from complaints, claims and disciplinary investigations. Communicating well in a team demands more than merely listening and passing on messages; it means accurately representing your level of expertise and working within it.

Mrs J, a dancer in her 40s, visited the emergency department with a sudden thunderclap headache at the back of the head. She was seen by F2 Dr Q. Dr Q organised a CT scan to rule out a subarachnoid haemorrhage, which came back clear.

His next course of investigation was to test the CSF for xanthochromia. Dr Q began setting up a tray and equipment to perform a lumbar puncture. A couple of nurses spotted that Dr Q was setting up the tray incorrectly, so alerted the registrar, Dr A, to what was going on.

Dr A took Dr Q aside and asked him about what he was planning to do. Dr Q admitted that he was unfamiliar with some of the equipment and had only ever read about the procedure. Dr A explained that Dr Q was working beyond his competence, which could have caused Mrs J harm. Dr A used the opportunity to give Dr Q an impromptu lesson, explaining the procedure as he successfully undertook a lumbar puncture.

MPS advice: Competency encompasses the need to keep up-to-date with changes in clinical practice and the systems that can impact on your role. Continued professional development (CPD) is a prerequisite of many jobs, but none more so than medicine, which is constantly evolving. Doctors effectively never stop learning; a heavy focus is placed on CPD whatever specialty a doctor may work in.

Recognising your own limitations is the key principle behind competency. The GMC's *Good Medical Practice* makes it clear that your duty as a doctor is to recognise and work within the limits of your competence. When providing care, you must work within your own competencies, and ask for advice when you feel out of your depth.

Relationships with patients

As a doctor's profession is defined by the duty of care to patients, it follows that standards of professionalism are entwined with the strength of the relationship between doctor and patient.

But this relationship doesn't just concern your clinical work – good communication, politeness and respect, and a caring, empathic manner are all vital components of an effective doctor–patient relationship. Similarly, avoiding allowing this relationship to descend into something less appropriate is the correct, and professional, approach.

MPS has written extensively on the importance of good communication, partly due to the oft-quoted fact that 70% of litigation in healthcare is related to poor communication. Here is an extract from an article that was published in MPS's *Sessional GP* magazine.

GOOD COMMUNICATION: WHY IT'S WORTH IT

By Sara Williams

Good doctors are good communicators – it's that simple. An Ipsos MORI poll published in November 2005 confirmed that the top characteristic the public wished to comment on in relation to their doctor's performance was their communication skills, followed by their technical ability, how much they involve patients in treatment decisions and whether they show their patients dignity and respect.[11]

Understandably patients experience difficulties in assessing the technical competency of a doctor, so will frequently judge the quality of clinical competence by their experience or their interpersonal interactions with a doctor. Developing good communication skills will improve clinical effectiveness and reduce medicolegal risk.

The GMC's view

Over recent years the doctor–patient relationship has evolved, moving from a paternal to a partnership model. In *Good Medical Practice*, the GMC says that doctors should "work in partnership with patients" by listening and responding to their concerns and preferences, "sharing with them the information they will need to make decisions about their care", respecting their right to be involved in decisions about their treatment and care, and supporting them in their own efforts to improve and maintain their health.

The GMC expects doctors to be effective communicators, so what if you are not?

How to communicate effectively

It is often said that body language speaks louder than words. Eighty per cent of communication is non-verbal, so it is crucial to the patient

encounter. A mismatch between verbal and non-verbal communication can lead to a strained encounter for both doctors and their patients.

Being aware of your own body language is the first step in understanding how your body language is perceived. Maintaining eye contact demonstrates that you are listening and showing an interest; this is particularly important at the beginning and end of a consultation.

Turning away and facing a computer indicates disinterest, so the patient may not give information critical to the consultation. Interruptions, and cutting off a patient before they have finished, are not effective means of communication.

Beckman found that the mean time taken for a doctor to interrupt a patient's opening statement was 18 seconds.[12]

His research showed that patients rarely presented problems in order of clinical importance, so allowing patients to complete their opening statement led to a significant reduction in late-arising problems. The longer a doctor waits before interrupting, the more likely the patient will "get to the point" quicker, thus avoiding presenting the key issue at the end of the consultation, where the adherence to time constraints could appear heavy-handed.

Handling patients' expectations

Part of communicating effectively is handling expectations. Patients will be dissatisfied if their expectations have not been met. Although these expectations may be unrealistic, eg, the doctor will have unlimited time and availability, they will solve all the issues at once and all treatments will be 100% effective, these expectations can be addressed if they are identified early on. So, once explored and respectfully corrected through effective communication, the patient will leave content with their treatment and more likely to comply with it.

When things go wrong

Despite the best intentions, some patients will remain dissatisfied and seek redress. In most cases this is not down to human error. MPS's experience is that a breakdown in communication and patients' dissatisfaction with a doctor's manner and attitude frequently give rise to complaints and claims.

Research by Bunting suggests that there are two sets of factors which influence the decision to sue or seek redress:

- Predisposing factors – rudeness, delays, inattentiveness, miscommunication, apathy, no communication.
- Precipitating factors – adverse outcomes, iatrogenic injury, failure to provide adequate care, mistakes, incorrect care, systems errors.[13]

According to Bunting, precipitating factors are unlikely to lead to litigation in the absence of predisposing factors; yet the media tends to report on the former rather than predisposing factors. So good communication could save your professional skin; patients who feel informed about their condition and are involved in deciding the appropriate treatment are more likely to comply with it and less likely to complain when things go wrong.

Tips for effective non-verbal communication

- Observe
- Show respect
- Be patient
- Be self aware (posture, eye contact, first impression)
- Be curious
- Assess patients' moods
- Show empathy.

Sessional GP, Issue 1, October 2009
www.medicalprotection.org/uk/sessional-gp/issue-1/good-communication

Another aspect of good communication is being honest and open when things go wrong. *Good Medical Practice* says, in paragraph 55: "You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:

(a) put matters right (if that is possible)

(b) offer an apology

(c) explain fully and promptly what has happened and the likely short-term and long-term effects."

For more on being open, see Chapter 4, "What to do when things go wrong".

Managing the relationship with patients also means respecting their right to confidentiality and maintaining professional boundaries. While doctors are rightly expected to show compassion and empathy when treating patients, it is undoubtedly a challenge to show this human face without blurring the boundary between professional and personal relationships. The GMC has published detailed guidance on maintaining boundaries in *Sexual behaviour and your duty to report colleagues* (2013).

Knowing how to maintain this boundary depends largely on a doctor's self-awareness and their ability to judge the particular situation. A reassuring hug, for example, depends largely on the pre-existing familiarity between doctor and patient. You should also be aware of cultural differences and whether or not an interpreter is necessary. Your best protection is to know yourself: become adept at identifying and monitoring your feelings towards your patients (whether these are negative or positive).

- Be aware of how you portray yourself to patients.
- Do you feel uncomfortable with a patient? If so, try to identify the cause – is it something they said, or did, or was it their body language?
- Do you feel a special rapport or sexual attraction to a particular patient? If so, seek advice from a colleague and deal with the situation before it escalates, either by establishing clear professional boundaries and sticking to them, or by referring the patient's care to another doctor.

Social media

Being aware of professional boundaries also extends to doctors' use of social media. It is now practically ever-present in people's lives, and doctors should be particularly aware of the risks. There have been numerous examples in the media about doctors revealing confidential patient information on blogs, Facebook, Twitter and other forums, while doctors who fail to restrict access to their private lives – and the particularly unsavoury photographs or videos that are a common feature for some – risk damaging their professional image.

MPS advice is that doctors should treat everything posted to social networks as if it is something they have written down – it is never truly anonymous and exists in perpetuity, meaning that the chances of such comments being traced to the author should never be disregarded. Comments made innocently about patients, treatments or particular procedures can potentially breach confidentiality, especially if they mention unusual symptoms or conditions – if just one patient recognised themselves from your comments, it is likely to be sufficient for the GMC to take action.

Social media is a new arena within which doctors must tread carefully, being mindful of their responsibility to maintain public trust and the standing of the profession. It is for this reason that MPS strongly advises doctors to avoid adding patients as "friends" on sites such as Facebook.

The GMC has published explanatory guidance on this topic – *Doctors' use of social media* (2013).

CASE STUDY

AFTER HOURS

Doctors are expected to be empathic and compassionate towards patients – but this emotional involvement must be managed carefully if the hallowed boundaries between doctor and patient are to be maintained.

Dr Evans was a GP registrar who had been working at his current surgery for two years. The surgery was owned by two well-respected partners who had practised in the village for more than 30 years.

Dr Evans, who was married, occasionally stayed late in the surgery, where he was usually joined by healthcare assistant Debbie as the only other member of staff in the building. Debbie was also a patient at the surgery and had consulted Dr Evans on at least a couple of occasions.

Around six months after Dr Evans began working late, his wife accidentally discovered text messages from another woman on his mobile phone. They were of a flirtatious and sexual nature. It soon emerged that the texts were from Debbie and that Dr Evans had been having sexual relations with her in the practice, during their evening work.

Ashamed, Dr Evans reported the affair to the partners and eventually resigned. He was reported to the GMC and faced a fitness-to-practise hearing, where he was suspended for a year and had several restrictions placed on his practice.

MPS advice: The GMC is clear that doctors should not pursue sexual or improper emotional relations with patients. There are many instances in which doctors have become entangled in their own strong emotional responses to a patient, and this can become further complicated if the patient is also a work colleague, with whom you share large amounts of time and a sense of camaraderie.

But although doctors such as Dr Evans would not describe themselves as predatory or exploitative, the fact is that power in the doctor–patient relationship is inherently unequal and to pursue those feelings would be unethical. Recognising the early warning signs is, therefore, crucial. These include:

- Frequently thinking about the patient on a personal level
- Looking forward to seeing the patient with a sense of anticipation

- Allowing consultations to run over, even though there is no clinical reason for it
- Giving the patient preferential treatment – eg, cutting another patient's consultation short to make room for them, expediting a referral for non-clinical reasons

Treating the patient as "special" – eg, showing unusual deference, divulging personal information about yourself

Creating opportunities to see the patient.

Some of this advice is taken from the *Casebook* article "Drawing the line", by Sandy Anthony and Sara Williams (Vol 16 No 2 – May 2008).

Working with colleagues

It is perhaps an understatement to say that teamwork is integral to the safe delivery of care within medicine, and the professional approach to good teamwork centres on good communication, mutual respect for others and proactively responding to any deficiencies in the team.

In 1999, the *BMJ* published research that had looked into bullying at a community NHS trust. It found that 38% of staff had reported being on the receiving end of bullying, while 42% said they had witnessed it.14 Your relationships with your colleagues should be comparable with those you have with your patients. As a healthcare professional, you set an example to others and are a role model to the rest of society – malicious behaviour has no place in the conduct of the meticulous, upstanding professional person.

Safe delegation and referral is another area of your work with colleagues where your professionalism can be called into question. When delegating a task – or, as a junior doctor, when a task has been delegated to you – all parties must be sure that the doctor to whom the task has been assigned has the competency to carry it out. Inappropriate delegation can lead to grave errors of judgment and, in some cases, adverse patient outcomes – MPS has experience of many such cases.

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When delegating a task, the GMC says in paragraph 45 of *Good Medical Practice*: "When you do not provide your patients' care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient."

Continuity of care is essential and you must ensure any transition of care, including referrals, is properly handled. This relies on clear lines of communication with colleagues and an equally clear line of responsibility.

CASE STUDY

WE DON'T TALK ANYMORE

Allowing personal rivalries and feuds to fester in the workplace is unprofessional in the first place; allowing them to interfere with the care of the patient is serious misconduct. This case highlights how such an incident didn't just land the doctors involved before the GMC – it also landed them in court.

Mr Y, a 35-year-old marine engineer, was undergoing surgery in the posterior compartment of the thigh to treat a congenital vascular lesion. Mr O, consultant vascular surgeon, was carrying out the procedure. The lesion was closely related to the sciatic nerve and some of its branches, and Mr O was hoping to avoid damaging the sciatic bundle, if possible.

The anaesthetic was given by Dr A, consultant anaesthetist. During the induction phase Mr Y had suffered repeated generalised muscular spasms, so Dr A had given a muscle relaxant, to prevent intraoperative movement of the surgical field.

During the course of surgery, Mr O used tactile stimulation to attempt to determine whether a nerve which was likely to be compromised by his surgical approach was the sciatic nerve, or a branch of the peroneal nerve. Reassured by a lack of contraction of relevant muscle groups, he continued to operate under the impression that the structure about which he was concerned was not the sciatic nerve.

Unfortunately, in the context of neuromuscular blockade there was no rationale for this approach. It transpired that Mr Y suffered severe foot drop as a result of extensive damage to the sciatic nerve. Mr Y sued Mr O as a result of his injuries.

The case hinged on whether Mr O had taken sufficient care in establishing the relevant anatomy during surgery. Dr A had documented in the anaesthetic record that he had given the muscle relaxant, and was adamant that he had told Mr O this fact. Mr O was insistent that Dr A had not informed him about the administration of the drug and thus had left him open to the error that he made.

During an investigation of events surrounding the case it became clear that there was a history of animosity between the two clinicians. There were unresolved investigations into allegations of bullying and harassment

between Mr O and Dr A. In the context of how Mr Y suffered his injury, and the clinicians' apparent failure to communicate, it was impossible to defend the case, which was settled for a moderate sum with liability shared equally between the two doctors.

MPS advice: It is a professional obligation of a doctor to, as the GMC says, "respect the skills and contributions of … colleagues and communicate effectively with colleagues within and outside the team".

Effective communication between healthcare professionals is essential for safe patient care. In the context of an operating theatre, where there are anaesthetic factors that may have an impact on the surgical outcome (and vice versa), it is vital that this information is imparted.

Unresolved personal or professional disagreements between healthcare professionals who share responsibility for patients is potentially prejudicial to patient care. It is the responsibility of all who work in the clinical team, and those who manage them, to make sure that patients are protected from any adverse outcome that results from doctors not working properly together. The wellbeing of patients must always significantly outweigh the personal problems of doctors.

Independent, external professional assistance with conflict resolution may sometimes be necessary and can be extremely effective.

This case originally appeared in *Casebook* Vol 16 No 2, May 2008.

Health

It is one of the great ironies that healthcare professionals are, generally, poor at taking care of their own health. Yet it is one of the core set of guidelines in *Good Medical Practice* that you have a responsibility to look after your health – if not for your own sake, then at least for your patients.

The GMC is clear that "you should be registered with a general practitioner outside your family". You should refrain from treating yourself. But research by the BMA's Doctors for Doctors shows that only one in three doctors would see their GP when unwell, despite almost all being registered with one.

The obvious reason is to prevent any illness being passed to your patients. The GMC makes it your duty to ensure you are sufficiently immunised against common serious communicable diseases, and also to report any fears you have about a potentially contagious illness.

Paragraph 28 says: "If you know or suspect that you have a serious condition that you could pass on to patients, or if your judgement or performance could be affected by a condition or its treatment, you must consult a suitably qualified colleague. You must follow their advice about any changes to your practice they consider necessary. You must not rely on your own assessment of the risk to patients."

Exposure to illness is not the only way your health impacts on your patients. Stress and anxiety, and alcohol or drug abuse, can leave you in an unfit state to provide care for your patients. Your professionalism is reliant on your ability to perform at an optimum level – anything less is a patient safety risk.

If you feel that conditions at work or interaction with colleagues is affecting your health it may be worthwhile speaking to your employer, to see if any reasonable alterations at work could significantly improve your wellbeing. Similarly, the BMA offers a counselling service for doctors suffering from stress and anxiety.

CASE STUDY

DEMON IN A BOTTLE

You have probably heard the proverb "physician, heal thyself". However, GMC guidance is clear that you should not try and assess your own health, or rely on a friendly colleague's assessment.

Dr A, an anaesthetic SpR, contacted the MPS advice line worried about one of her colleagues, another SpR; she was concerned he might have a habit but did not have any hard evidence to go on. They had only been working together for about 18 months, but she had known him for longer than that. They had always got on well together, but were not close friends.

Lately, he had been moody and abrupt with everybody. It started gradually a few months ago, and she did not think much about it at first, assuming he had some personal problem and needed space. In the last few weeks, though, he had got a lot worse and very changeable – either snapping at people for no reason or being really remote and unapproachable. This was not like him.

One of the most disturbing things was that he had always been a very conscientious doctor – but had become very unreliable, turning up late and sometimes calling in sick at the last minute. And for a previously quite dapper dresser, he had begun to look quite slovenly.

Dr A searched the internet for a list of signs of substance abuse, and thought that her colleague's recent behaviour ticked a lot of the boxes. She was at a loss at what to do. She was very reluctant to raise her concerns 'officially' in case she was wrong, but was concerned that if he was taking narcotics, patients' lives may be at risk.

MPS advice: Dr A was reassured that she was right to be concerned and that her fears about getting it wrong were understandable. She was reminded that doctors are human, and can become unwell and develop addictions like anyone else. She was told, whilst the easiest thing to do would be to ignore it, that would be wrong. It was explained that the most important issues were the doctor's health and wellbeing and patient safety.

In addition, in line with the GMC's *Good Medical Practice*, Dr A had a responsibility to ensure that any doctor whose health may be affecting their work received the appropriate assistance. Her colleague had a similar obligation to seek help for himself.

It was suggested that in the first instance, Dr A approach a consultant within the department. In turn the consultant would need to report the matter to the head of department. Her colleague should then be referred to an occupational health physician, in order to establish whether he currently had any health problems and/or was abusing drugs or alcohol so that he could receive the appropriate medical treatment. The occupational health physician should also decide if it is necessary to keep the doctor away from the clinical setting to ensure he does not pose a risk to his patients.

In response to Dr A's concern that the consequences might be punitive for her colleague, she was reassured that although there were formal processes that the hospital and GMC needed to follow, the emphasis would be on ensuring that her colleague received the necessary help and support to overcome his difficulties. Her colleague would, for example, be put in touch with (or if necessary referred to) one or more of the organisations that exist to support doctors in this way (for example, the Practitioner's Health Programme, the BMA's Doctors 4 Doctors and the British Doctors and Dentists Group).

3

GREAT EXPECTATIONS

Today's doctors are working in a constantly evolving environment, where many of the old expectations regarding the role of doctors, nurses and patients are being replaced by new ones.The roles themselves are changing – doctors are clinicians, leaders, teachers, managers, commissioners and purchasers of services.

Public expectations of medicine have never been higher, and political scrutiny of performance has never been greater. In this chapter, we will look at how these expectations have changed over time.

Where many years ago, poor practice by a minority would have been tolerated, doctors are welcoming patient autonomy and pursuing quality through knowledge, transparency, accountability and collective responsibility for setting and maintaining professional standards.

So what led to this change? Through the 1970s, 1980s and early 1990s, the system of medical regulation faced mounting criticism, increasingly from the public and independent commentators, much of it focusing on the failure to identify early, and deal effectively with, doctors who were a potential danger to their patients.[15]

In the early 1990s, a series of highly publicised medical scandals, some to do with poor practice by individual doctors, others to do with local service failures in which patients were harmed, gave rise to mounting public concern. The Bristol Inquiry into the poor standard of care offered in the paediatric cardiac surgery service in that city, and the avoidable deaths that resulted, was a major turning point.

Nationally strides were made to move away from the autocratic "doctor say patient do" system to a more patient-centred one where doctors and patients would work together in a partnership.

The medical and nursing professions only started to recognise the extent and seriousness of patient harm from medical errors in the mid 1990s. Before this medical error was seldom acknowledged or written about. In 1990 the editor of the *BMJ* argued for a study of the incidence of adverse incidents and was criticised by the president of a royal medical college for drawing national attention to medical error.[16]

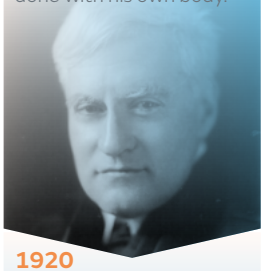
Key decisions, observations and incidents that have influenced expectations around standards of professionalism over the years:

START

1858
General Medical Council is established.

1871
The patient has no more right to all of the truth than he has to all of the medicines in your saddle bag. He should get only so much as is good for him."[17]

1914
Justice Cardozo states: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."[18]



1920
Latrogenic disease recognised for the first time.

1954
Lord Denning found in favour of a surgeon who deliberately lied to a patient, accepting that the lie was in the best interests of the patient.[19]

1995
BBC reports that the death rate for paediatric heart surgery on patients under one year old at Bristol Royal Infirmary was twice that of other hospitals.[20]

1997
Longest disciplinary GMC hearing in history follows the Bristol scandal, which sees two surgeons banned from practising medicine.

1999
Introduction of the Health Act underpins clinical governance and a statutory duty of quality.

2000
BMJ publishes special edition focusing on medical error.

2000
Harold Shipman is the only British doctor to be convicted of the murder of his patients. He is found guilty of killing 15 patients and of forging the will of one of them.

2002
"No standards were laid down against which performance in the NHS and quality of care could be measured", concludes health secretary Alan Milburn of the Bristol Inquiry.[21]

2002
"Patients and the public must be able to obtain information as to the relative performance of the trust and the services and consultant units within the trust" – Sir Ian Kennedy summarising the Bristol Inquiry report.

2005
"However bad a doctor is, another doctor, acting as an expert in disciplinary proceedings, will usually be willing to say that the doctor's actions were within the limits of acceptable practice." Janice Barber, managing partner, Hempsons Solicitors.

2005
"Harold Shipman would, of course, have passed any appraisal of fitness to practise with flying colours." Drs Jonathan and Bridget Osborne, *BMJ* article.

2005
Final stage of the Shipman Inquiry is published: it is established that Harold Shipman killed 250 people in total.

2007

"NHS Choices puts patients in the driving seat – giving them access to information not previously available to them so they can make informed decisions from advice about healthy eating to identifying the right hospital for their treatment." Patricia Hewitt, health secretary on launching NHS Choices.

2006

"The system of medical regulation and the structures and processes for assuring and improving the quality of care and patient safety in local health services have not related well to each other in the past. This needs to change." *Good Doctors, Safer Patients*.

2006

"Pretending that nothing happened, or telling about it in incomplete ways, is lying." Lucian Leape.[24]

2005

"Reform to the system of medical regulation over the last 150 years has generally been piecemeal... There has never been a comprehensive consideration of the core purpose of regulation."[23]

2005

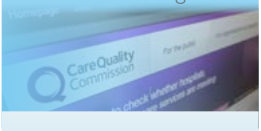
Society for Cardiothoracic Surgery began publishing survival rates for all adult cardiac surgery. The SCTS has since detected a 50% reduction in risk adjusted mortality in the UK.[22]

2009

"Apologies do not constitute an admission of liability." National Health Service Litigation Authority, *Apologies and Explanations*, letter to chief executives and finance directors, May 2009.

2009

Care Quality Commission (CQC) is established as a non-departmental public body to regulate and inspect health and social care services in England.



2009

"Discussing patient safety incidents promptly, fully and compassionately is the best way to support patients and staff when something does go wrong."[25]

2010

Health secretary Andrew Lansley announces a public inquiry into the role of the regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust, to establish why the serious problems were not identified and acted on sooner.

2013

The Francis Report reveals appalling suffering by patients of Mid-Staffordshire NHS Foundation Trust.

2012

"The introduction of revalidation in 2012 will be the biggest change to medical regulation in more than 150 years... Through revalidation, doctors will demonstrate on a regular basis their fitness to practise in their chosen area of medicine." GMC Chair Peter Rubin.

2012

"The most striking thing – apart from the sheer horror of what was done to patients – is that even though lots of different people knew bits of what was going on, nobody put it all together and did anything about it." Dr Gabriel Scally, chairman of the NHS review panel comments on the Winterbourne View report.

2012

GMC launches new tribunal service for doctors in biggest shake-up of fitness to practise hearings since it was established.

PATIENTS' EXPECTATIONS

"In society we can see the 'triumph of the autonomous individual', but this shift has been difficult to accommodate in the professional mode rooted in 19th century value systems of a clinician as 'expert' and 'authority'. Unmodified, medical paternalism will perish in a global market-led economy where individual choice, autonomy and consumerism reign supreme."

Glyn Elwyn (2005)[26]

This statement is a manifestation of the shifting power dynamic between doctors and patients, as discussed previously. In response doctors have had to reflect on and improve their communication skills, adopting various consultation methods to facilitate shared-decision making and more patient-centred care.

Immanuel Kant expressed the view that each person has intrinsic worth and possesses certain rights that others are obliged to respect. The right of an individual to follow their own self-directed choices in life is called autonomy. Such behaviour may not always be dignified (eg, choosing to drink to excess and getting drunk). However, the acceptance and understanding exhibited by the healthcare provider who subsequently treats that same individual for an injury sustained whilst they were drunk, demonstrates a respect for autonomous behaviour and also restores some dignity to the situation.

COMPETENCE

A doctor has a duty to provide care of an appropriate standard to avoid allegations of negligence. The progressive upward revision of the required standard of treatment to be provided is based on evidence that is constantly evolving, and is also influenced by the local culture and laws, as well as patients' expectations. As a result, the skills, diagnosis and treatment options for delivering medical care have changed dramatically over the past ten years. In addition, clinicians face greater demands from patients who want more information about the benefits and risks of any treatment they undergo.[27]

RESPECT

By adopting a respectful attitude to your patients and colleagues you will protect their dignity and earn their respect in return. The professional relationship is inevitably enhanced by an approach that recognises each patient as an individual, with feelings and sensitivities of their own, and which may differ from those of the previous patient and, possibly, from your own.

It is not necessary to agree with all that a patient believes or feels but it would be unethical to deny them such freedom. Respect does not necessarily imply deference but it does exclude selfish or prejudiced behaviour on the part of the clinician. The concept of respect predates any legal rights that may have subsequently been introduced in an attempt to protect the rights of the individual.

Most medical boards and medical councils around the world issue guidance on professional conduct, which stresses the need to treat all patients with respect and dignity. In some countries these principles are also enshrined in codes of human rights or similar legislation. Consequently, a failure to recognise and address issues relating to ethnicity, religion, sexual preferences, disabilities etc can have far-reaching professional consequences.

A patient's expectation of their surgeon

"For patients, important characteristics of a surgeon are skill, experience and empathy. We would expect the surgeon to have a good reputation with their colleagues and, if we needed unusual surgery we would expect the surgeon to have that sub-specialist expertise and, if not, that they would refer us onwards to someone who did. We would assume that they would have up-to-date knowledge, and would expect that the profession would make assessments to ensure that was so.

"Finally we would expect a transparency in all dealings, and an ability to independently check any claims made would be key to earning and maintaining trust. We would expect the professional societies responsible for the practice of surgery under consideration to set clear standards of care, monitor those standards, and use the data to drive quality improvement. We would also expect them to have a strategy for getting information to patients about the relevant disease and treatments, as well as providing comparative clinical outcomes, to help us become an informed partner in any decision making process."

David H Geldard MBE, patient representative and board member of Society for Cardiothoracic Surgery.[28]

CONTRASTING PATIENT EXPERIENCES OF THEIR GP

Patient A: I've got a very good GP now, I have got a GP who actually knows what fibromyalgia is, he's prepared just to sit and listen, he listens a lot, he'll let me try new medications, obviously because of my science background I probably know more about fibromyalgia than he does because I read so much in research papers, but he's very willing to let me be a guinea pig and to work with me, which I think is important with a doctor/patient relationship, you've got to work on this path of chronic pain together.

But you've also got to be very honest with your doctor, you can't just go out and start trying a new treatment without telling him, because then he can't monitor what's going on. My doctor likes to monitor what my drugs are doing, and if I want to start a new therapy I will go and tell him, I am going to start this now, and then we'll discuss it and decide is this actually working, is it actually making any difference, so we can see if I'm wasting my money or not, but also I think you have to appreciate with your doctor what he can do and what he can't do.

Like he cannot take your pain away, so there's no point in keeping going to him and saying "Oh I'm still in this pain", there's nothing that he can specifically do, you have to accept his limits. Like he can refer you to a physiotherapist, he can refer you to occupational therapy; he can help you with...

So if I want a specific referral, I'll go and say I need to see a physiotherapist at the moment and he'll just do the referral or I think I need a bit more of this drug, can we just try it, rather than just experimenting on your own, which actually might be dangerous, because the interactions with the different drugs, he's there to point me in the right direction so we work together and it works really well. But I don't bother him all the time with things I know he can't solve, because that is where the frustration gets in, yes it works well.

29-year-old female patient diagnosed with fibromyalgia – www.healthtalkonline.org

Patient B: The first appointment that we had with the doctor wasn't actually my own GP. It was obviously my GP practice, but it wasn't my GP and she was, negative's maybe going a little bit too far, but her exact words to us were, because my husband came with me, "Of course this is very, very early on in your pregnancy and there's no guarantee that you will actually go to full term." And I mean I was quite horrified. I just thought, "I really can't believe you've just said that." My husband was really quite upset by it, and really, you know, "We shouldn't tell anybody and the risk must be huge," and I said, "Well, no, it's not. I mean, it's something like, what, 25% or something?" I said, "But, you know, I'm really quite horrified that she said that." But she said, "But not of course that I'm suggesting that will happen but, you know, you are aware of that." And I did actually mention it to my own GP when I went back the following week and said, you know, "If that is what she's saying to other people, that could really, really upset people."

33-year-old lecturer, four months pregnant – www.healthtalkonline.org

PROFESSIONAL EXPECTATIONS

Any doctor who specialises in a particular field would be expected to keep up-to-date in that area. This would apply to all fields of medicine. Surgeons with a special interest would be expected to keep up-to-date with developments both in the field of general surgery and their area of special interest. A patient and indeed a court of law would expect the practitioner to have a reasonable grasp of current concepts and ideas, as well as any controversies within their specialist subject. This means reading the latest peer-reviewed journals from across the world, and attending postgraduate meetings and conferences organised by specialist societies.[29] Obstinately persisting in using outdated techniques contrary to recognised opinions and evidence is both unprofessional and unethical, especially when those techniques have been shown to cause demonstrable harm in the past.

A clinician may be perfectly competent and capable at one moment in their career, only to find their competence being challenged at some subsequent time. This may be due to illness or deterioration in physical health. It might follow a temporary (or extended) absence from clinical practice, or reflect psychological or emotional problems. In all these cases, it is a clinician's responsibility to ensure that at all times they are able to carry out medicine safely, and to an acceptable standard. Where there is any doubt that this is the case, the clinician has an ethical duty to seek appropriate (eg, medical) advice, and to act upon it.

It can be difficult to maintain an objective evaluation of your specialist competence and ensure you keep up-to-date, while also focusing on patient care in an intensive working environment. Appraisals and revalidation have an important role for every clinician, and you can also help colleagues by the feedback you give and how you yourself receive feedback.

Learning from colleagues

To learn only from one's own mistakes would be a slow and painful process and unnecessarily costly to one's patients. Experiences need to be pooled so that doctors may also learn from the errors of others. This requires a willingness to admit one has erred and to discuss the factors that may have been responsible. It calls for a critical attitude to one's own work and that of others.

No species of fallibility is more important or less understood than fallibility in medical practice. The physician's propensity for damaging error is widely denied, perhaps because it is intensely feared... Physicians and surgeons often flinch from even identifying error in clinical practice, let alone recording it, presumably because they themselves hold... that error arises either from their or their colleagues' ignorance or ineptitude. But errors need to be recorded and analysed if we are to discover why they occurred and how they could have been prevented.

The Critical Attitude in Medicine: The Need for New Ethics, by Professor Neil McIntyre and Sir Karl Popper (1983).

SUMMARY

The unsettling fact that healthcare can harm as well as heal us is why it is at the heart of healthcare quality. The wider public wants a health service in which they can take the optimum performance of their doctors for granted. The biggest challenge for doctors in the future is whether they are able to meet these expectations.

"The culture of the future must be a culture of safety and of quality; a culture of openness and accountability; a culture of public service; a culture in which collaborative teamwork is prized; and a culture of flexibility in which innovation can flourish in response to patients."

Sir Ian Kennedy, Bristol Inquiry.[30]

Useful links

- Bristol Royal Infirmary Inquiry – www.bristol-inquiry.org.uk
- DH, *Good Doctors, Safer Patients* – www.dh.gov.uk
- The Shipman Inquiry – www.the-shipman-inquiry.org.uk
- DH, *An Organisation With a Memory* – www.dh.gov.uk

Society for Cardiothoracic Surgery in Great Britain and Ireland, *Maintaining Patients' Trust: Modern Medical Professionalism* (2011) – www.scts.org

4

WHAT TO DO WHEN THINGS GO WRONG

> To err is human, to cover up is unforgiveable, and to fail to learn is inexcusable[31]

The overwhelming majority of patients receive safe and effective care. However, when things do go wrong, it can be catastrophic for all involved. Part of being professional is having the knowledge and awareness to deal with such situations effectively.

Good communication lies at the core of rebuilding trust and supporting healing for the patient, their loved ones and the healthcare team involved. Poor or no communication compounds the harm and distress that has already been experienced. MPS has long supported and advised members to be open with patients when something has gone wrong.

The significant cultural shift in the relationship between the medical profession and patients over recent years has changed both the definitions of professionalism, and how that professional should respond when things go wrong. The traditional, paternalistic doctor–patient relationship has been largely replaced by a doctor-patient partnership, where patients can rightly expect open and honest communication and shared involvement in decision-making: "no decision about me, without me." Patients increasingly see themselves as consumers, and have consumer expectations. Medical professionals have to respond accordingly.

WHAT DO PATIENTS WANT WHEN THINGS GO WRONG?

Most patients want doctors to be open and honest about the mistakes that have been made. An MPS survey on openness found that 95% of people are most likely to think that it is 'fairly' or 'very important' that they receive an open and honest explanation of what went wrong, or ensure that the problem that occurred is corrected.[32] A similar proportion, 94%, think it is important that those responsible learn lessons in order to prevent it happening again, while nine in ten say that it is important that they receive an apology.

Similarly, many studies show that patients take legal action primarily because they are angry – often because they are given incomplete or delayed information about what happened and why. The majority of patients say that the main reason they initiated litigation was 'to make sure this doesn't happen to anyone else'. Patients want information, and they want that information used to make healthcare safer.

DUTY OF CANDOUR

From 1 April 2015, a duty of candour applies to all health and social care providers regulated by the CQC, including GP practices.

The duty, which was introduced by the government through regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, applies to NHS organisations such as trusts and foundation trusts and bodies including GP practices, dental practices and care homes.

How it affects you

Under the terms of the new duty, you need to make sure that your practice acts in an open and transparent way:

- With relevant people
- In relation to care and treatment provided
- To service users
- In performing a regulated activity.[1]

After becoming aware that a notifiable safety incident has occurred, you must:

- Notify the relevant person as soon as is reasonably practicable (CQC guidance refers to the ten days required by the NHS standard contract)
- Provide reasonable support, such as providing an interpreter for any discussions, or giving emotional support to the patient.

Your notification must:

- Be given in person by at least one representative of the practice involved, and then followed by a written notification
- Provide a true and accurate account of the incident
- Provide advice on what further enquiries into the incident are required
- Include an apology
- Be recorded in a written record, which should be kept securely.

What is a notifiable safety incident?

The regulation states that there are two meanings of a notifiable safety incident; one for a health service body, the other for registered persons – registered persons being GPs and primary care dental practitioners.

According to the regulation:

"In relation to a registered person who is not a health service body, "notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional –

(a) appears to have resulted in –

i. the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition,

ii. an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,

iii. changes to the structure of the service user's body,

iv. the service user experiencing prolonged pain or prolonged psychological harm, or

v. the shortening of the life expectancy of the service user; or

(b) requires treatment by a health care professional in order to prevent –

i. the death of the service user, or

ii. any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a).

What is harm?

"Harm", as listed above, is further defined in the regulation as:

- Prolonged psychological harm - means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.
- Prolonged pain – means pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

About the duty of candour

Introduced for NHS bodies in England from 27 November 2014, the key principle of the duty of candour is that care organisations have a general duty to act in an open and transparent way in relation to care provided to patients. The statutory duty applies to organisations, not individuals.

Further information

The Care Quality Commission, Regulation 20: Duty of candour. Issues for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare (March 2015) –www.cqc.org.uk/content/regulation-20-duty-candour

1 "Regulated activity" is defined by the Safeguarding Vulnerable Groups Act 2006

WHAT SHOULD OPENNESS LOOK LIKE?

Doctors have a professional and ethical obligation to be open and honest when things go wrong. GMC guidance states: "You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:

(a) put matters right (if that is possible)

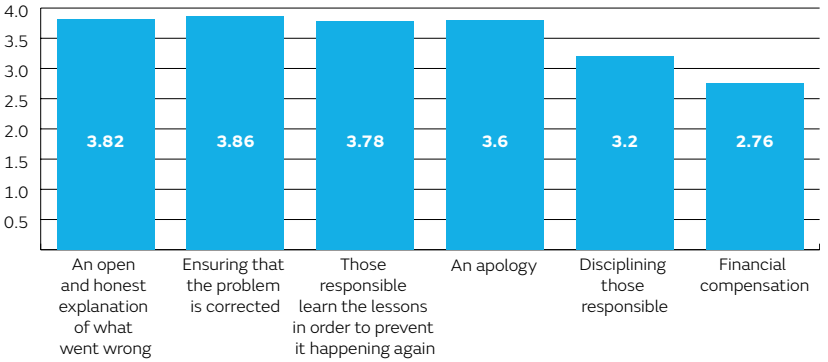
(b) offer an apology

(c) explain fully and promptly what has happened and the likely short-term and long-term effects."[33]

When things go wrong, saying sorry is not enough – as the graph below, taken from an MPS survey, shows. Patients want an explanation of what went wrong and why, and doctors need to rebuild the relationship of trust. Notably, patients are least likely to think that financial compensation is important – 52% think it is fairly or very important.[34]

If something went wrong when you were receiving medical treatment or medication, how important, or otherwise would it be to you that each of the following took place?

KEY: Individual responses were given numerical scores whereby 4 = important and 1= not at all important. Mean scores were calculated to aid analysis.



CASE STUDY THE IMPORTANCE OF BEING OPEN

I presented at the Emergency Department (ED) with a terrible pain down my arms and back after a fall. After some investigations, which came back negative, I was given some painkillers and sent home.

The next day, I went to see my GP because I was in so much pain. She prescribed me four different painkillers and advised me the pain should settle in a week or two.

Six and a half weeks later, the pain was as bad as ever. I was referred to a neurologist, who thought I might have a slipped disc. He arranged a CT scan, which showed that a vertebra in my neck was broken in three places.

I was horrified that the fracture had been missed for so long. I now know that I could have been paralysed and should have been placed in a neck collar immediately. Instead, I had spent the past six weeks following my doctor's advice to be as active as possible, even going for a 10k run.

I understood that the doctors missed the fracture because they were more concerned to find out why I had had the fall. They were trying to do their best. We're all human and fallible.

Immediately, the neurologist acknowledged they had missed the fracture and was very open about the mistake. He apologised, but at that point, saying sorry wasn't high up on my agenda. I was more interested in what was going to happen and whether I was going to be ok.

He didn't try to cover anything up and asked for an internal investigation straightaway. He also said that I was under his care. This made me feel like I wasn't just another patient being moved from one place to another. This doctor would look after me. He reassured me everything would be ok.

Once I was feeling a little better, I kept running through my mind what could have been. I knew something bad had happened, and that something even more catastrophic could have happened. I realised there was a problem in the system; another woman on my ward also had a slipped disc which wasn't picked up in the ED. I didn't want this to happen to anyone else. I decided to write a letter of complaint.

The hospital wrote to confirm receipt of my letter and stressed they were taking the complaint seriously. However, I waited months for a response. The time lapse made me think they had something to hide, or were scared of legal action.

After months of chasing, when the response came, I was initially relieved. However, the hospital hadn't answered my key questions. They apologised, admitted the mistake, and explained they were changing systems, but they didn't comment on whether their failure to diagnose had made my condition worse. I wanted someone to take responsibility for what had happened to me.

By Farzana Hakim

FITNESS TO PRACTISE (FTP) PROCEDURES

Sometimes, when an adverse incident occurs, the GMC can take action if a doctor's fitness to practise is called into question, which could be due to:

- Misconduct
- Poor performance
- A criminal conviction or caution in the UK (or elsewhere for an offence that would be a criminal offence if committed in the UK)
- Physical or mental ill health
- A decision by a regulatory body either in the UK or overseas.
- Following a complaint to the GMC, FTP procedures begin. The procedures are divided into two stages:
- Investigation – The GMC investigates cases to see whether they need to be referred to the Medical Practitioners Tribunal Service (MPTS).
- Adjudication – Hearings for cases which are referred are conducted by an MPTS FTP Panel.

INVESTIGATION

Sometimes, concerns that are raised in a complaint to the GMC may not raise concerns about a doctor's fitness to practise. In such cases, the matter is usually referred on to the doctor's employer. If a concern does raise questions about a doctor's fitness to practise, investigations will begin.

The complaint is disclosed to the doctor's employer or sponsoring body. At this stage, the doctor is given the opportunity to comment on the complaint.

Panels hear evidence and decide whether a doctor's fitness to practise is impaired. These allow the GMC to respond to the most serious concerns which call into question a doctor's fitness to practise and right to retain unrestricted registration.

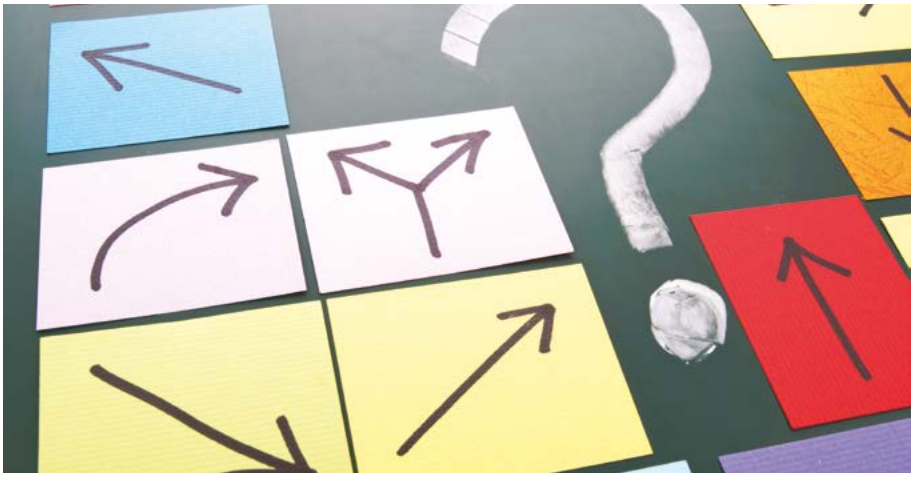
Hearings are the final stage of procedures following a complaint about a doctor.

HOW DO FTP HEARINGS WORK?

The GMC and the doctor in question are both invited to attend. The GMC is normally represented at the hearing by a barrister and the doctor is usually present and legally represented. Both parties may call witnesses to give evidence, who may be cross-examined by the other party. The Panel may also put questions to the witnesses.

Panels meet in public, except where they are considering confidential information concerning the doctor's health or they are considering making an interim order.

An FTP Panel is appointed through open competition by the MPTS against agreed competencies. In addition to the chairman, who may be medical or non-medical, there must be at least one medical and one non-medical panellist on each panel. A legal assessor sits with each Panel and advises on points of law and of mixed law and fact. One or more specialist advisers may also be present. Their role is to provide advice to the Panel in relation to medical issues regarding a doctor's health or performance.



DECISIONS

- Once the Panel has heard all the evidence, it must decide:
- Whether the facts alleged have been found proved
- Whether, on the basis of the facts found proved, the doctor's fitness to practise is impaired
- Whether any action should be taken against the doctor's registration.

If the Panel concludes that the doctor's fitness to practise is impaired, the following sanctions are available:

- To take no action
- To accept undertakings offered by the doctor provided the panel is satisfied that these protect patients and the wider public interest
- To place conditions on the doctor's registration
- To suspend the doctor's registration
- To erase the doctor's name from the medical register, so that they can no longer practise.

Decisions must be made in line with the GMC's indicative sanctions guidance, which aims to ensure consistency of decision-making. Any proposed action has to be sufficient to protect patients and the public interest.

If a Panel concludes that the doctor's fitness to practise is not impaired, but there has been a significant departure from the standards set out in *Good Medical Practice*, it may issue a warning to the doctor.

Where the Panel makes a finding on disputed facts, it applies the civil standard of proof.

Where the Panel decides whether or not the doctor's fitness to practise is impaired, it uses its judgment. The same is true when the Panel decides what sanction should be imposed on the doctor.

APPEALS

Doctors have a right of appeal to the High Court against any decision by a Panel to restrict or remove their registration. The appeal should be filed within 28 days of the doctor being notified of the decision; the appeal should be made to:

- the Court of Session in Scotland if the doctor's registered address is or would be in Scotland
- the High Court of Justice of Northern Ireland if the doctor's registered address is or would be in Northern Ireland
- the High Court of Justice in England and Wales in any other case.

Likewise, the Council for Healthcare Regulatory Excellence may also appeal against certain decisions if they consider they were too lenient.

APPLICATIONS FOR RESTORATION

Any doctor whose name was erased from the medical register by an FTP Panel can apply for their name to be restored. However, this cannot be done until a period of five years has elapsed since the date their name was erased.

REMEMBER TO REMAIN PROFESSIONAL

It is important to remember that an adverse incident is not necessarily a sign of being unprofessional, or of poor clinical practice. Mistakes do sometimes happen. Getting your response right when things go wrong is the hallmark of a professional. Being open and honest can go a long way in defusing a tense situation and can prevent a complaint or claim being made.

Similarly, if you are reported to the GMC, and an investigation takes place, be open and honest about it. Contact MPS and your employer at the earliest opportunity and be as co-operative as possible if you are asked to provide evidence. Keeping a cool head in the face of criticism about your professional performance or clinical practice is a sign of true professionalism.

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NOTES

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In the interests of confidentiality please do not include information in any email that would allow a patient to be identified.

1992:09/15