Written evidence submitted by The Doctors' Association (NLR0071)_

Submission on behalf of The Doctors' Association (DAUK) and other named parties below

Main Enquiry: What is the impact of the current cost of litigation on the financial sustainability of the NHS and the provision of patient care?

Focus of this DAUK paper

How important is it that any clinical negligence system encourages lesson learning and commitment to change as the result of any action?

What changes should be made to clinical negligence claims to enable a move away from a blame culture and towards a learning culture in the NHS?

Who are we?

The Doctors' Association UK (DAUK) is a professional association which provides an important grassroots voice for frontline doctors, led by doctors. Our platforms cater for over 30,000 doctors and medical students. Founded in 2018, DAUK advocates for transformational change of the culture of fear and blame in parts of the NHS, campaigning to develop a culture in which we can learn in a constructive, fair way when things go wrong, and in which staff feel willing and safe to speak up early about concerns.

DAUK launched our *Learn not Blame* campaign in Parliament in 2018. Philippa Whitford MP chaired the inaugural meeting, bringing together NHS staff, organisations and patients. In the same year NHS Improvement published *A Just Culture Guide*, aiming to support managers reviewing patient safety incidents in understanding whether a staff member needs support or intervention, or whether the issue is wider; in which case singling out the individual is often unfair and counter-productive. The guide also aims to reduce unconscious bias in making these decisions, recognising that there is disproportionate disciplinary action in the NHS against black and minority ethnic staff. DAUK is currently working to expand the campaign across both primary and secondary care by promoting a series of simple, yet effective changes in the workplace in order to reduce the widespread effects of the blame culture.

To what extent does the adversarial nature of the current clinical negligence system create a "blame culture" which affects medical advice and decision making?

The total annual cost of NHS litigation is currently £3.6 billion (2018/2019). Damages make up the greatest proportion of costs (£1.5 billion). Surgical specialties have the greatest number of claims annually (2847) but Obstetrics has the greatest total litigation (£1.9 billion) and cost per claim (£2.6 million). Number of claims, total costs and cost per claim are significantly greater in 2018/2019 than in 2009/2010[1] and greater than would be expected by inflation alone.

DAUK's specific contribution to resolution of this problem relates to highlighting 'the blame culture' which exists in healthcare and it on is this we would like to focus our report. The 'blame culture' is at the heart of lack of transparency when things go wrong as well as being significantly responsible for

the inexorable rise in defensive medicine. Medical advice and decision making is profoundly affected by it. Although In 2017/18 the largest number of claims against the NHS related to Emergency Medicine.[2] The frequency and cost of litigation within EM is increasing disproportionately to both attendance rates and economic inflation. There is a national shortage of clinical staff, hospital beds and as a result over-crowding throughout the NHS. This is not surprising, given the pressurised working environment, pressures on staffing, the undifferentiated caseload which is being managed and the ever-increasing problem of exit-block and long waits for hospital beds.[3]

Defensive Medicine

Defensive medicine is defined as a deviation by a healthcare practitioner from standard practice to reduce or prevent complaints or criticism and is just one of the consequences of the blame culture coupled with the threat of litigation. Studies in the UK attempting to quantify the prevalence of defensive medicine are limited but snapshot surveys have suggested that only about 14% of respondents (doctors) believe they are working in a blame-free culture and 78% (n=159) volunteered that they were practising some form of defensive medicine. Interestingly, it reduced in prevalence amongst more senior doctors.[4] Defensive medicine increases health care costs without improving health outcomes. In a recent peer-reviewed US study, orthopaedic surgeons recorded in real time whether imaging was required for clinical care or ordered for defensive reasons and found that physicians ordered 19.1 percent of imaging tests and 38.5 percent of MRIs for defensive reasons. Tellingly, physicians who had been sued within the past five years were substantially more likely to order defensive imaging. The same was true for physicians who had practiced medicine for more than 15 years. [5]

There is a right way and a wrong way to reduce the costs of defensive medicine. One proposal might be to arbitrarily cap the amount of damages that may be awarded in negligence suits. However, this might only reduce national health spending by a small amount. While such caps would have a barely measureable impact on health care costs, they might adversely affect health outcomes as patients might not be able to obtain full and just compensation for their injuries.

What do frontline doctors say about defensive medicine and the 'blame culture?'

"ED front door/triage staff are too frightened to turn people away who maybe should not be there but could access care in other ways for fear they might be the 1 in 1 million who has a bad outcome."

"Order tests for simple infections which I know are self-resolving but they don't want to miss anything. These tests can include invasive tests with complications like lumbar punctures where spinal fluid is taken off."

"Patients can get after effects which are not pleasant from these procedures. CT head for example is ionizing radiation which if they have a number, especially from a young age can increased your risk of cancer."

" Doctors are trying to provide safe patient care in a broken NHS system - that will still hold them responsible as individuals for the failings of the Government and the system."

"Defensive medicine wastes resources and time on additional inappropriate and unnecessary investigation which reduces the availability for those that need it and leads to unaffordable healthcare."

"Healthcare workers are scared that a mistake, unavoidable human error or perception of error even where none exists will lead to serious consequences such as GMC investigation or criminal charges."

Solutions

It is of vital importance that any clinical negligence system encourages lesson learning and commitment to change as the result of any action. A more transparent process would benefit everyone. Most claims settle out of court and when this happens there is no proper translation of 'lessons learned' due to confidentiality issues. If the reasons underpinning a compensation award in a civil case could be shared more widely then mechanisms could be put in place to prevent recurrence. All this could happen without singling out individuals for blame except in the most egregious cases

Practical ways to reduce blame and tackle the climate of fear in the health service could include

(i) Better ways to manage complaints, such as early apology (saying sorry does not admit liability) as well as organisations being held to account as a whole, instead of focus on the individual (unless there are serious issues with underperformance).

(ii) Acknowledging system errors contribute to human error.

(iii) Acknowledging individual accountability should be acknowledged and demonstrated.

(iv) More understanding that some adverse outcomes are blameless and are part of the risk of life. Also that some human error is inevitable in order to achieve healthcare delivery. Systems need adequate resource to minimise the chance of human error harming patients.

(v) Acknowledging that complaints and litigation are disproportionately harmful to clinicians AND other patients (defensive medicine and forced errors). The systems set up to deal with both complaints and litigation should make allowances for the impact of this on all of those concerned in a transparent and equitable way.

(vi) Acknowledging that although we know that patients will come to harm from medical error occurs in every single healthcare system and every effort must be undertaken to reduce this risk. It is also right that people who have come to harm from avoidable error are compensated for this. It is arguable that adversarial. Often, an indemnifier will direct a trust/Dr to recognise blame and provide compensation. As Don Berwick said "fear is

toxic to both safety and improvement, and health systems must abandon blame as a tool.[6]"The threat of loss of job and personal cost borne by those who have made mistakes needs to be managed fairly too. This can be done by greater use of confidential enquiries and recognition that those who have erred are also going through investigation are properly supported. When honest errors happen, the people who have erred need support not condemnation.

(vii) Ensuring we have the right checks and balances and finding balance in a system where at present we do not have it. Defensive medicine is common because of fear of career-ending mistakes. Cases such as that of Dr Hadiza Bawa-Garba weigh heavily in the minds of clinicians, particularly those in training: no one wants to be the one person in the department who is blamed for a poor outcome. The importance of the "second victim" in incidents has been only slowly recognised in the UK, if at all. Indemnifying the organisation is would be a more collaborative idea. There should be a move away from blaming individuals, except in exceptional cases, to more of an investigation of the system in order to make it better.

(viii) Recognising that solicitors often fail to represent the complexity of the case and instead focus on whether NICE guidance has been followed completely or not. Medical practitioners may interpret NICE guidance to fit the complexity of the case, but if they fear criticism if they fail to slavishly follow guidelines then we risk over medicalisation and 'tick boxing' which means that other patients may suffer but the doctor is in the clear. We should define the standard of care clearly with guideline adherence but not use this as a set of rules like some lawyers and coroners do. The importance of clinical judgement is crucial. This is what we all learn as healthcare professionals. We will keep losing good doctors and nurses if we don't tackle this problem. We need to completely change the culture, and recognise in an underfunded, under resourced, high stress system errors are inevitable.

Individuals need to be able to report near misses without fear of judgement or effect on their careers.
High profile cases, such as that of Dr Christopher Day [7] need to be resolved and their whistle blowing protection reinstated. Anything less means no one will speak up in future due to concerns of losing their careers. Individuals should be encouraged to speak out when they have a concern. From a primary care perspective there are currently limited ways to enable GP practices sharing errors, information and their solutions. This too needs to change and an anonymous national database might help.

We need to shift away from personal shame and blame if there is an error/near miss, to recognise we are all cogs in the system, the individual is just the end of a long line of pressures which have contributed to any errors, but this is often not emphasised through medical school or training. The Swiss cheese model of accident causation illustrates that, although many layers of defence lie between hazards and accidents, there are flaws in each layer that, if aligned, can allow the accident to occur[8].

In primary care the positive things which can help are electronic prescribing, so interactions and contraindications are drawn to clinician's attention. The alert system can be placed on records of potential risks. Some of these are automated. Some can be tailored by an individual practice. This needs to expand in secondary care now we have more advanced IT systems, whilst recognising that "alert fatigue" is a recognised phenomenon.

A 'no fault' alternative model of healthcare which saves money and gets compensation to anyone who should be compensated quicker should be investigated by government. It would be difficult to cite another country's model as best as each country has varying health systems but any principles from examples like Sweden or New Zealand which could be integrated into the British system may be helpful.

Use technology: One example is that of procalcitonin, a biomarker which can aid in the diagnosis and monitoring of sepsis. Sepsis is a life-threatening complication of an infection. It occurs when mediators released in the bloodstream to fight an infection trigger inflammation throughout the body. This can cause a cascade of changes that damage multiple organ systems and sometimes even result in death. Symptoms of sepsis include fever, difficulty breathing, low blood pressure, fast heart rate, and mental confusion. Treatment of sepsis includes antibiotics and intravenous fluids. Procalcitonin (PCT) is a host response biomarker that is sensitive and specific to bacterial infection.PCT may aid clinicians in determining a patient's risk of progression to severe sepsis and septic shock. This could help identify better who needs more investigation and who does not but it still will require careful roll-out. This is currently under investigation in a massive national study called "PRONTO.[9"]

Control of costs in healthcare

The best way to control costs is to improve safety so that both patient harm and subsequent litigation are reduced. Improving safety in health systems overall is likely to reduce the level of avoidable harm and thus decreases litigation**.** Understaffing, poor state of buildings, lack of proper equipment, and challenges in information technology directly affect safety with additional effects on workplace morale, ability to provide compassionate and safe care, and burnout. At an individual level staff can be supported to reduce their risk of litigation by providing the patient with a comprehensive understanding of the choices available, and the risks and benefits for them of each of them. The range of outcomes has to be explained and all the patient's questions answered honestly. This leads to trust in the clinical relationship. Staff must also feel that they can trust their organisation as well as their colleagues as part of a team when things go wrong. This reduces the defensive behaviour and improves the likelihood of everyone learning from untoward clinical events. Organisations should raise awareness of litigation claims in each department. More openness enables clinicians to learn from incidents and to be supported. In turn they can support their patients through a mutually difficult experience[2].

Other solutions to support staff include a real commitment to learning and improvement, learning from high performance. Examples of this include the individual being enabled to improve their technical proficiency, participation in multidisciplinary training, coordination, use of data and intelligence about safety and quality, and restating the normal standards of behaviour are all important. Enabling and supporting system-wide safety improvement protects all staff.

Supporting Staff through Clinical Negligence Claims.

It is vital to understand the impact a claim can have on NHS staff as well as how to support them through the process and identify if staff require support or intervention will also be included.

Doctors are very concerned about the prospect of a negligence claim, particularly in the context of the pandemic. A Medical Defence Union (MDU) GP survey found that "63% are concerned about facing a complaint or claim related to the pandemic." This is despite the fact that they have been state indemnified and not financially responsible for claims relating to covid-19 treatment. They would still have to give evidence and face the distress and anxiety of having their clinical work criticised and decisions questioned when the public memory of the extraordinary circumstances they have been working under has faded[10].Mental health problems are not uncommon in NHS staff subject to claims from lengthy clinical negligence proceedings long after the event. The two main areas of concern are alleged delays in diagnosing serious conditions such as cancers and stroke during remote consultations and delays in referrals for further investigations due to the backlog of non-covid related treatment.

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How can the Healthcare Safety Investigation Branch work to improve short term responses to patient safety incidences and therefore reduce the number of those who are forced to pursue litigation as a means of obtaining non-financial remedies?

What legislative changes would be required to support these changes?

We welcome the fact that the purpose of the Health Service Safety Inspections Body (HSSIB) does not appear to be assessing or determining blame but we believe that it should ensure that all relevant staff as well as families and patients should be explicitly included in the processes. These processes must include the concept of a "safe space" for giving evidence and this MUST be included and does not appear to be stated clearly at the beginning in the draft legislation. It is also not clear what level of certainty will be used to determine a "fact." We welcome the concept that its focus will be on ascertaining risks to safety of patients on a collective basis but we are unclear why individuals can be adversely affected if there is no intention to focus on individuals. We would seek further clarification on this. HSSIB reports could assist coronial inquests in fact-finding BUT it would be

important that staff statement undertaken in a ‘Safe Space’ could not be automatically disclosed so they could be used in an adversarial way in a coroner’s court.

Contributing Authors

Dr Jenny Vaughan and the DAUK committee

Jenny Vaughan is a consultant neurologist in NW London. She is a leading campaigner for reforming the law on gross negligence manslaughter when applied to those working in healthcare. She articulated the unease many people felt at the conviction of the surgeon David Sellu and, as campaign chair for his appeal, was instrumental in getting his conviction overturned. She also campaigned successfully, with others, for Dr Hadiza Bawa-Garba to be restored to the medical register and worked to ensure balanced reporting and understanding of her case both nationally and internationally. Dr Vaughan supports recent recommendations to improve communication with families affected by medical error and that avoidable harm must be tackled as a top priority by both the NHS and private healthcare. Dr Vaughan is Chair and ‘Learn not Blame’ lead at the Doctors’ Association UK (DAUK), a lobbying organisation for frontline doctors. Her interests include patient safety and 'Just Culture'.

Dr Graham Johnson

Graham Johnson is a consultant in emergency and paediatric emergency medicine and has been in post since 2015. He is joint lead for the research in emergency medicine group in Derby (REMEDY). Together with colleagues he has carried out an investigation of trends in litigation in emergency medicine over the last 10 years, which is accepted for publication but not yet in press.

Mr Leslie Hamilton

Leslie Hamilton is a retired cardiac surgeon - past President SCTS. Chair independent Review of Gross Negligence Manslaughter. Past member of Council, RCSE (co-author of Good Surgical Practice and consent guidance).

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