Medical Accountability

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The third in the College’s new series of one-day symposia on ‘Controversial Issues in Medicine’ was held on June 5th under the above title. One speaker, Mrs M. Saunders from the Public Consultation Unit of the GLC, referred to the wider social responsibilities of doctors; and within the title the discussion could certainly have included examples of this, such as Tudor Hart’s concept of the ‘community general practitioner’, making specific use of the opportunity given him by a relatively defined population within his reach. But in the event, discussion focused on the accountability of the individual doctor to his patient. As usual in such discussions, the large number of episodes in which a reasonable process of care leads gently to a satisfactory outcome was not given much prominence; attention was concentrated on the problem cases in which things go wrong. A bad outcome may of course be inherent in the clinical situation; it may arise from a misreading of the complex uncertainties of disease; it may represent idiosyncrasy in the reaction of a patient, or in the performance of a doctor. More seriously, it can arise, as Dr Gwyn Williams pointed out, from ‘sloppy medicine’; this may be the equivalent for the physician of ham-handed technique for the surgeon, whose disasters, when they occur, are more likely to be conspicuous.

The initiative for the conference, with support from the King’s Fund, had come from the group ‘Action for the Victims of Medical Accidents’, commonly shortened to AVMA. This group was set up after public interest had been stimulated in 1980 by the showing of the TV drama ‘Minor Complications’, by Peter Ransley, now President of AVMA, who attended the conference. It was appropriate that the first and longest paper should be given by Mr A. Simanowitz of AVMA. He described cases in which it was fairly clear that either the treatment given, or sometimes the withholding of appropriate treatment, had been the main cause of a patient’s deterioration in health. It had often proved difficult to extract the information required to obtain redress, and he appealed to doctors to change their present attitude, which he looked on as commonly too secretive, towards one of ‘frank disclosure’. He was aware that this might carry some cost, both financial and to reputation; but suggested that our profession would gain in moral stature by so doing. He compared the current defence subscriptions paid by doctors with that paid by solicitors in the UK, which he quoted as £1,200 p.a.—still a small sum in comparison with American rates for doctors. He suggested that greater openness about clear-cut mishaps might actually save us from going further along the American road to very high defence costs; another possibility was a ‘no fault’ system. In the brisk discussion that followed, Dr P. Harvey suggested a role for the specialist societies, which might set up panels to review treatment given by their colleagues, perhaps those at some distance. Dr G. H. Hall suggested that there might be an excess of masochists and a deficiency of sadists among those doctors likely to attend this kind of conference. The participation of administrators in dealing with complaints was criticised, especially if they tried to prevent discussion between patients or relatives and the responsible doctor; but Mr Wall reminded us of the frequent, and indeed statutory, involvement of the health authority. Miss Katharine Whitehorn asked if there were anything to be learnt from the private sector, where perhaps there was less administration and more time; but no quantitative answer was forthcoming, though the private sector was not immune from mishap. Dr David Sumner pointed out that the word ‘negligence’ carried unfortunate overtones for doctors, whereas for lawyers it was simply a term of art; and Mr Simanowitz agreed it should be ‘de-mystified’. It became clear that in some regions senior doctors were being given the useful responsibility of assisting the Regional Medical Officer to deal with complaints.

Next, Dr Peter Reynell gave what I shall describe, in terms of high praise, as a very physicianly paper on the importance, and also the problems, of ‘information given to patients’. It was very possible to alarm patients needlessly by forcing information on them which they did not want or need; and on at least one occasion he had been reproached by a widow for doing so. It was worth consulting the spouse of a patient about how much the patient should be told. Referring to the Siddaway case, his own view was that patients should be warned of likely dangers, but not of remote ones (Mr Simanowitz had also referred to this case, declaring his conviction that if the patient had known how the operation would turn out, she would have refused it; it occurred to me that, if the surgeon had had equal foresight, he would not have done it). Because of the great diversity among patients and their illnesses, Dr Reynell did not favour a ‘bill of rights’ for giving information to patients. Of course the doctor had an ethical (not a legal) obligation to give appropriate information; but ‘appropriate’ was not necessarily ‘complete’, even if that were practically possible. In summary, what he wanted to see between patient and doctor was ‘a system of trust, not a set of rules’.

Sir John Walton gave a crystalline account of the mechanisms available to the General Medical Council, in
dealing with complaints made against doctors, or doctors convicted in the criminal courts. These are also clearly set out in the GMC Blue Book, which has recently undergone important revision. Questioned as to the part which patients could play in proceedings relating to the conduct of doctors, Sir John stated that formal proceedings had to be initiated with a statutory declaration by the complainant; and thereafter they would be called as witnesses, and examined and cross-examined, as in a court of law.

Dr A. M. Dawson reminded the meeting that the object of medical activity was to improve the care of patients, and for that they were accountable to themselves and to their colleagues. Litigation was necessary in certain cases, but its contribution to patient care was minimal, and might even be negative if it were to promote unnecessary investigation and defensive medicine generally. That all consultants were equal in status created the possibility for genuine peer review; and this should, in his view, be made mandatory, and a condition of accepting a hospital for training purposes. Over the past 30 years, the power of medicine to do good had greatly increased, but so had the possibility of doing harm, whether by ill-judged action or by failure to take the correct action. In discussion, the idea of selecting cases ‘with a lesson’ was raised; but our President commended considering cases as they arose, since there was no case from which nothing could be learned.

In considering the responsibility of doctors towards their nursing colleagues, Miss E. Winder described the changing status and responsibility of nurses. While some retained the traditional attitude of subordination to medical staff, nurses were really entitled to a role in which, while certain aspects of their work were still subject to medical supervision, the area of nursing autonomy, for example in special care units, was increasing. It was very important that nurses should acquire these particular skills while at the same time conserving the basic nursing responsibility of caring for the patient in the full sense of the word. In a spirited intervention, Dr Ian Munro maintained that the duties laid upon us arose from our moral, ethical and professional responsibility, and should not require legal enforcement, nor appearance before the disciplinary mechanisms of the GMC.

Dr B. Pentecost described some of the ways in which complaints arising in hospital practice could be handled. The matter could be discussed informally with the patient, though an administrator should be kept in touch with this; if the complaint was not satisfactorily dealt with in this way, it could be made formally in writing to the health authority, and considered by the Regional Medical Officer. There was in the background always the possibility of legal action, but from time to time patients or relatives would affirm convincingly that they did not wish to damage a doctor, but were only concerned to prevent a similar mistake happening to someone else. To meet this case, the Joint Consultants Committee set up a few years ago what has been described as a ‘second opinion procedure’. Over the years, this College has been concerned with about 100 such exercises, in which a consultant from another region discusses the case both with the complainant and with the consultant concerned, with the object of reassuring the complainant, and reporting the result to the RMO. In about half the cases, there has been a fault of communication, which might be in the manner more than in the actual matter. Some doctors clearly evaded discussions with patients or relatives. On the other hand, there were patients with whom communication was difficult, because they themselves were in a difficult situation, as members of ‘a sensitised family’, e.g. a family with an elderly dependent parent, or a handicapped child.

Sir Antony Buck, MP, who had chaired the Select Committee which had recommended additional complaints procedures, to which the ‘second opinion procedure’ was the profession’s response, said straightforwardly that what had happened was somewhat different from what he and his committee had had in mind.

Certain threads ran through the day’s proceedings—the unpredictability of outcomes; the tendency of doctors to be less than forthcoming when asked to criticise their colleagues; the vital importance of communication; and the public and political feeling that, in spite of the various mechanisms for handling complaints, some problems remained. The occasion was educational and not judgmental; and I felt that good had been done by bringing out the range of attitudes as between doctors, lawyers and pressure groups. Our visitors may have accepted the plea that some bad outcomes are inevitable, and do not imply medical shortcomings; we were made aware of the strength of feeling that we may not yet have done enough to protect the public, and, indeed, our own profession, either from isolated scandalous happenings, or from persistent malpractice.

Occasionally in the past I have had an odd feeling that in some quarters the flame of love for the patient was fuelled by hate for the doctor. I did not suffer from a recurrence of that feeling at this conference. We were made soberly aware of a very real problem, not perhaps for the first time; but I came away with the notion that we should be doing more about it than we are. For example, I was shaken to hear that the ‘second opinion procedure’ may take two to three years to complete—almost as long as litigation. Even if we do no more than speed up a procedure which is within our own hands, we shall have done something useful.