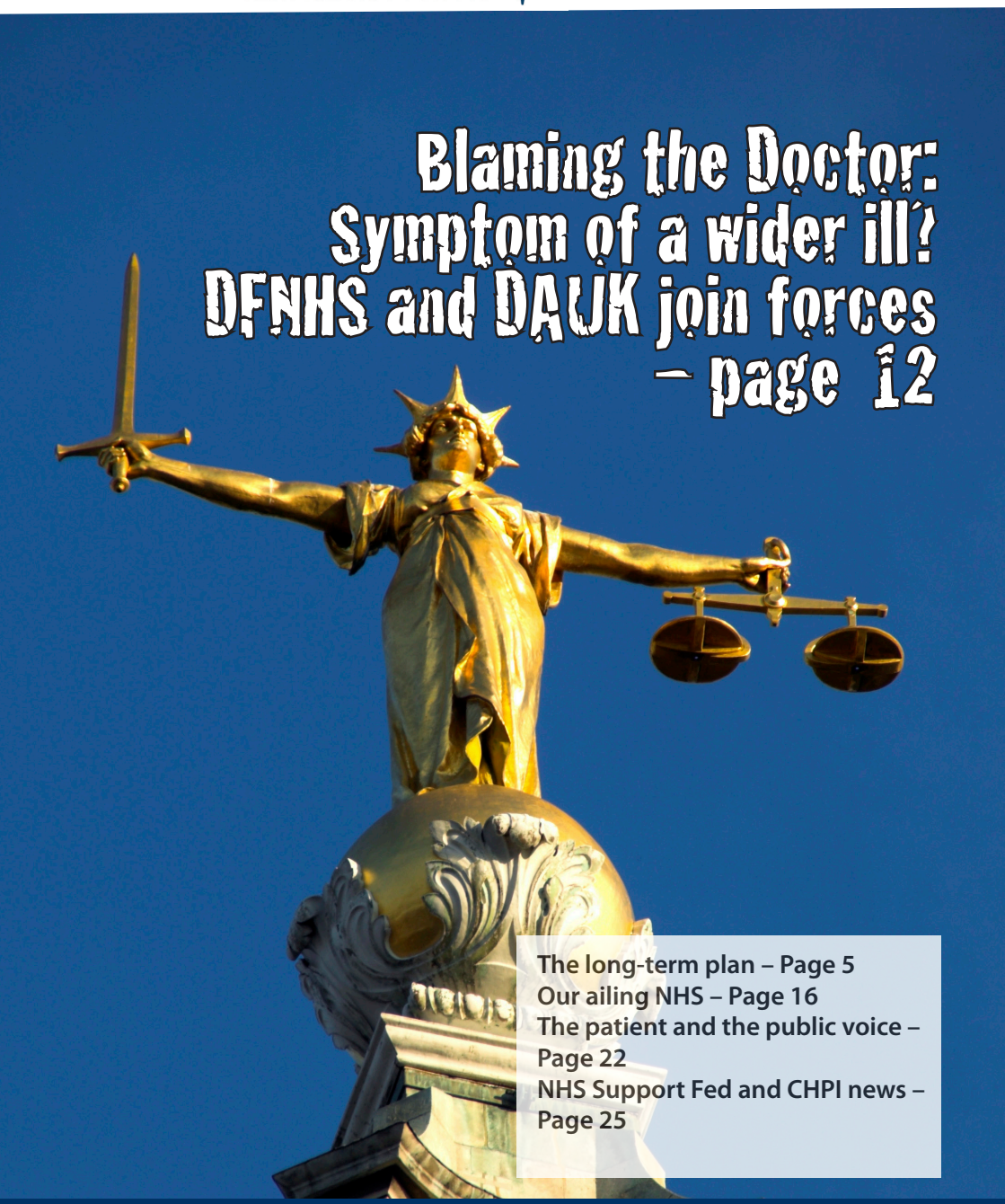
DOCTORS FOR THE NHS
SERVICE NOT PROFIT
NEWSLETTER

Blaming the Doctor: Symptom of a wider ill?

DFNHS and DAUK join forces – page 12



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Published quarterly. Contributions welcome.

The NHS Works Because of People – Trust Them

There are at least two significant themes to 2019 already established in the health service.

The first is the much-publicised long-term plan for the NHS which could be summarised as a compromise between what we need and what the government is prepared to give, discussed in a separate article (see page 5). The second, less publicised theme is the search for a Just Culture. Although very welcome I do not think it had any publicity and it took some searching to find out about it at all. It may be a response by NHS England to concerns, so widely expressed about the absence of a just culture revealed in the high-profile cases in this issue.

The document, 'Developing a patient safety strategy for the NHS - Proposals for consultation' was published by NHS Improvement (NHSI) in December, I became aware of it in January and we were able to submit responses just before the closing date in February. The document is still available online, it states –'We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.' Our response is available on the website (https://bit.ly/2EwEzSS).

It is highly commendable that NHSI has taken this initiative and we have responded with a clear and firm assertion of the steps that need to be taken, the need for openness and transparency, the need for further development of professionalism and the need to speak truth to power. It is the reaffirmation of some of the most basic principles of the NHS that will make this project succeed. We state – at its simplest the NHS is here to address clinical needs of patients and it is because this overpowering principle has been ignored that previous attempts at improving safety have not delivered.

Safety is an issue for all healthcare systems and we must credit Don Berwick of the USA for making this a high priority issue last century. The NHS responded with an excellent document, foreword by Alan Milburn who was Secretary of State for health in the year 2000, called 'An Organisation with a Memory'. It spelt out the principles of error prevention and constructive error management but it did not go far enough in terms of addressing the need for culture change.

This is an area where my experience in the blood transfusion community can be used as an excellent example of how to get it right. In the 1990s, with increasing threat of HIV, transfusion specialists decided to adopt a no blame reporting system for transfusion mishaps as the best way to monitor this threat. Early on it became clear that infections were only a small part of the harm done by transfusion and that human error resulting in blood being given to the wrong patient was more frequent and could be more quickly fatal.

This initiative was known as Serious Hazards of Transfusion (SHOT), it required any consultant haematologist being aware of a transfusion mishap to report it to the central office which was attached to the National Blood Transfusion office in Manchester (i.e. independent from hospital authorities). Later they allowed anyone to report. They emphasised that the single purpose of the investigation was to gain knowledge as to how the mishaps happen in order to share that knowledge for universal benefit. SHOT has a website which enables anyone to learn through the collective experience. They have demonstrated how human factors have been major components in error but also that the guidelines themselves have needed improvement.

SHOT has shown through repeated use of root

cause analysis that the person present with the patient at the time of the mistake, the person often named and blamed, is not always the person responsible for the event.

At the start of the century I was involved with broadcasting the message, which appeared to be a new one at the time, that the best way to improve safety, the most powerful ammunition that you have, is to learn from mistakes. I recall considerable resistance to this message, largely from those people who told me that they never made mistakes and that if other people made them they should be dealt with. I think the NHS as a whole is better prepared to listen to the message now. There will still be pockets of resistance. I do recall a heckler making a good point as I was preaching the benefit of openness; he shouted: "if you admit you made a mistake the solicitors will have you". I recall retorting that we needed to educate the legal fraternity too.

Since then I have spoken at expert witness conferences to mixed receptions from the lawyers. In this issue I include the 'When Things go Wrong' conference report (see page 8) and the book review by the barrister Giles Eyre (see page 27) as welcome news that the tide is turning in legal minds too.

The final frontier is the NHS management culture. Many years ago I joined an organisation called the British Association of Medical Managers after hearing of their enlightened approach to the problems of being a manager. Success in management was too often a result of a strategy to climb the greasy pole by pleasing one's superiors or by meeting arbitrary objectives, they said. They tried hard to develop a system whereby doctors could maintain their professionalism and become successful medical managers. The organisation did not last long, the NHS management culture is too top-down and too competitive; our managers too, are under pressure.

We need to recognise that the strength of the NHS is its workforce and with our report to NHSI we have stated how and why we need change, we have given examples of success which can be generalised to the NHS as a whole. We wish NHSI success with this initiative and we shall be happy to work with them and organisations working to improve working within the NHS.

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The Long-Term Plan

In 2014 Simon Stevens announced a five year forward view and now, 5 years later, we have a long-term plan from the same author. His struggles to coach more funds from the Treasury have been headline news in the medical and lay press, the outcome is an average 3.4% increase, less than the average 4% per annum for most of the last 70 years.

In other words it is a forecast for further tightening of our belts at a time of stress and disappointment. Performance targets are being missed all year round. At a time when the service is short of 100,000 doctors, nurses, and other staff.

The plan itself states: "Local implementation plans will be brought together in a detailed national implementation programme in the autumn."

The whole of England is to be covered by integrated care systems (ICSs) in just over 2 years, with ICS "central to the delivery of the long-term plan".

The 30 worst financially performing NHS trusts will be subject to a new "accelerated turnaround process" as part of plans to bring the provider sector into the black by 2020-21.

Although it has been reprted that the NHS is asking the government to rip up key parts of the Lansley Act on competition, the detail of how this will happen is hard to understand with current legislation in place. The answer appears to be an attempt to work around the legislation, with the regulator consulting with "clinicians and NHS leaders" to present government with a "provisional list" of requests for changes to legislation.

GPs will sign new "network contracts" as part of NHS England plans to extend the scope of primary and community services.

Formal regulation of senior NHS managers could be introduced to improve their standing and help fill the most difficult jobs, with the NHS to consider "the potential benefits and operation" of a professional registration scheme.

The NHS and government will look at funding key public health services from the NHS budget, including considering "whether there is a stronger role for the NHS in commissioning sexual health services, health visitors, and school nurses, and what best future commissioning arrangements might therefore be".

More doctors will be encouraged to train as generalists rather than specialising in a specific area of medicine in an effort to shift away from the dominance of "highly specialised" medicine and to recognise the needs of the many patients with more than one condition.

No commitment made on when the service will get back to meeting its core statutory access targets, although the document pledges to speed up access for the sickest patients.

Patients will have "a new right" to switch from their existing GP to a "digital first" provider and all patients in England will have access to a "digital first primary care offer", such as online or video consultations, by 2022-23. (See below.)

The target for all secondary care providers to move to digital records has been pushed back to 2024.

Specific waiting time targets for emergency mental health services will be introduced from 2020, while a new national waiting time for children and young people's services and access standards for community mental health will also be introduced.

Plans for a digital future

The plan shows that in addition to improving access to consultation for patients, NHS England sees digital GP services as a way to boost workforce participation, stating "emerging experience that digital GP models can help

expand the GP workforce participation rate by offering flexible opportunities to part-time GPs". They go on - "We will review GP regulation and terms and conditions to better support the return to practice and increased participation rates by GPs wanting to work in this way."

There are a growing number of companies offering online consultations in the NHS, but most do so as an extension of a patient's current GP practice, rather than replacing them.

One of the first digital first GP practices and one which is giving rise to concern is Babylon's GP at Hand, which offers patients in London and surrounding areas free video consultations if they register with its practice based in Fulham.

Health and social care secretary Matt Hancock has repeatedly promoted the expansion of digital first GP services and Babylon GP at Hand specifically. The company has ambitions to expand nationally but has, thus far, been blocked by NHS England. The company only provide limited services, typically concentrating on attracting those patients who have the least need of medical attention to join them. Their services are not available to patients with complex, long-term problems nor do they handle maternity services. They are also blatantly commercial with an aggressive advertising campaign. In addition, the plan said NHS England will ensure that "digital first" GP practices are safe and the GP payment model did not favour one type of provider over another.

"The company only provide limited services, typically concentrating on attracting those patients who have the least need of medical attention to join them."

The plan also promotes a similar expansion of online consultations in secondary care to meet the ambition of avoiding a third of all hospital outpatient appointments within 5 years. It said: "The NHS will offer a 'digital first' option for most, allowing for longer and richer face-to-face consultations with clinicians where patients want or need it. Primary care and outpatient services will have changed to a model of tiered escalation depending on need."

That is how NHS England explained the situation. I have looked into this little deeper as it is clear that there are benefits to be had from using the vast amounts of data that can be assimilated onto computers so that if properly used we can benefit from the experience of thousands of doctors and hundreds and thousands of patients.

My own surgery uses WebGP and it is a great asset. I shall explain for those unfamiliar with the service. The panel shown in Figure 1 is on the surgery's website – you click on the box and it asks you standard questions in the way that a doctor would normally take a history. The advantage of the computer is that it asks for more questions than the average consultation and in my experience has asked all the relevant questions that would be asked by a highly conscientious and well-informed doctor. In fact it asks so many that the business of answering them can take a long time, much longer than face-to-face consultation ,but this has its advantages.

I do recall, as a student, being told by one wise old physician that you make the diagnosis from the history and examination will give you the

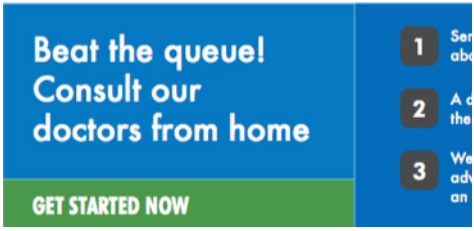

Figure 1

site. Whilst this overstates the importance of the history it does contain more than element of truth in that a well taken history is of huge importance and may well justify the time taken in respect of time wasted further down the road either because of delayed diagnosis because of inappropriate referrals and investigations.

I have also tested a number of other systems, our local CCG arranged a workshop where we were able to try several different products. So far I'm happy to report that WebGP asked enough questions to identify the alarm symptoms and stated that my real life GP would need to see me. This was not the case with all of the systems tested.

I tested the systems with a number of symptoms and presentations including a scenario I know well; my real life problem as a 12-year-old with a sore knee. Some of the systems did ask useful questions such as whether the pain radiated, which it did, it was the first symptom of a spinal tumour. We do not expect computers, at this stage to make a diagnosis but it is possible to construct a branching system of questions and checklists to capture alarm symptoms so that such patients can see a real doctor quickly.

They can also record all the answers to the questions so that when you do get to see your doctor he or she can see all the questions and your answers which saves a lot of time; and some of the systems can make suggestions as to the likelihood of various diagnoses and even what the doctor may wish to do next.

The CCG did not find any of the systems it tested to be worth investing in. This did not surprise me as there needs to be more work done to develop them. It was disappointing to speak to so many salesman convinced that their product was wonderful but without any real understanding of how to incorporate the benefits of IT into the medical world.

Other people have shown more energy and patience in exploring the other digital systems available eg Dr Murphy has placed a video on

Twitter of him using the Babylon app. He enters information about a minor nosebleed and after answering many questions is told it will probably settle by itself. However it also includes a list of possible causes such as a leak from subarachnoid haemorrhage or from an aneurysm which it explains as a swollen blood vessel in the tummy.

It is very clear that we need careful regulation of services that can give unhelpful and possibly alarming information to patients. Justin Madders MP has also raised questions as to whether the Secretary of State has acted with due propriety in this enthusiastic endorsement of Babylon.

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Conference Report: When Things Go Wrong

Medicine and the Law – working towards a meeting of minds
Royal Society of Medicine. October 2018

2018 will hopefully be remembered as a watershed in the treatment of medical error.

There have been many examples of problems in the recent past but it was this year that health professionals and much of the public sensed that many legal procedures have not brought justice and have done more harm than good. The outrage felt by many professionals has been manifest in public comments, a resolution of no confidence in the GMC passed by the BMA and new associations and social media groups such as Doctors Association UK and #LearnNotBlame. They have described recent events as a lightning rod for a profession at breaking point.

'When things go wrong' was the title of a one day meeting at the Royal Society of Medicine on Friday 26th October. They stated Litigation, both civil and criminal, against doctors is increasing, but so are the costs involved, potentially even crippling the NHS, but not always benefiting patient safety as it should.

In the conference we learned what happens when things go wrong, in the medical world, and with patients, and the current, correct legal meaning, definitions, interpretation and consequences in the UK of Consent, Negligence vs. Gross Negligence, and Manslaughter. Naturally, as the meeting was organised by the anaesthetic section of the society it mostly involved clinical issues but it addressed major issues for both professions.

It was good to hear so many high profile, established and experienced authorities in agreement that we must find a better way to deal with poor outcomes than pinning the blame on the one individual who was at the centre of the action. Whilst the tragedies provoke mixed reactions we must recognise how dreadful it is for the relatives who have lost a loved one and how they may feel more angry if they feel they have been denied natural justice. All the recent tragedies have had a significant back story of system failure and yet the hospitals who failed to provide a safe environment have so far, escaped Scot free. The primitive urge to blame an individual not only does an injustice to that person but leaves the factors that caused the problem unchanged. The fundamental faults that need fixing – be it understaffing, lack of support and supervision or back up for staff under pressure – will remain.

Failure to identify the root causes leads to a system that most often picks on the weakest to be sacrificial lambs of an imperfect system. A senior barrister commented that we appear to be doing something if we send the occasional person to prison but we do not fix the underlying problem and most important is the effect on morale of the health professionals who know it could have been them in the dock. The idea that a harsh punishment as Napoleon put it *pour encourager les autres* 'to encourage the others' has in fact the opposite effect.

As in so many areas of medicine the causes of the problem are multi-factorial and a comprehensive plan is needed in response. One particular problem involves the Gross Negligence Manslaughter (GMN) law, all the experts were agreed that this should only be used when the circumstances are truly exceptional. Outside of the conference, Sir Robert Francis explained to the Commons Health and Social Care Committee

that it is flawed because, unlike other areas of law, it asks a jury to decide what is, or what is not a criminal offence. At the conference we heard of multiple problems; the charge of GMN is rare and out of 151 investigations only 7 were prosecuted. The police who carry out the investigations are unlikely to have been involved in anything of similar complexity and have experienced difficulty in adjusting their style from everyday police work to the more complex task of clinical work and clinical judgement.

This means that many doctors, later to be cleared of all charges have had to go through the ordeal of being taken to the custody area (ie behind the locked doors) for interrogation. No police were there to speak but a solicitor for the MDU described the process as stressful. The police then report to the Crown Prosecution service (CPS) who need to decide if it is worth going ahead and there is huge variability between different branches. This means that, for the same case, in one part of the county a doctor could be congratulated for tireless life saving efforts or imprisoned for GNM in another.

The jury system means that jurors, ordinary people with no prior knowledge of the law, need to make extraordinarily difficult decisions, and in the Sellu case the jury came back to the court after 3 days of deliberation to explain to the judge that they did not understand the problems sufficiently to make a decision. It was the judge's duty to explain the law to the jury and the fact that he misdirected them was a reason for the conviction to be overturned on appeal. The CPS could have retried the case but did not. They appreciate that the system has to improve and were co-sponsors of the conference.

A major presentation on GNM was by Sir Norman Stanley Williams, former President of the Royal College of Surgeons of England. He was knighted in the 2015 New Year Honours. Professor Sir Williams is now the Chair in reviewing issues relating to gross negligence manslaughter in healthcare. The Professor Sir Williams Review was set up by Jeremy Hunt to conduct rapid policy reviews surrounding these situations. Jeremy Hunt had stated that he wanted the NHS to be the safest healthcare system in the world and asked Sir Norman to chair the review and he agreed with the qualification that he wanted nothing to do with politics.

He reminded us that avoidable deaths do occur all too frequently , probably around 5% and that there are marked inconsistencies in how these are handled. Graham Catto missed the diagnosis of sepsis in a child who later died and he has stated that he delayed giving antibiotics. He was in the same situation as Hadiza Bawa-Gaba but the outcomes are different. It is possible, that like Sir Graham, she could become the chair of the GMC and receive a knighthood but she may prefer a quieter life.

Sir Norman described the work he had carried out including interviews with all relevant parties including judges and concluded that all agree on the need for improvement. The aviation industry was again used as the gold standard in establishing a safe place where errors can be openly admitted and these needs to be established now in all fields of medicine.

Prof Justin Vale, highly experienced in safety issues and formerly Deputy Medical Director at Imperial College, stated that even the most conscientious and competent clinician will have complications and these really test their mettle. He gave examples of good and bad outcomes

and how the doctor's behaviour after the event influenced the final result.

In the first case a surgeon who had not been in theatre during the pre-op stages of a spinal decompression, realised that he was operating on the wrong side he checked the X-rays then began again on the right side. He did it by the book by declaring the incident, explaining it to the patient (i.e. fulfilling the duty of candour) and co-operated fully in the investigation. This allowed learning to take place, one simple point being the skin prep could wash off the markings of the operation site.

In the second case, a surgeon operating on a patient with a neuroendocrine tumour gave a sample to the nurse who threw it away. This was only discovered when the histology report was required. The background was that the surgeon normally only carried out gastric bypass or other weight reduction procedures at that hospital and samples were routinely thrown out. At the investigation he was bullish and not prepared to accept any criticism. He did not see the need to make sure a sample was sent. A simple acknowledgement from him that he had not ensured that the patient had gained full benefit from the operation would have closed the complaint quickly. Instead it grumbled on, the take home message is obvious.

Bertie Leigh Chairman NCEPOD (National Confidential Enquiry into Patient Outcome and Death 2009-2015) gave an impressive address, classic barrister style – no PowerPoint but a meaningful look into the eyes of the audience. He is highly regarded by his legal peers with comments such as "'Leading light' Bertie Leigh is the senior partner at the firm, as well as head of the clinical negligence practice. Described as 'the doyen of defendant clinical negligence', he brings over 35 years' experience to bear on his work for defendants." (Chambers UK 2011) and

"Known as 'the top dog' in clinical negligence defence work. Bertie Leigh is 'a phenomenal lawyer'…'charismatic speaker"…and 'original thinker'." (Chambers UK 2013)

He commented that as NCEPOD chair he had seen many cases where there was a need for improvement. However whether action was taken and what action should be was another matter. He, like other speakers pointed out the bar should be high in terms of the level of culpability for GNM cases. He drew parallels with death caused by varying degrees of bad driving. There could be a simple mistake by a driver who was otherwise blameless i.e. did not see the other person. Or the driver could be irresponsible, not signalling but not deliberately being dangerous; and at the other extreme there is the driver who may be drunk and is deliberately speeding for kicks who not only causes death but then denies the event. Society has a strong and visceral revulsion to the third of these cases. The law will recognise the differing levels of guilt and punish accordingly. Society, as reflected in the laws passed by parliament, has not taken on addressing how we should try to discriminate in terms of a graded response to medical involvement in adverse outcomes.

Expert witness

There was also a session about the expert witness including advice on how to choose one. There are currently no regulations to govern who can call themselves an expert witness the presenter, Rick Porter gave three categories: real experts, people regarded as experts by their peers and people who consider themselves to be experts. The last category can do a great deal of harm, he gave one example who quoted from a textbook which was 50 years out of date.

Although there is an increasing frequency of litigation there are fewer genuine experts choosing to do expert witness work as the final stage in their work, i.e. the court appearance can be very stressful.

NHS Resolution, the body which handles legal matters for the NHS, does have a list but it is unclear how they decide whom to include. There are also 'clubs' and associations that you

can join and they will promote you as an expert witness irrespective of your knowledge, abilities or performance.

The expert witness Institute has a system which requires applicants to present two cases they have handled for peer review and these have to be satisfactory before applicants are allowed in. There is University which gives a qualification but it has no significance in terms of guaranteeing performance. There is a slowly evolving system of accreditation but it is only embryonic and it will be expensive.

Surprisingly word-of-mouth seems to be the main source of recommendations which suggests it is worth asking those experienced in the field for opinions. (Barristers who are in the know will demonstrate this by having successful court appearances on their CV usually available on their website.) There is no register of performance which means that a witness could be roundly criticised for being incompetent by a judge but this is only recorded in the details of the case and the witness can continue to announce themselves as an expert.

The most important points to ensure that the expert witness was engaged in relevant practice at the time of the incident and is highly regarded in the field.

We all know that the practice of medicine brings daily reminders of a need for improvement. Although we are not in the limelight many of us have the experience of working in understaffed and under-resourced departments. Although we use aviation as the gold standard we should acknowledge important differences. If the pilot finds that the co-pilot is off sick and the cabin crew are half strength he will most probably cancel the flight. Would we cancel our sessions if we found we did not have the support we need? And if we did who would support us?

With that qualification we should continue to look for examples from aviation as they have an excellent record in learning from errors and near misses.

Conclusion

The conference was excellent in bringing together so many from different fields with a shared purpose of making the necessary improvements. It was remarkable that when many conferences suffer from the Friday afternoon syndrome of an emptying auditorium from 2pm onwards that the hall was still packed to hear the final speaker, David Sellu the victim of a miscarriage of justice.

His talk was subtitled 'Noblesse oblige' roughly translated that those in power need to be responsible in order to justify their position. His talk showed the high cost of failings in the system. His powerful talk to a previous meeting is available through the RSM website. He concluded by quoting from the pilot Captain Chesley Sullenberger who successfully landed his crippled plane in the Hudson River. Sullenberger's quote also sends a powerful message:

> **"Everything we know in aviation, every rule in the rule book, every procedure we have, we know because someone somewhere died... We have purchased at great cost, lessons literally bought with blood that we have to preserve as institutional knowledge and pass on to succeeding generations. We cannot have the moral failure of forgetting these lessons and we have to relearn them."**

We now have a network of professionals committed to improvement, I eagerly await the next meeting.

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A New Voice – A Stronger Chorus

Cicely Cunningham describes how Doctors' Association UK was born out of concern for the way doctors were being treated over gross negligence manslaughter. DFNHS has recently affiliated with them (see page 24) to tackle the hostile culture threatening doctors.

I vividly remember the evening of 25th January 2018, when I first heard about the decision of the High Court in the case of Hadiza Bawa-Garba to uphold the GMC's argument that she should be erased from the medical register.

I'd put my children to bed and had settled down for the usual evening of scrolling through my phone on the sofa. But I was shocked and appalled at the accounts I read of the events of 18th February 2011 – how one individual doctor and two nurses were held criminally responsible for the failures of care that occurred that day, and which tragically led to the death of 6 year old Jack Adcock.

So many individual elements of the situation as described in accounts by consultants from Leicester who supported Hadiza resonated as familiar occurrences to me as a junior doctor in the NHS. I too had experienced extra workload and responsibility unwillingly thrust upon me because of rota shortages, I too on occasion had been on call with a less than supportive consultant, I too had experienced the chaos that occurs when IT systems fail, I too had worked in situations where nursing staff were short of regulars and reliant on agency staff. I had also experienced the return to clinical practice after long maternity leave breaks, an experience I can only describe honestly as petrifying.

Yet only by the grace of God, I felt, had I not experienced any single occasion where these elements had come together to produce the same degree of disaster as it had for the Adcock family.

I couldn't shake the sense of injustice of the situation, and I couldn't sleep that night. In the days and weeks that followed, I joined the social media whirlwind as the crowdfunding appeal was put together by Chris Day, James Haddock and Moosa Qureshi. But I also wanted to do more. I put myself forward with a group of others who wanted to raise our collective political voice, and so The Doctors' Association UK (DAUK) was born.

Our aim, then as now, was to speak up on issues that matter to UK doctors, and to the NHS as a whole. We are a campaigning and lobbying organisation, which now has membership open to all. We are strictly non-profit, and all those on the committee are volunteers and will remain so. We aim to become a fully democratic organisation, with elections for committee positions, during 2019. In the meantime, we aim to be as open and transparent as possible, with a broad base on social media to which we feel accountable.

DAUK's work to date has largely centred around the fall-out from the Bawa-Garba case, whereby our institutions and establishment try to make sense of where that leaves the profession and – more importantly, perhaps – patient safety.

First campaign

DAUK's first action as a nascent campaigning group was to coordinate 4500 doctors in writing

to Charlie Massey, Chief Executive of the GMC, to protest the GMC's actions in the case of Hadiza Bawa-Garba, and to press him to abandon plans to establish automatic erasure in any case of gross negligence manslaughter. As a result of our pressure, the GMC subsequently announced that it had dropped this plan.

Shortly afterwards, DAUK provided written evidence to the rapid review led by Professor Sir Norman Williams Review into gross negligence manslaughter commissioned by the Department of Health. We argued strongly that the terms of the review were set too narrowly, as the review was only set out to look at the application of the existing law, and that the review instead should consider the nature of the current law. We argued that introducing a requirement for recklessness or wilfulness to be demonstrated in the offence of gross negligence manslaughter as applied to healthcare would make it more appropriate. We also argued that the GMC should have its power to appeal Medical Practitioner Tribunal Service decisions rescinded – a recommendation which was accepted in the final report of the review.

DAUK provided a media presence around the 13 August judgement of the Court of Appeal, when it ruled that Hadiza Bawa-Garba should in fact not have been erased from the medical register. Our Chair, Dr Samantha Batt-Rawden, our Vice-Chair Dr Rinesh Parmar, and I provided interviews to all the major news outlets, including Sky, BBC News, ITV and Channel 4, arguing that this decision was both the right one for justice and for patient safety. We also provided an opinion piece to the *Guardian*, and were quoted in various medical publications such as *GP Online* and *Pulse*.

Since then, DAUK has again written to Charlie Massey, with the backing of many doctors, including DFNHS member Dr Philippa Whitford MP, requesting that he refer the GMC to the Health and Social Care Select Committee for an investigation into the events surrounding the Bawa-Garba case. Following this, the Health and Social Care Select Committee held a one-off evidence session on 16th October, for which DAUKK, along with only the British Medical Association, was asked to provide written evidence.

As a result of DAUK's correspondence with Charlie Massey, we have secured a meeting with him (that at the time of writing has yet to occur). It is disappointing that the GMC appears not to have undertaken genuine reflection following the Bawa-Garba case, and continues to appeal MPT decisions. We are seeking an undertaking that the GMC will desist from this practice, and comply with the spirit of the recommendations of the Williams Review, despite the letter of the law not yet having been brought into line with it. Moreover, we wish the GMC to reflect more deeply on their role in creating an atmosphere where genuine commitment to patient safety can flourish, rather than allowing a culture of fear to pervade.

Learn not blame

The central plank of DAUK's campaigning activity is our Learn Not Blame campaign. In the campaign, we are aiming to develop a groundswell among doctors calling for change in the NHS. Change so that what happened to Hadiza Bawa-Garba never happens again. Change too so that what happened to Jack Adcock never happens again. We believe that doctors working together can be a potent force for transformation.

Through this campaign, DAUK is encouraging doctors to take small steps that lie within their

Cicely Cunningham campaigning

capabilities, to demonstrate the kind of behaviours that allow colleagues to feel supported, empowered and encouraged. We believe that making these small changes will lead to a change in the environment, leading to a more supportive and collaborative culture. In this culture, people will feel able to speak up, to suggest ideas, to identify areas for improvement. We believe that doctors demonstrating these behaviours is a powerful statement.

The future

But it is not the only thing we need – we also need to see change in the institutions for whom we work. Too often the concern of Boards of NHS organisations is for reputation management over genuine openness and drive for improvement. Too often investigations are poor quality, communication with patients, families and staff is insensitive or lacking, too often opportunities for learning are missed. We will advocate that a changed culture is good for patient safety, good for individual NHS organisations and good for the NHS as a whole. Doctors speaking collectively need to make this argument, and demand change.

DAUK secured high profile backing for this campaign, with Dr Philippa Whitford MP hosting the formal launch of the campaign in Parliament on 20th November. She was joined by a panel of speakers, including Scott Morrish, a bereaved parent who speaks powerfully about his son Sam's death at the age of 3 from sepsis with failings in NHS care, and subsequent failures in investigations and dealings with his family. He now campaigns for a just culture in the NHS. Also on the panel were Nick Ross, broadcaster and campaigner, Dr Edwin Jesudason, former consultant surgeon and whistleblower, and myself. We made the argument that whether patient or doctor, whether someone who has suffered significant harm or not, we all need a better system in the NHS, to allow learning to take place, and improvements in patient care to happen.

We really hope you will join us in this campaign. From 20th November you can sign up to the Learn Not Blame campaign on our website and receive a campaign pack. You can also support the work of DAUK in a number of other ways. Any doctor with a GMC number can join us as a full member – find out more at www.dauk.org/membership. All membership fees go directly towards campaign activities and materials. Follow us on social media via our Facebook page (www.facebook.com/TheDoctorsAssociationUK) and Twitter (@TheDA_UK and @learnnotblameuk), or join our mailing list – drop us an email on contact@dauk.org.

We look forward to working with and for YOU!

Cicely Cunningham
Doctors' Association UK
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Our Ailing NHS: The Follies Beyond our Financial Struggles

Have our successive healthcare reforms provided better efficiency and value for money? Or have they created psychological and social damage to health carers and the care they provide?

In 2014 the King's Fund published a report, *Reforming the NHS from Within. Beyond hierarchy, inspection and markets.*

This had the familiar hallmarks of that organisation's work: thorough research, sharp analysis and clear writing. Certainly the analysis and conclusions remain as essential now to any more sustainable and humanly responsive service as they were in 2014. In brief, the messages are:

1. The NHS is chronically underfunded compared with similar (ie European) nations.
2. Serial efficiency-seeking and money-saving reforms over the last two decades have mostly achieved neither.
3. There needs now to be discriminating decentralisation; we need more areas of intelligent devolution and local accountability.

This report was written 4 years ago, but I had not seen it before it was recently given to me by its author, Professor Chris Ham, the Fund's CEO, shortly before his retirement. He offered it to me, I think, as a kind of valedictory personal summation of what he thinks most ails our NHS.

Certainly, it remains a probing and cogent account of wider and enduring fiscal and systems failures. As such the report has qualities typical of the King's Fund's dependable staple and reputation: non-partisan and solidly objective analysis of finances, systems and outcomes. The robustness of all of these has been well-demonstrated by the clear pattern of events of the last few years.

So this report remains formidably valid: solid arguments, thorough research, competently collated data, clear exposition, accurate prediction… So far, so good. Yet, to my mind, there are important dimensions missing: seminal questions of a social and psychological kind. Why have we adopted these systems in the way we have? And what are these systems now doing to us?

For some years I have followed this other line of enquiry – to understand how and why we have adopted the often misconceived systems we have, why they are so difficult to undo, and the personal and relational damage that follows – both individually and en masse.

My answers to these questions make up my response to the King's Fund report: *Industrialised healthcare: how do we replant our human sense?* [1], a kind of compensatory critique that attempts to add those missing dimensions to their report. This abridged version here outlines its main points.

A personal formulation

I was asked recently about my overall view of the changes the NHS had undergone during my long frontline employment as a doctor (since 1969). I replied: 'Everything to do with technology is better; almost all that is dependent on human understanding, relationships, or meaning is much worse.'

What does this mean? Well, broadly that divergence can be seen in a number of ways. For

example, it equates with what I term 'curative treatments' (flourishing), as distinct from 'pastoral healthcare' (perishing). We can see it in the dehiscence of the science of medicine from the art of its practice. This schism is reflected, too, in our different kinds of knowledge: how, for example, generic notations of quantifiable data are increasingly displacing other kinds of personal and experiential language and knowledge.

In practice this divergence is manifest in how technical treatments for the curable have generally become much better, but personal care for the less-than-curable is likely to be worse. So if, say, you need surgery for cataracts or coronary artery disease the outcome is likely to be far better than 30 years ago.

But what if, instead, you need comfort, support and guidance to help you endure and heal what cannot be decisively fixed by technology? These are the commoner and myriad ailments of mind and body from life's losses, disconsolations and inevitabilities – our misfortunes, our stresses, our lost anchorage, our ageing declines, our often mysterious predispositions – then, with all these, it is very different. You are unlikely now to receive the kind of personal continuity and understanding that underpinned our erstwhile better pastoral healthcare, especially in General Practice and Psychiatry, 30 years ago – before our successive waves of depersonalising reforms.

These divisive reforms have arisen in an unprecedented culture: one increasingly in thrall to quantitative data and evidence. This bias toward the systematised and standardised leads to a specious, if undeliberate judgement: that curative treatments are evidence-based and effective; the less quantifiable pastoral healthcare struggles to produce this kind of evidence or resolution. Therefore it has seemed to make organisational and financial sense to preferentially concentrate thought and money on treatment rather than care.

The result? A systematic neglect, demolition and fragmentation of those services whose functional 'spine' is personal continuity of care [2] – General Practice and mental health services, again, are especially vulnerable examples here and yet, crucially, provide most NHS consultations. Both currently struggle to keep intact their functional spine – as a very simple indicator of this consider how few patients can name the clinician they last saw. What kind of care is that? Clearly, we have depersonalised these services.

The result? Patients feel uncontained and adrift; practitioners are deprived of the deeper meaning and gratifications that grow with personal bonds. The health consequence of all this far exceeds mere comfort or niceties [2]. In the meantime staff recruitment drops, burn-out and drop-out rises, the little human connection that still exists struggles to survive, the spine disintegrates further [3]…

This is the legacy of a healthcare system that designs-out, or even destroys, personal bonds, relationships and understandings.

Increasingly, inevitably, nobody-knows-anybody.

Of course, technology-prevalent services – say Orthopaedics or Intensive Care have their struggles: for example, for finances or resources. But they are not deracinated of human connections, opportunities and understandings in the same way or with the same impact as pastoral healthcare.

So what is it about our efficiency-seeking, money-saving reforms that seem not only to fail their primary task but, in addition, add this kind of human collateral damage?

Dehumanising systems

My understanding is that we are now governed by three major and growing forces. These three have converged to produce such human depersonalisation, dispiritedness and alienation. This convergence has had a compound, sometimes exponential, effect. The combined administrative power is synergistic: each part interlocking with, then boosting, the others.

The first of these receives fuller description and analysis, as much is also common to the other two.

The 4Cs

The 4Cs stands for competitive commissioning, commodification, commercialisation and computerisation. The first three of these comprise models derived from manufacturing and distribution industries. The last – computerisation – is, of course, now a ubiquitous and seminal force throughout our post-millennial world. It is included here as it is crucial to the functioning of the other three – like the last leg on a four-legged chair.

We now have growing awareness of the wasteful bureaucratic inefficiencies, even nefarious corruptions, of commercialisation in healthcare [4]. Competitive commissioning and commodification – when serving a commercialised system – all too often serve a commissar-like function overtly for the 'service user' (patient), though covertly – but more in reality – for the commercial interest of the 'provider' (increasingly big business). Hardly ever does such business-determined proceduralism nourish the better spirit of our care.

Computerisation has now become not only the 'glue' that holds the other three together, but also provides the 'data-fuel' from which they can operate. This 4Cs organisational quadruped can then, with increasing coherence and efficiency, function apparently more and more like a precision-engineered machine. Such is the intended power and promise of our ever-more cybernated systems.

And what is this marketised machine like, to work in or be cared for by? Well, the pattern is becoming increasingly clear: satisfaction is highest among the system's designers, commanders and nest-featherers – elsewhere, particularly in pastoral healthcare, we see increasing malaise: confusion, anomie and signs of absent or disrupted attachments [3].

> "And what is this marketised machine like?... the pattern is becoming increasingly clear: satisfaction is highest among the system's designers, commanders and nest-featherers."

In General Practice and mental health this malaise is evidently and equally true of both staff and patients. There is much data to show how healthcarers are buckling and leaving. The resulting problems for patients – of declining access, of increasingly depersonalised and discontinuous care – becomes inevitable. A nobody-knows-anybody service is proving bad for all our health and welfare. The evidence for this is massive [5].

REMIC

REMIC (remote management inspection and compliance) is another manifestation of Welfare governance that has been accelerated and anchored by computerisation. Modern IT systems can now monitor and instruct innumerable practitioners in a way that was impossible two decades ago. Such capacity has led to ever-increasing command-and-control systems and then mindsets. The generating idea is to be like an air-traffic control-tower, but for the management

of healthcarers. Precise protocols and routes are designated to all practitioners, who are then instructed, monitored and inspected according to standardised templates. Compliance is essential to REMIC, so deviation is rarely tolerated. This has led to a health-culture aptly termed *Technototalitarian* [6].

The results of REMIC?

These are probably more harmful than helpful. While some (very few) egregiously and irredeemably bad practitioners may be stopped by our REMIC system, for the vast majority the situation is far more complicated. Most practitioners, at least initially, want to do a safe and caring job. With intelligently vigilant and supportive management they will – with few exceptions – continue to deliver this, so long as the work conditions and expected tasks are viable.

> "Regimes based on inspection and micro-management simply do not work. But it is worse than that... REMIC inevitably becomes destructive of vocational spirit ... and intelligent creativity."

But REMIC has largely undone this erstwhile sustainable culture of trust and intelligent support, and replaced this with something very different: mistrustful regimes of didactic and hierarchical power that drive strict compliance to generic specifications. We have seen how often this then leads to increasingly demanding, yet shallow, box-ticking: 'we've all got to play the game'.

So what is going on? Well, firstly, as NHS commentator Roy Lilley[7] often points out, regimes based on inspection and micromanagement simply do not work. But it is worse than that, because REMIC – as all technototalitarian systems – inevitably becomes inimical and destructive of vocational spirit, trusting relationships, intellectual autonomy and intelligent creativity.

The result of REMIC is all too often such psychological and social damage as to yield us a hollowed-out, miserable, resentful and anxious workforce that now has existential problems with staff health, recruitment and retention [5]. Patient care is a tragically unavoidable casualty.

So, operating together with the 4Cs, REMIC then offers us an ingeniously perverse hybrid: the mendacious opportunism of capitalism, merged with the oppression, stupidity and paranoid unviability of Soviet-style managerialism.

Gigantism

Gigantism is a cornerstone of manufacturing and distribution industries: these will always scale-up as much as they can, wherever and whenever they can. 'Bigger is better' is a pragmatic principle for efficiency-savings in logistics, standardisation, monitoring and personnel management etc.

This approach may make good sense with, say, the manufacture of washing machines. What about healthcare?

Problematically, the results are much more mixed in healthcare. Scaling-up to larger and fewer units can make much sense in very hi-tech and specialised activity, for example coronary care or most forms of surgery. Large units, even if physically distant, are then the best compromise.

But this may not apply to most hospital admissions: the elderly frail who need competent, kindly medical and nursing care, but not of the hi-tech variety (eg ICU, CT or MRI scans). These people cannot be managed at home, yet their care may be most humanely and effectively delivered if it is homely. Smaller size, proximity and familiarity of staff and surroundings are here paramount. Our erstwhile many smaller hospitals used to provide these things well; our remote, giant conurbations

mostly cannot.

The mandate of Gigantism in General Practice is causing increasing damage to pastoral healthcare. Generally, the larger a practice the less well people know one another – patients, doctors, colleagues, receptionists… Larger then, paradoxically, often means lonelier.

Does it matter if we don't get to know these others? Well, the more you see of someone, the more of someone you see. So to understand experience, meaning and subtext in other people we have to develop relationships. And this can only develop from personal continuity of care [2]. Of course this cannot be provided everywhere, for everyone, under all circumstances, yet it remains an anchoring principle for our best human (as opposed to procedural) mental and primary healthcare.

Yet Gigantism with its ever-larger centres and rapidly rotated teams is barren soil in which to plant our endeavours of personal continuity of care. Procedures become clearer; people become hazier. Fulfilled vocation becomes replaced by sharp but corporatised job descriptions.

"Gigantism is barren soil in which to plant our endeavours. Procedures become clearer; people become hazier. Fulfilled vocation becomes replaced by ...corporatised job descriptions."

The cost of this? Consider the morale, recruitment crisis and the public's growing disconsolation with our GP and mental health services.

What can be done?

How may we best de-industrialise, so rehumanise, our NHS?

The following is a preliminary list of measures that would help free up and re-establish our better human sense and connection. Many of these would require the demolition of recent reforms, so would find obdurate resistance from established authorities. For reasons of relative brevity I have not added explanatory commentary here, though have done so elsewhere [8]:

(a) Abolish the entire marketisation of healthcare and its apparatus: of purchaser-provider splits, autarkic Trusts, financially-based commissioning, payment by results, financial penalties for underperformance etc.

(b) REMIC (remote management, inspection and compliance) needs substantial disarmament and reduction.

(c) Stop the hunting and closure of small, popular General Practices.

(d) Restore personal lists to General Practice: patients to register with a person, not a place.

(e) Abolish geriatrics; bring back General Physicians.

(f) Bring back consultant-led firms with dedicated wards and support staff.

(g) Bring back smaller, more local, lower-tech hospitals.

(h) Bring back nursing schools and hospital Matrons.

(i) Break up medical schools into more but smaller units.

References and notes

[1] Industrialised healthcare: how do we replant our human sense? A response to a King's Fund report. 2018. Article 109 on www.marco-learningsystems.com

[2] Pereira-Gray, D.J. et al (2018) in his BMJ open article Continuity of Care with doctors – a matter of life and death, showed statistically and clearly how personal continuity of care contributes, for example, significantly to longevity.

[3] Kay, A. (2017) *This is Going to Hurt. Diaries of a junior doctor*. Picador
This is one of several recently published books graphically describing, in personal detail, the increasing human disconnection experienced by NHS doctors.
[4] Wrigley, D., Davis, J. and Lister, J. (2015) *NHS for Sale: Myths, Lies and Deception*. The Merlin Press
This, again, is one of several recent books documenting current tangles of folly and malfeasance brought about by recent NHS reforms.
[5] The evidence for this is vast and wide and here space-prohibitive. In particular, I have drawn from NHS Digital, Office for National Statistics, Social Care Information Centre, British Medical Association and the King's Fund. Also newspapers: *The Guardian* and *The Daily Telegraph*.
[6] Edward: shot in his own interest. Technototalitarianism and the fragility of the therapeutic dance. 2005. Article 19 on www.marco-learningsystems.com
[7] Roy Lilley. ihm.org.uk/roy-lilley-nhsmanagers/
[8] See, for example Plummeting morale of junior doctors: one branch of our blighted tree of Welfare, 2016, Letter 47 on www.marco-learningsystems.com.

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You didn't come into medicine to see the NHS die. So help save it.

The Patient and Public Voice in the New Organisations

Looking at the many changes to our organisation over the years it is easy to be cynical. Whilst I like to see myself as an optimist (why else would one undertake the hard graft of being a doctor?), I often find it hard to convince others that proposed changes will be an improvement.

That is certainly the case with the STPs and could be in respect of the ICSs. I have a role in the STP as the Chair of the Service User Advisory Group (SUAG). This is our STP's way of involving patients and the public. I have always taken interest in patient groups in particular cancer support groups as my interest in medicine developed as a teenager during my years of treatment for the spinal tumour.

Over the years I have seen great works done by patient groups, in particular the national conference of cancer self-help groups played a very significant part not only in helping patients through the difficulties of dealing with the illness but also in articulating the patient's view to the Department of Health and other powerful bodies. That organisation which had hosted an annual conference of around 400 people could not continue when charitable funds were withdrawn, I think in 2011. I mention it because it did show what a valuable contribution patients could make give a little help in the form of a grant to cover admin expenses.

Viewing the video of Simon Stevens launching the long-term view it was interesting to see how well he praised patient groups for their input and it would be useful to see the STPs and ICSs follow suit. In my area, South Essex, this is not the case.

Our experience of reorganisation began in 2016 when it was announced that the NHS in Essex, because it was repeatedly overspent, would be subject to a 'Success Regime' with extra funding made available to help services work better together.

The main target of the proposal was the fact that there were three DGHs within 15 miles of each other and that rationalisation would bring economic benefits. The plans were well underway before any form of public consultation took place. A freelance communications professional was contracted and she asked the CCGs for public representatives then invited us to a meeting in August 2016 to explain the plans in general and to say that a Chair and Vice Chair would be elected and they asked for nominations.

Little happened until January 2017 when they decided that patient input was required to address the reconfiguration of hospitals. The Service User Advisory Group was convened, we were given hundreds of pages of documents to review and then invited to score the proposals at one meeting. The documents addressed issues such as centralisation and economies of scale and the scoring exercise involved choosing which of the hospitals would have a full A&E department and which of the other hospitals were to have a form of downgraded A&E department.

Being the chair of the SUAG group I had the experience of taking part in the exercise once in my capacity as a service user and also as a member of the STP programme management board. Whilst the STP board enjoyed a comfortable experience, in the Essex County Cricket Club lounge, overlooking the hallowed turf, with the services of the Boston Consulting Group in attendance, the patient experience was different. We had 30 people squashed into a small room, overlooking the car park and we were told to have detailed discussions and achieve a consensus.

When we reported that there were differences of opinion especially when it came to whose A&E department was going to be downgraded the atmosphere deteriorated. Many of the patients who had put a lot of work into trying to make sense of the often contradictory evidence explained that the scoring system did not do justice to the complexity of the issues involved. They asked questions of the managers present for clarification. Some of the managers present tried to help by saying that it didn't really matter what we thought so long as we put some figures down on the scoresheet.

The atmosphere was becoming heated with one manager shouting to the effect that we were getting out of time so we should put down numbers and go. At that point the communications manager was clearly delighted to see so much energy in the room and turned to me to say 'Isn't this great?'. I told her it wasn't . I told the group that we would need to have a reality testing session afterwards to address all the unanswered questions that the group had raised.

At the subsequent meeting the group were told that their replies were being considered and when asked about the scoring they were told that although the group were not keen on downgrading any A&E departments the STP management board was only obliged to note their comments and was not required to act upon them. From that point it has been hard to maintain any credibility that patient's views are taken seriously. The group continues, it has terms of reference stating that it is a means of 'meaningful engagement' with the board. As STPs change to ICSs it may be possible to rewrite the rules on public engagement.

It is interesting to note that around the world there is increasing interest in the value of knowledge gained from patient experience, particularly the computerised use of Big Data this is especially important for tertiary centres who may not be involved in long-term follow-up of patients such as in oncology [1].

As Mid and South Essex prepared to transition again, this time from STP to ICS we shall have a new chair and this role will be separate from the role of the implementing officers. This appears to be a response to the fact that the top-down management style of the current NHS is clashing with the decision-making processes of local democracies. For example in Luton the council are opposed to the STP's plans along with Bedford and Milton Keynes.

As the ICS begins to take shape there will need to be improved working relations with local councils as well as new rules of engagement with the public and patients considering what we have learnt so far.

References

[1] Fessele, K.L. (2018) The rise of big data in oncology. *Seminars in Oncology Nursing,* 34(2), 168-76

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The BMJ-DFNHS Essay Prize for Junior Doctors 2019

Following last year's great success, DFNHS will again join forces with the BMJ to run an essay competition for junior doctors.

The title will be:

"Where have all the doctors gone….. and why?"

Closing date will be announced in the June issue, and the winnner will be invited to present their essay at the AGM in October.

Last year's essay competition – offering a first prize of £500 and runner-up prize of £200 – drew over 30 entries, for which the standard was impressively high.

More details will be announced in the BMJ.

Affiliation to Doctors' Association UK (DAUK)

DFNHS has been accepted as an affiliate to DAUK.

Eric Watts is our representative. DAUK is concerned about the fate of doctors accused of making mistakes (see page 12). Colleagues in this situation are vulnerable and there is a dearth of support when they most need it.

The role of defence unions, the selection of expert witnesses, and the beahviour of Trusts is something DFNHS has voiced concern about in the newsletter on several occasions, including cases of manslaughter brought against doctors where – it has to be said – the role played by their employing organisations can at best be described as 'ambivalent' (if not bordering on callous, for some). DAUK developed via social media. From their website:

"We are a new campaigning and lobbying organisation, comprised solely of UK doctors. We advocate for both doctors and patients, and we're fighting for a better NHS for everyone. We grew from online community of 29,000 UK doctors, but have become an independent force for change. DAUK has been responsible for national campaigns such as #ScraptheCap and #LearnNotBlame."

https://www.dauk.org

They also have a Facebook page, "The Consulting Room" (www.facebook.com/TheDoctorsAssociationUK).

News from the NHS Support Federation and the CHPI

NHS Support Federation launch new publication: 'The Lowdown'

The NHS Suport Federation, which DFNHS has supported on several occasions, has launched a new weekly newsletter for health activists.

The Lowdown covers health news, analysis and campaigns. The CHPI said:

"Seeing the evidence on the issues which will decide the future of our NHS is so important that we decided to launch a new publication - *The Lowdown,* to help keep all NHS supporters connected."

The pilot issue contained articles on:

- "Stroke of a pen" can end NHS competition… but are the privateers still smiling? (Comment - NHS competition)
- Denied vital NHS cancer care and sent away with a bag of medicines (News analysis - migrant rules)
- What is an integrated care system? (Explainer - NHS changes)
- Five reasons the experts say the NHS needs more cash more. (Explainer - NHS funding)
- So what's the plan? Explained: The new NHS Long Term Plan (Explainer)
- NHS plans falls short on national staffing crisis (New analysis)
- Weekly news round-up

You can see the latest issue at https://bit.ly/2Siinj l

Comments are invited.

Centre for Health and the Public Interest appoints new Director

The CHPI has appointed David Rowland as its first Director.

In a letter to Eric Watts, David said:

"This is just a short note to introduce myself as the first Director of CHPI.

I was initially involved in setting up the Centre 6 years ago and I have worked with the Executive Management Team since then to help build the organisation.

I have also contributed to the Centre's research outputs on patient safety in private hospitals, social care markets, and also on the private finance initiative.

Having worked for a decade or so in healthcare professional regulation, I realised that the time was now right to take on running the Centre full time.

This has been made possible by the generosity of lots of individual donors like you and so a very big thank you for your support.

Over the next 6 months I will be working with Vivek Kotecha - our brilliant Research Manager - and the rest of the CHPI team to undertake research on Conflicts of Interest in the NHS, the mass sell-off of NHS land, and how money is leaking out of the social care sector in the form of profits and debt payments.

If you would like to read my latest blogs on the NHS Plan and on Brexit and the NHS (with Prof Tamara Hervey the Specialist Advisor to the Health Select Committee on Brexit) you can find them here: https://chpi.org.uk/blog/

I will be in touch again soon, but if you ever have any ideas or suggestions then please do drop me a line: d.rowland@chpi.org.uk"

Book Reviews

Bad Blood – Secrets and Lies in a Silicon Valley Start-up
John Carreyrou. Random House. (Kindle £6.02)
Financial Times and McKinsey Business Book of the Year Award 2018 (Business)

This is an amazing story, spelt out in such a gripping manner it has won many prizes.

In essence a college dropout believed she could change the world by developing new biotechnology. No ordinary dropout. From a well-connected family and gifted with real zeal, enthusiasm and dedication she was able to start a company with ambitious aims. Unfortunately she set her goals too high, well established companies were investing huge amounts into improving their products too and were making progress. She believed she was different and smarter. Unable to appreciate that her dreams were unachievable, she lowered her goals and her standards and ploughed on, attacking anything in the way.

There is a similar theme in great tragedies such as Macbeth in that it was fated to end badly and this story may only have been possible in the heady atmosphere of Silicon Valley a decade ago. Anywhere else she would have realised or her friends would have told her aims were simply unrealistic.

There are topical issues in medicine – leadership and innovation. She had the charisma to make a flying start and to charm rich backers to invest in her business. She also used the keyword of innovation to explain why her products were not subjected to orthodox testing and evaluation, claiming they were too different. This approach worked well in Silicon Valley where they celebrate those qualities and with a degree of eccentricity she was keen to present herself as the next Steve Jobs. In 2014 she was on the front cover of *Fortune* magazine with a comment that her company was 'poised to change healthcare'. She was lauded by the media and hailed as a visionary leader.

That was the high point but she promised too much, how she got to the heady position of having a $9 billion company and what happened next is compulsive reading. It is written by a *Wall Street Journal* journalist who methodically and painstakingly investigated many leads including how they had deceived the FDA and actually started to operate as a legitimate blood testing company. Although we do not know the extent of the damage we do know that real people suffered real harm as a result of tests being conducted on poor quality equipment inadequately validated.

The fact that start-ups can crash is well known and there are successes and failures to come out of Silicon Valley. What this story adds is the fact that the laissez-faire regulation in that cauldron of high-tech invention is a long way from the safety first approach we rightly expect for medical devices.

This is an essential read for anyone excited by the possibilities of disruptive technology. Invention and innovation should be celebrated but honesty and reliability are essential in health if not in all aspects of business. Whereas the slogan 'fake it till you make it' worked well for social media companies, medicine is a very different matter, requiring proper evaluation and licensing in the interests of safety. The heroes of this book, are not the flamboyant and colourful inventors, but the painstaking professionals with a conscience, whom prevented harm on a bigger scale.

It is soon to be made into a film, final comment from a man who knows the Tech industry well, Bill Gates:

> **"This story is even crazier than I expected and I found it impossible to put down. It has everything, elaborate scams, corporate intrigues, magazine cover stories and ruined family relationships...as well as the demise of a $10 Bn company."**

Clinical Practice and the Law – a legal primer for clinicians
Giles Eyre. Professional Solutions Publications. £34.95

This is an excellent book and although I approached it with some trepidation, fearing vast expanses of incomprehensible jargon it is the exact opposite. It is concise at 160 pages and describes all the important concepts with impressive clarity.

Both the legal and medical professions have long histories of their own cultures and a degree of mistrust of each other but what the book makes clear is that there are times when they have to interact. The natural fear that any doctor may have about having their work scrutinised can be reduced simply by adhering to what is generally accepted as good professional standards.

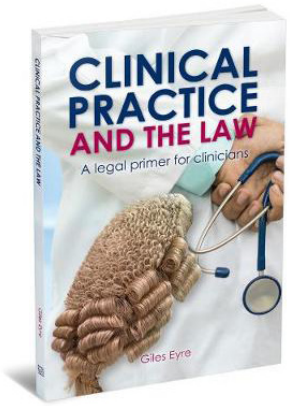
During his years in practice Giles had extensive experience in conducting and advising in personal injury and clinical negligence claims of all kinds. Giles' personal injury practice arose from work place and road accidents, as well as claims relating to occupational health issues. This book reflects this wealth of experience reaching into all medico legal areas with good examples.

The book opens with insights into the legal mind particularly the use of words, logic and reasoning and how they really expect to see these in action in medicine as well. It is particularly important to use words clearly with the precise meaning in context. One example from the clinical field would be to say to patient was 'better' which could either mean improved or completely cured. There is necessarily a great deal on evidence and its various forms e.g. direct, hearsay, oral, witness and documentary evidence.

It is reassuring to note that a medical opinion is more easily supported when the accompanying facts and reasoning are displayed. The days are gone when the expert, however experienced can simply say 'this is Castleman's disease because I say it is', the findings that led to the conclusion should be sufficient to show why the conclusion was made. The helpful summary statements such as 'Explain decision-making ; Show your reasoning' throughout the book to make sure that the key points make an impact.

The content includes chapters on proof, preparing a witness statement, acting as an expert, records and making notes and helping the police. There are some issues which will not be common for pathologists but we need to be aware of such as communication with patients, patients in custody and mental capacity. The important subject of When things go Wrong is very helpful with the essential principles clearly explained in a manner which reflects real-world experience.

The final statement in his 'Author's note' says: "If you think there is something the next edition should include, let me know – I too am happy to learn". Showing his commitment to continuous improvement and how we can and should continue to read, discuss and learn.



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EXECUTIVE COMMITTEE : Elected at AGM 2018

Contact information is provided so that members can if they wish contact a Committee member in their area or working in the same specialty.

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