Risk management and substandard clinical care

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This conference was held at the Royal College of Physicians on 30 March 2000.

An onerous but reasonable duty has been placed on doctors by the General Medical Council (GMC) in their publication Good Medical Practice\(^1\). Under the heading 'Your duty to protect patients' the GMC states 'You must protect patients when you believe that a doctor's or other colleague's health, conduct or performance is a threat to them (the patients)'.

The problems of poor performance are categorised by the GMC as matters of knowledge, skills and attitudes, and these will be detected in the future during the process of the regular appraisal of all doctors within their directorate or trust structure. Closely allied to the process of appraisal is the regular review of doctors' job plans, which allows doctors to comment on any potential lack of resource for their work, and management to comment on aspects of doctors' behaviour. Markers of poor performance often relate to poor or late clinic attendance with cancelled lists and poor outcomes, or non-participation in or absence of commitment to audit. The existence of dysfunctional teams, leading to poor communication and attitude problems, may be highlighted by adverse clinical incidents. Complaints or litigation concerning a particular team will be a prominent pointer to poor performance.

In 1994, a disturbing report was published by Donaldson. Over a five-year period, concerns serious enough to warrant the consideration of disciplinary action were raised\(^2\).

The most effective way to minimise these problems is to have in place procedures that will both assist the physician in establishing an effective pattern of clinical work and give early warning of likely trouble in the future. As in the disease process, so early diagnosis often prevents progress to tragic pathological developments. Rapid identification of problems might be possible if all physicians were regularly appraised within the setting of well developed programmes of clinical governance at their place of work. Assessment of services and external peer review would add to early identification. The emphasis is on structured continuing medical education, measures of continuing professional development, regular appraisal and adequate audit. Audit should be backed up by efficient information technology systems. Doctors must move in a culture which regularly questions clinical competence, skills, and relationships with other members of the medical team. This process must be more formal and demonstrably adequate.

Most physicians have been assessing their own performance by maintaining postgraduate education and keeping up to date with advances in medical practice, resulting in generally high standards of clinical practice in the NHS. Focusing on poor performance does not denigrate the whole profession; there needs to be more openness and an ability to share mistakes, and better communication between professional groups with an understanding that sometimes things will go wrong. A procedure for reporting and analysing unexpected (critical) incidents is a positive way to encourage more open attitudes and is enacted already in many hospitals.

Many bodies and organisations will be involved in the process of assessing performance and there will be a need for regular dialogue between them. The royal colleges are involved in training, personal development, education, peer review and invited clinical visits. Local initiatives exist in some trusts, and all trusts have to set up adequate systems of governance. The Commission for Health Improvement (CHI), the GMC, the National Institute for Clinical Excellence (NICE), the specialist associations, and documents such as the national service frameworks all contribute to this process. The development of the intranet within a trust is proposed as an effective method of co-ordinating all the aspects of measurements of performance and aiding communication related to them.

Peer review visits

A number of specialties have established informal voluntary peer review visits, where medical teams are inspected and
assessed, and conclusions are shared with them. Great benefit can result from inspections of this type, but the process of inspection may be too soft without the mandatory powers needed to insist that change takes place. This approach should be compulsory if it is to be effective, and accompanied by a system to ensure that adverse comment is acted on. There are many critics of the present system, although even now the process should be beneficial. However, effective peer review visits may take many days, and consideration must be given to a balance between the use of time and finance against the demonstration of beneficial outcome. Striking examples of peer review are the British Thoracic Society Peer Review System and the pathologists' EQUAS system.

**The Commission for Health Improvement**

The Commission for Health Improvement (CHI) was established on 1 November 1999. The work of CHI is to review the process of clinical governance and examine systems such as management arrangements, relevant non-clinical policies and approaches within clinical teams. Further, it is to be concerned with patients' experiences of NHS care.

CHI's programme of work is extremely ambitious. It plans to carry out 25 reviews between April 2000 and March 2001, and then in excess of 100 reviews each year thereafter so that every NHS institution will undergo review every four years. This can only be described as a massive and possibly over-ambitious programme. The review visits will normally last about five days and the review teams will comprise health professionals, doctors, nurses, therapists, health service managers and at least one person without a clinical or NHS background who will concentrate in particular on patients' experiences. Health professionals will be chosen only from those in active clinical practice.

The primary purpose of these visits is to ensure that systems of clinical governance are put in place and functioning well. However, it is inevitable that in the course of such visits, problems will be identified with the practice of professionals or teams. CHI will have the ability to set up investigations and enquiries, and it is here that considerable discussions will be required between CHI and other organisations who may be requested to carry out 'investigations' when systems fail in hospitals – the royal colleges, GMC, UKCC and internal trust investigations. CHI draws a distinction between an investigation involving the gathering of evidence through the examination of documents and interviewing of individuals, and an enquiry characterised by a hearing before a panel.

A most important aspect of the work of CHI is the unrestricted publication of their reports.

CHI intends to set up assessment centres to assess poorly performing professionals, but it is not clear who will staff such centres and whether there will be a significant workload for them if an active process of on-site visits is being carried out simultaneously.

**Invited clinical reviews**

At management conferences over the years, the College has discussed with managers how the process of clinical governance can be facilitated. The suggestion, in 1999, that there should be a College governance advisor in each trust met with severe opposition. As a result, the College produced a paper entitled *Clinical governance – the role of the Royal College of Physicians service support for trusts.* These recommendations appear to be appreciated by trust management. The provisions of the service support are as follows:

- to provide advice to medical directors, particularly in respect of consultants who are not performing well in their clinical practice
- in certain instances to provide a mentoring resource for the trust when problems arise with an individual physician
- medical directors can be provided with advice on validated outcomes of specific clinical services
- trusts can be advised on how to deliver clinical practice with maximum efficiency and effectiveness, including specific advice on service realignment and reorganisation
- advice can be given when there are implications for standards in research programmes
- the College can provide external review of a service or a particular individual.

The Royal College of Physicians is equipped to offer these services through the Clinical Effectiveness and Evaluation unit; 25 specialty subcommittees; its extensive knowledge of job plan development; and its production of numerous guidelines and protocols.

As the culture of the health service and attitudes towards poor performance change, and as the reality of active clinical governance is increasingly appreciated within trusts, problems of difficult or poorly performing doctors and clinical teams feature prominently in the minds of trust chief executives and medical directors. The fact that CHI and the GMC are high profile public bodies may be the reason the colleges are increasingly being approached to investigate a range of difficult situations in hospitals. In the past, this has occurred only infrequently. However, during the last three years, 15 such requests have been received by the Royal College of Physicians alone. Reasons behind these requests relate to a dysfunctional team or physician, advice on service development, workload issues, and the appropriateness of the size of a hospital for a particular district.

The visitors offer advice on aspects of clinical work within the trust; they do not represent an investigation. They speak to a wide variety of people, and are available to any person who wishes to speak to them. Their aim is to assist the trust to improve patient care.

Their report becomes the property of the trust requesting the visit and access to it is determined by the trust. However, natural justice demands that if any individual is
criticised, he has the right to inspect the information together with the evidence leading to that criticism. (Relating to legal aspects of such visits, the numbers of the visiting team are indemnified by the trust and the reports are examined by lawyers before being sent to the trust.)

The relationship of College visits to subsequent reports from CHI will need to be discussed. The College regards these visits as helpful in supporting staff, improving the quality of patient care and advising management how best to proceed when considering outside independent opinion.

Summary

Physicians must now openly demonstrate their competence and ability to perform their role as consultants. Measures have been developed which allow early identification of problems and provide procedures to examine in detail where and when problems arise. A number of organisations will be involved and efforts must be made to co-ordinate the various initiatives.

References

1. General Medicine Council. Good Medical Practice (2nd ed). London: GMC, 1998.
2. Donaldson LJ. Doctors with problems in an NHS workforce. Br Med J 1994;308:1277–82.

Medication for Older People
SECOND EDITION 1997

Report of a working party of the Royal College of Physicians

Older people are often the greatest beneficiaries of appropriate drug therapy. This new report discusses the influences on prescribing patterns and the challenges to clinicians in ensuring that older people received appropriate medication. Problems of polypharmacy, the avoidance of adverse drug reactions and inappropriate therapy are also discussed. The report emphasises the need to assess carefully an individual's capacity to benefit from treatment, irrespective of age and the importance of balancing the benefits of treatment against potential risks. The medical and therapeutic care of frail older people in continuing care is discussed with particular reference to arrangements for their care and regular review of their medication.

Among the extensive recommendations aimed at achieving informed and optimal prescribing for older people are role of audit measures, the wider use of information technology and the need for better education for medical students, doctors in both the primary and secondary care setting, nurses and pharmacists. Recommendations are also made for the criteria that should be used when drugs are licensed that are likely to be used by older people.

The report will be of considerable interest to doctors in all sectors of the health service who are caring for older people, hospital managers and pharmacists, nurses, those in charge of nursing and residential homes, nurses the pharmaceutical industry.

Price: UK £10.00 Overseas £13.00 A4 report, soft cover 48 pages ISBN 1 86016 055 7

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