When things go wrong: protecting patients and supporting doctors

Irving Taylor

Abstract

A healthcare system should ensure that surgical errors are kept to a minimum, and if possible are avoided altogether. Unfortunately, errors do occur however carefully one tries to avoid them. Once recognized an error must be rectified as soon as possible. An appropriate apology to the patient or their relative is an absolute requirement. In this article I review the processes available to deal with errors both locally and through the regulatory authorities if considered necessary. I look at how lapses, both clinical and non-clinical, are handled locally and by the appropriate regulatory body. I also discuss how allegations relating to fitness to practise are investigated. Whilst the over-riding responsibility of all these structures is to protect patients, as mentioned it is necessary also to support doctors and to learn the lessons on how and why the errors have occurred. The maintenance of professionalism is essential. As well as supporting and protecting the patient, support for the surgeon in the workplace is a necessary requirement.

Keywords Candour; consent; professionalism; protecting patients; supporting surgeons

Introduction

All surgeons are human. However careful, however experienced, and however conscientious a surgeon is, errors will occasionally occur compromising patient safety. This has been expressed succinctly by Sir Liam Donaldson, a previous Chief Medical Officer, in 2004 when he said, '*To err is human ….to cover up is unforgivable…to fail to learn is inexcusable.*'

Although a single error, even in a previously unblemished career, may lead to litigation, unless the error is grossly incompetent, such as removing the wrong organ or limb, so-called 'never events', or associated with evidence of dishonesty in an attempt to cover up the mistake, it would not normally lead to an investigation of fitness to practise. However, the recent well-publicised case of Dr Bawa-Garba, found guilty of the negligence manslaughter of a 6-year-old child, might appear to contradict past legal precedent. Although a 'never event' appears to have occurred, since there was a mix- up with patient identity with serious consequencies. Dr Bawa received a 2-year suspended prison sentence. The Medical Practitioner Tribunal Service (MPTS) imposed a 12 months' suspension. Subsequently the GMC argued that erasure was necessary to uphold public confidence in the profession and a High Court judgement supported this view. She was therefore erased form the medical register. Dame Clare Marx is now leading a UK independent review into how gross negligence manslaughter (in England) and culpable homicide (in Scotland) are applied to medical practice.

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Never events

Sadly 'never events' continue to occur, for example between April and November 2017, there were 279 such events reported within the National Health Service (NHS).[1] These included wrong site surgery (112), retained foreign object (78), wrong implant/prosthesis (42) and wrong route administration of medication (16). Table 1 highlights the never events to be reported that are of most relevance to surgical practice.

Such events are usually associated with litigation and are unacceptable. NHS Improvement states very clearly that '*Never Events are key indicators that there have been failures to put in place the required systemic barriers to error and their occurrence can tell commissioners something fundamental about the quality, care and safety processes in an organisation.*' In other words, never events indicate systemic failures within the organization and are clearly negligent. This applies directly to the case of Dr Bawa-Garba. However, as far as the individual doctor or surgeon is concerned, a never event usually results in litigation and is very costly.

Complaints

Any complaint from a patient, carer or family, whether serious, trivial or unwarranted, can generate serious anxiety and impact on a surgeon's confidence with resulting depression. In attempting to rectify the error, in dealing with the patient or relatives and in facing peer judgement, surgeons become second victims[2] Recent books by Atul Gawande and by Henry Marsh have reflected on these issues in detail and are well worth reading for a doctor in training.[3,4] One review has suggested that the prevalence of second victims after adverse events varies from 10% to more than 40%. Surgeons report strong negative reactions to adverse events such as anger and irritation, sadness and depression, shame and self-blame.[5] Patient safety is obviously of paramount importance and every effort must be directed towards protecting patients from harm, however, supporting surgeons when a surgical mishap has occurred is also a requirement.

Consent to treatment

Surgeons must be cognisant of and familiar with the implications of the recent change in the law on informed consent following a Supreme Court judgment. As a result of the judgment in the case of *Montgomery v Lanarkshire Health Board (2015)*, surgeons must now ensure that patients are aware of any 'material risks' involved in a proposed treatment, and of reasonable alternatives. This is a marked change to the previous 'Bolam test', which asks whether a doctor's conduct would be supported by a responsible body of medical opinion? The Bolam test will continue to be used more widely in cases involving other alleged acts of negligence (i.e. diagnosis). In a move away from the 'reasonable doctor' to the 'reasonable patient', the Supreme Court's ruling outlined the new test and states '*The test of materiality is whether, in the*

NHS never events of relevance to surgical practice

Surgical	Medication	General
Wrong site surgery	Mis-selection of a strong potassium solution	Chest or neck entrapment in bed rails
Wrong implant/ prosthesis	Administration of medication by the wrong route	Transfusion or transplantation of ABO-incompatible blood components or organs
Retained foreign body	Overdose of insulin due to abbreviations or incorrect device	Misplaced naso- or oro-gastric tubes
	Mis-selection of high dose midazolam during conscious sedation	

Table 1

circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.'

This ruling has been supported in a statement from the GMC chief executive, Niall Dickson, who states '*We are pleased that the court has endorsed the approach advocated in our guidance on consent.* Good Medical Practice *and* Consent: Patients and Doctors Making Decisions Together[6] *make it clear that doctors should provide person-centred care. They must work in partnership with their patients, listening to their views and giving them the information that they want, and need, to make decisions.'*

The Medical Defence Union (MDU) has looked at the ruling in depth and has identified and documented a number of tips to assist in following the correct procedures (Table 2). The new ruling should directly and indirectly protect patients whilst at the same time supporting surgeons should a question of litigation arise. However, to achieve these aims and to be effective, the new ruling must be understood and followed by medical staff.

Duty of candour

The GMC have provided clear statements on the importance of candour (being open and honest) when things go wrong.[7] This applies to all aspects of the care pathway and the concept should be accepted by surgeons. In summary the key features of the statutory duty of candour are;

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care and causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:

- 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.

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns.

Typical examples of 'things going wrong' include recognized complications such as a leaking anastomosis or a postoperative haemorrhage, or technical errors such as damage to the bile duct during cholecystectomy. These potential complications would have been discussed during the consent process but nevertheless if they do occur the patient should receive an apology and full explanation. There are no legal concerns about taking this course of action: it is quite different from admitting liability.

Very often a full and frank explanation of the postoperative complication is all that patients want. Litigation can arise as a result of patients feeling that information is being withheld because an error has occurred and is being 'swept under the carpet' or an attempt is being made to deliberately and dishonestly mislead. So, whenever there is an unexpected or unanticipated event, an apology and explanation is an absolute requirement. This should be given in the presence of a third party witness and documented within the patient's medical records. This is the duty of candour.

Maintaining professionalism

As surgery has become more advanced and increasingly technologically based, as well as increasingly specialized, there is a growing perception that authentic professionalism is being squeezed out of surgical practice, in part due to the disproportionate emphasis now being placed on target-driven competitive and commissioned delivery of health care. To support this one merely has to note the ever-increasing proliferation of reports

Ten 'top tips' for implementing the new law on consent (taken from MDU)

1. Make full notes
2. Discuss reasonable alternatives to treatment being proposed
3. Ensure adequate time is set aside for discussion
4. Focus on the individual patient.
5. Engage in a genuine, two-way dialogue, recording both sides of the conversation
6. Do not simply focus on percentages
7. Consider the risk of intervening events, not just catastrophic outcomes
8. Think very carefully before relying on the therapeutic exception
9. Patient understanding
10. Leafleting is not enough

Table 2