

INSIGHT

SECONDARY

Featuring: Raising concerns amidst COVID-19 /
Remote consulting in the coronavirus outbreak /
Dealing with racism / Making SEA work for you

Peak performance

Emergency medicine
doctor Stephen Hearn on
performing under pressure



Welcome

Dr Greg Dollman
Editor



WELCOME to the first issue of *Insight Secondary Care* — one of three new quarterly magazines we are launching at MDDUS to broaden the scope of content we produce for all our medical and dental members. I am excited to take on the role of editor and hope you find this inaugural

issue both interesting and useful. All comments and suggestions are most welcome.

Coronavirus is presenting an enormous challenge for the health service, so in this issue we feature relevant, practical advice for clinicians. On **page 4** risk adviser Kay Louise Grant highlights key points when raising safety concerns in times of crisis. Remote consulting has become a crucial part of coronavirus care. On **page 5** risk adviser Alan Frame explores how to minimise risk in treating patients online or via telephone or video. If anyone knows how to perform under pressure it's emergency medicine physician and helicopter rescue medic Dr Stephen Hearn. He talks fighting fatigue and avoiding "frazzle" on **page 8**.

Significant event analysis is not easy to get right and many of the SEAs we see at MDDUS are more description than analysis. On **page 10**, Liz Price offers tips on making them more than just box-ticking exercises.

On **page 6** we look at what to do when confronted with racist patient behaviour — challenge it or simply "turn the other cheek"?

Professor Deborah Bowman offers a personal perspective (**page 13**) on how even "small things" can reflect ethical choices when it comes to dealing sensitively with patients.

Our case study on **page 12** highlights issues around consent in a patient diagnosed with an inguinal hernia.

Addenda on **page 14** includes some curious cardiac imaging, reviews of Bill Bryson's brilliant new book *The Body* and the corporate crime film thriller *Dark Water*, along with a vignette of Dr Margaret Fairlie — pioneering obstetrician and gynaecologist, and the first professorial chair in Scotland.

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Insight – Secondary Care is published quarterly by The Medical and Dental Defence Union of Scotland, registered in Scotland No 5093 at Mackintosh House, 120 Blythswood Street, Glasgow G2 4EA. Tel: 0333 043 4444 Fax: 0141 228 1208 Email: General: info@mddus.com Membership services: membership@mddus.com Marketing: marketing@mddus.com Website: www.mddus.com The MDDUS is not an insurance company. All the benefits of membership of MDDUS are discretionary as set out in the Articles of Association. The opinions, beliefs and viewpoints expressed by the various authors in *Insight – Secondary Care* are those of the authors alone and do not necessarily reflect the opinions or policies of MDDUS.

INSIGHT Briefing



MEDICATION

HIV treatment roll-out

THE preventative HIV treatment PrEP is to be rolled out across England thanks to a £16 million funding boost.

Over the next year, local authorities will receive the cash to make the drug available in sexual health clinics for anyone who is at a high risk of contracting HIV.

The move is part of the government's aim to end HIV transmission by 2030.

Studies have shown that, taken daily, PrEP reduces the risk of getting the virus from sex by about 99 per cent.

It is currently available in England through the three-year PrEP impact trial which has recruited more than 20,000 participants. The new funding boost will ensure those taking part in the trial can continue to take the drug once the trial ends.

The move comes almost three years after the Scottish Government made PrEP freely available in July 2017 to individuals across Scotland at highest risk of HIV.

Health and social care secretary Matt Hancock said: "This will benefit tens of thousands of people's lives."

DATA PROTECTION

Information sharing

NHSX in England has said that in the current circumstances with COVID-19 it could be more harmful not to share health and care information than to share it.

The organisation has had assurances from the Information Commissioner that she "cannot envisage a situation where she would take action against a health and care professional clearly trying to deliver care".

NHSX states: "We will need to work in different ways from usual and the focus should be what information you share and who you share it with, rather than how you share it."

Find out more at tinyurl.com/twabbcl



Fees waived

STUDENTS starting their foundation year 1 post early to assist the COVID-19 response will have their MDDUS membership fees waived. To take advantage of this offer, email marketing@mddus.com

ANNOUNCEMENT

Message from CEO Chris Kenny on COVID-19



WE know that the practical, ethical and legal challenges you face will only increase in the coming weeks.

Continuity

Our full service will remain available to our members throughout the duration of this uncertain time. We will keep you informed of any changes we are required to make in response to new UK Government legislation.

We know that Government has confirmed it will provide indemnity for clinical negligence liabilities arising from NHS activities carried out in relation to coronavirus where there is no existing indemnity arrangement in place.

The vast majority of MPTS hearings will be scaled back until 5 July. We're pressing regulators to respond pragmatically across the board, being robust in triage of cases and getting certainty quickly, rather than cutting corners.

Business continuity

I have asked my entire team to work from home for the foreseeable future. Our team is of sufficient size, diversity of skillset and flexibility that we believe we can maintain business as usual whilst working remotely from our two offices.

Reporting a claim and ongoing cases

We must urge members to use email rather than telephone communication wherever possible. Not only will this mean fewer unavoidable delays to us assisting you, it also means we will be able to help more members, more efficiently.

If you do need to call us, our number remains **0333 043 0000**. This service will continue on a 24/7 basis, and as the coronavirus situation develops we will invest in new lines to embed this service and ensure its sustainability.

Membership

I want to give three clear messages about membership:

- First, we are enabling the return of recently retired members by automatically giving free non-claims indemnity to doctors returning to clinical practice who retired up to six years ago, and who have been granted temporary registration by the GMC. You do not need to contact us to access this — we are writing to all members who fall into this category.
- Second, we know that counting hours and sessions will be one of the last things on your mind. So we will enable retrospective adjustments where you either cannot sensibly forecast your workload or it varies suddenly and unexpectedly.

- Third, we are giving the option to reduce subscriptions for doctors in private practice facing reductions in their income. We will continue to do our best to provide the best value that we can as we consider future pricing.

How we will keep you updated

We have developed a coronavirus information hub at www.mddus.com/coronavirus. It features links to the latest official advice as well as common medicolegal queries and employment law Q&As. We will continue to refine and update this information.

We will continue to support you with risk management training material and also communicate with you via our social accounts, predominantly our Twitter account [@MDDUS_News](https://twitter.com/MDDUS_News)

At this unprecedented time our entire effort is to support you, our members. If you have a concern, or are unsure who to contact about a difficult decision, contact us. If you are worried about a colleague or your own capability, contact us. And if you need general advice about your membership or regarding work you are being called upon to deliver, contact us.

MDDUS is here for you.



Blood test holds promise

A NEW blood test has the potential to detect more than 50 types of cancer as well as their location within the body, say researchers.

The test uses DNA sequencing to identify the presence of cell-free DNA from specific cancerous cells entering the bloodstream upon cell death. In the study, investigators analysed 6,689 blood samples, including 2,482 from people diagnosed with cancer and 4,207 from people without cancer. The samples

from patients with cancer represented more than 50 cancer types.

The researchers report that the test was over 99 per cent accurate in detecting that cancer was present and it correctly identified the organ or tissue where the cancer originated in more than 90 per cent of cases.

Dr Geoffrey Oxnard of the Dana-Faber Cancer Institute, co-lead author of the study, said: "The test can be an important part of clinical trials for early cancer detection."

RAISING CONCERNS AMIDST COVID-19

Kay Louise Grant
Risk adviser at MDDUS

HEALTHCARE services are facing increasing pressure to cope with demand caused by the coronavirus outbreak — and some NHS staff are already working at capacity. Practising in this type of environment and treating patients under new protocols means that you may have concerns about the risks to patients, colleagues and yourself.

In times of crisis, the care of your patient must remain your first concern. However, significant extra demands can lead to fatigue, lapses in concentration, heightened stress levels, and suboptimal decision-making and team communication, all of which can impact on patient safety.

Common concerns include individuals being asked to carry out duties they may not have the necessary skills or knowledge to undertake, unclear or absent emergency planning and poor infection control.

Clinicians will have understandable concerns about whether to speak up or simply carry on trying to provide appropriate care until these problems are resolved. GMC guidance is very clear that:

“All doctors have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies and procedures in the organisations in which they work.”

This applies even in this challenging time and you can access the specific guidance at tinyurl.com/uwc9mzr.

Doctors should always consider whether they can resolve a concern themselves, or at least offer practical suggestions to resolve the matter. You should try to familiarise yourself with local policies in relation to raising concerns and follow these. If you are not sure how to raise concerns, seek advice from a senior colleague and/or MDDUS.

Raising concerns without delay is particularly important in fast-moving situations such as the current crisis. If you have a concern regarding patient safety, you must act on this immediately by informing your clinical team lead, line manager or head of department, in line with local policies. If you don't feel comfortable raising a concern with a particular individual (perhaps because



they may be part of the problem), speak to someone else within your organisation. Be specific about the risks or potential risks you have encountered or foresee.

You should keep a record of any concerns raised. This does not mean you have to put those concerns in writing, but it is best practice to do so in order to demonstrate the steps you have taken.

All doctors have a responsibility to act on concerns raised to them but those with management or leadership roles have greater responsibilities. Should you submit a concern having followed your organisation's policy/procedures and receive no response or an unsatisfactory or inadequate response, you should consider escalating your concern to the next appropriate level depending on the nature, seriousness and urgency of your concern. In a hospital setting, you may need to contact the clinical director or medical director. You should escalate the matter as far as necessary to achieve a proportionate response; ultimately this may involve alerting an external organisation, such as the GMC.

A recent article in the *Guardian* featured reports that some hospitals and NHS bodies are warning doctors and nurses not to air concerns on social media over shortages of personal protective equipment. The Doctors' Association UK said it had evidence that some staff were reprimanded by managers or threatened with disciplinary action after posting comments online. MDDUS would urge

clinicians to proceed with caution before posting to social media and to ensure they have followed all appropriate channels for escalating concerns. Be sure to comply with GMC guidance *Doctors' use of social media*. It would also be advisable to contact your medical defence organisation before taking action.

If a concern is reported to you, inform your colleague as to what steps you will take to address that concern. You do not have to provide full details but they should receive some formal feedback — otherwise your colleague may feel they have a professional responsibility to escalate the matter further.

Raising concerns is an area that causes members much stress and worry. Remember that you will be able to justify raising a concern if you do so honestly, on the basis of reasonable belief and through appropriate channels.

ACTION POINTS

- Make yourself aware of specific GMC guidance on raising and acting on concerns.
- Don't ignore an issue in the hope it will disappear or won't be a problem; take action promptly.
- Follow your organisation's policy on raising concerns, focus on the specific risks you have identified within your communication, and document any action and responses.
- Escalate your concerns if the issue is still unresolved.
- Take advice from MDDUS at an early stage of the process.

REMOTE CONSULTING IN THE CORONAVIRUS OUTBREAK

Alan Frame

Risk adviser at MDDUS

IF COVID-19 has shown us anything, it's how resilient NHS staff are in the most stressful situations. Patient demand has probably never been higher across the UK and yet — given how quickly coronavirus has spread — the health service must also contend with the need to reduce the risk of exposure both to staff and patients.

Doctors have little choice but to change the ways in which they normally operate — and one key approach will be increased utilisation of online, telephone and video consultations. Hospitals are actively exploring greater use of video and telephone to consult with patients and manage ongoing care, and where appropriate to reduce unnecessary proximity contact.

NHS England has also sent information to the public concerning planned hospital appointments. It explains that they have asked hospitals to review ongoing patient care. Some clinics and appointments may be cancelled or postponed and patients will be notified of any changes.

Now is an opportune moment to reflect on the benefits of using remote consulting, as well as potential pitfalls. It gives patients access to medical advice, while protecting other patients, staff and clinicians from possible virus exposure — but healthcare staff must be aware of the risks.

Hospitals/trusts/health boards may have their own particular approach to remote consultations but here we offer some general advice.

PROCEDURES AND TECHNOLOGY

- Few hospital clinicians will be accustomed to assessing patients via remote technology. Increased time should be allocated to appointments with peer support put in place. Colleagues experienced at consulting remotely could offer support/supervision.
- Call-back procedures need to be more considered. Patients offered a remote consultation should be given a clear timeframe for the appointment and instructions on how to access and use any relevant system. Ensure also that they have the necessary technology to participate. This will act as a safety net for any technical issues or potential



misunderstandings — for example if the patient's phone number has been incorrectly recorded. Admin staff can help by making sure contact details are correct and clear information has been noted about the reason for their call.

- Ensure that you have clear guidance on pursuing call-backs and how many attempts should be made before recording a failed contact. A consistent process should be agreed and implemented.

THE CONSULTATION

- Remember patient safety comes first. You must be confident that assessment via remote means will be adequate. Establish quickly whether the patient needs further review or examination.
- Stay up-to-date with local health service arrangements to advise and signpost patients. Establish the identity of the patient/their representative, confirm consent where necessary and ensure adequate measures are in place to maintain confidentiality. Record that you have done so.
- Check with the patient that they understand why a remote consultation is necessary at this time and that a face-to-face assessment can be arranged if indicated. If in doubt, check that the patient has capacity to understand the advice you are providing and make decisions.
- Allow sufficient time in remote consultations to listen carefully to the information provided and to ensure that

the individual you are consulting with is clear on what you are advising.

- Be aware of the increased importance of “para-verbal communication” in video consultations, i.e. tone/nuance of voice and body language. Individuals may take longer to relax and “open up” more fully about their presenting complaint.
- Record in the patient notes that, due to coronavirus restrictions, the appointment has been via remote consultation. Make an adequate record of information relayed to the patient or carer, including specifics on any safety netting advice and any red flags relevant to that patient.

Prescribing can be particularly difficult in remote consultations.

Checking understanding of dosage, contraindications and other issues can be more problematic. Adequate time is important to ensure safe compliance.

- Be sure to restate the agreed position and any required actions to the patient at the conclusion of the consultation, as this may be your last chance to ask for clarification and pick up something important (in case you have been “barking up the wrong tree”). It will also better conclude the consultation for the patient, who should be more reassured.

DEPARTING FROM ESTABLISHED PROCEDURES

The GMC has published recent guidance including specific advice on adapting practice to cope with patient demand during the coronavirus outbreak. They understand that special measures may need to be taken to protect your patients and yourself. They say:

“It is likely that, as the situation develops, some doctors will need to depart from established procedures to care for patients.”

Ongoing communication with patients is key in order to reduce uncertainty or resistance to these temporary measures. Significant announcements, such as changing clinic appointments to remote ones, should be conveyed promptly.

LINKS

- GMC: Remote consultations – tinyurl.com/ydy6z4pg
- GMC: Prescribing guidance – tinyurl.com/wqdnawm
- GMC: Coronavirus information and advice – tinyurl.com/s3cfuzk

RACIST abuse directed towards NHS staff by patients appears to be on the rise. A recent ITV report found that recorded racist attacks against NHS staff increased from 589 in 2013 to 1,448 last year — a 145 per cent jump.

The report featured a moving interview with Mr Radhakrishna Shanbhag, who has worked as a senior NHS surgeon for more than 20 years. He described how a patient request to be operated on by a “white doctor” left him feeling “devastated” and gave him cause to reconsider his position in the health service. Unsure of how he would be supported in the event of a complaint, Mr Shanbhag reluctantly agreed to enquire about an alternative surgeon.

A nurse from the Philippines also told ITV that racial abuse from patients happened so frequently that it was becoming normal and she felt there was no point in reporting it.

Although the reason for the rise in abuse was unclear, it is thought that contributing factors may include a greater willingness to report, as well as changing attitudes in the wake of political events such as Brexit.

The report sparked much debate amongst clinicians about how best to respond to racism. Some said such behaviour should never be tolerated. But many agreed that ignoring comments or adhering to racist requests is the simplest solution, despite acknowledging it rewards bad behaviour.

So should you simply carry on treating a patient despite feeling abused and threatened? Can you refuse to treat such patients or have them transferred or removed from your list?

Whatever the reason, it is important to state that such behaviour is unacceptable and doctors should never be expected to tolerate it. Your hospital/trust/health board should have a policy in place to offer guidance in this area, but below are some practical tips.

APPROPRIATE RESPONSE

Depending on the seriousness of the incident and the level of offence caused, there are a range of potential responses.

A patient asks for an ‘English-speaking’ or ‘non-foreign’ doctor. It may be enough to politely explain that such a request is inappropriate and emphasise you are fully trained and qualified. Clearly document any discussion and action taken in the patient record. Should such behaviour persist, you should then escalate the matter to a more senior colleague.



TURNING THE

What should doctors do when confronted by racist behaviour from patients? Risk adviser Kay Louise Grant offers advice

Verbal abuse or threats. First, stay safe. If at any point you feel threatened, take steps to safely end your care of that patient. If necessary, seek assistance from security or the police. Such behaviour may understandably result in a breakdown of trust to the point where you no longer feel able to treat the person. If so, seek help from a senior colleague and be mindful of the GMC’s *Ending your professional relationship with a patient*, which has a section on patients who have been “violent, threatening or abusive to you or a colleague”. Key considerations include making factual and objective notes in the patient record and ensuring appropriate

arrangements are made for the patient’s continuing care. You should also be prepared to justify your decision.

In delivering care where any delay could result in patient harm, MDDUS advises that you prioritise urgent care needs before taking any action to transfer care to another doctor. Your organisation’s policy should have clear guidance on how these situations are to be handled.

Record of events. Keeping a diary of events can be a useful tool in reporting abuse. Take note of what happened, when it happened, who was involved and what witnesses there were.



“We all need to act to ensure racism in our NHS is eradicated. It is not the responsibility of those who suffer racist abuse to challenge it alone”

OTHER CHEEK?

EMPLOYER SUPPORT

The British Medical Association offer specific advice for employers when dealing with reports of discrimination and how to act on such concerns. They stress the importance of “effective implementation of appropriate policies”. Employers are also reminded of their duty under the Equality Act 2010 to protect their staff from discrimination relating to race, gender, religion or other protected characteristics.

Despite this, a recent study carried out by the GMC, *Specialty, associate specialist and locally employed doctors workplace experiences survey*, found that many doctors still feel unsupported in their organisation.

One survey question asked about the challenges doctors face in the workplace, including abuse. A quarter of SAS doctors answered that they disagree/strongly

disagree that their working environment is a fully supportive one, and over a third of SAS doctors and a quarter of locally employed doctors disagreed that they were always treated fairly.

One consequence of this is that doctors may feel reluctant to report or seek help when faced with abuse. This could negatively impact a doctor’s wellbeing, which could in turn impact their ability to deliver a high standard of patient care.

With the current NHS workforce crisis, it is more important than ever that staff feel supported and safe in their organisation. Where the demands of the hospital seem to be put before the wellbeing of the doctor, this sends a harmful message that can deter staff from speaking up.

In response to the ITV report, Matt Hancock, Secretary of State for Health and Social Care, wrote to all NHS staff in England stating: “If a patient asks to be

treated by a white doctor, the answer is ‘no’. Your management must and will always back you up.

“We are very proud that everyone in the UK is entitled to healthcare at the point of delivery, according to need not ability to pay. No one is entitled to choose the colour of the skin of the person giving that healthcare.

“We all need to act to ensure racism in our NHS is eradicated. It is not the responsibility of those who suffer racist abuse to challenge it alone.”

ACTION POINTS

- Avoid reacting out of anger. Take the time to assess the situation before responding.
- Consider whether a formal warning to the patient would be enough to deter them from further abusive comments/behaviour.
- If you or a colleague feel threatened in any way you may need to take immediate action such as phoning security/police and having the person removed from the premises.
- For employers, ensure you are complying with the Equality Act 2010 and the Health and Safety at Work Act 1974. Have clear policies and procedures in place that protect your staff from abuse of any kind.

Kay Louise Grant is a risk adviser at MODUS

UNDER PRESSURE



A conversation with doctor and author Stephen Hearn on the challenges of performing in high-pressure situations

DR Stephen Hearn is an emergency medicine physician based in Glasgow. He was the lead consultant with Scotland's Emergency Medical Retrieval Service (EMRS) until 2019, providing critical care and safe transfer of patients from remote healthcare locations and at accident scenes by helicopter, plane or fast response vehicle. He is also author of a new book — *Peak Performance Under Pressure*.

Jim Killgore spoke to him in late March, just as the UK was gearing up to face a peak in the coronavirus outbreak.

HOW WOULD YOU CHARACTERISE THE PRESSURE HEALTHCARE PROFESSIONALS NOW FACE WITH COVID-19?

It's absolutely unprecedented in peacetime — and there are a number of specific pressures on healthcare professionals. I think fatigue is the biggest one that could potentially compromise performance. That will come from the intensity of work, the duration/frequency of shifts, and reduced rest periods — especially in covering for ill colleagues.

Fatigue has numerous negative effects on our ability to perform — and a lot of research has been done on this, particularly in military contexts. Number one, it reduces our ability to take on board information and make accurate decisions, to consider options and to choose the right course of action. It also compromises our ability to communicate, which is very important in high-pressure situations, both in terms of verbal and non-verbal communication. When we're tired, our ability to pick up subtle facial expressions and changes in the tone of people's voices is reduced significantly — and also our ability to focus attention on what people are saying to us.

Fatigue also affects performance by reducing our ability to plan and innovate, which in the current situation is vital. Few healthcare professionals will have faced this type of challenge before and certainly not on this magnitude. Planning and innovating is really important, but when we're tired our ability to do that is compromised.

A fourth aspect is that, unfortunately, when we're fatigued, our insight into how we're performing decreases. Maybe we're not performing practical procedures quite so well but our awareness



becomes reduced significantly so we don't know when to stop and rest, or ask for help.

IS HAVING POSSIBLY TO WORK IN DIFFERENT AREAS OF PRACTICE ALSO A FACTOR?

Having additional help in the current situation will certainly be beneficial in reducing the pressure on existing frontline healthcare staff but it's important that individuals drafted in are given roles they are comfortable with, and that we provide clear guidance and cognitive aids. We don't want them to feel excessively pressured or put into situations where the consequences of error could be significant. The way tasks and roles are delegated to those individuals, to ensure they perform well, is vital.

SOME CLINICIANS WILL BE UNUSED TO WORKING IN HIGH-PRESSURE SITUATIONS LIKE EMERGENCY MEDICINE OR CRITICAL CARE. WILL THIS BE A PROBLEM?

Yes, it already is. When we're dealing with a real-time situation we use a part of our short-term memory — called working memory — to store information, consider options and make decisions. We also use it to perform practical tasks. Unfortunately, the size of the working memory is very small. The volume of information that we are having to process about COVID-19 is considerable and is also very dynamic. Guidance and research evidence is changing on a daily basis — therefore cognitive overload is already an issue as we try to get up to speed on how we diagnose and manage these patients.

IS PERSONAL RISK A MAJOR FACTOR?

Pressure can be divided into two categories — intrinsic and extrinsic. Intrinsic pressure for a healthcare professional is that involved with making a diagnosis, deciding on a treatment, or planning a practical procedure. Extrinsic pressures are those that surround the job, such as the consequences of making a wrong decision or an error in carrying out a practical procedure, which could be catastrophic for both patient and doctor. But people will also be going into clinical shifts with a high degree of pressure coming from their personal life that is impossible to leave at the door.

Healthcare professionals — like anyone else — are naturally



anxious about the risk of this disease to themselves and to their families. So all of those pressures will combine and potentially have harmful effects on personal performance.

HOW CAN THE NHS HELP EASE THESE PRESSURES?

There are a number of ways. To tackle fatigue, we need to ensure sustainable rostering. Many people are having to do extra shifts to cover for increased demand but also for colleagues off work unwell or looking after relatives. We have to consider that this situation is going to go on for months and to stay cognisant of the effect of working excessive hours for prolonged periods. I think it's vital to maintain rostering systems that allow sufficient rest periods.

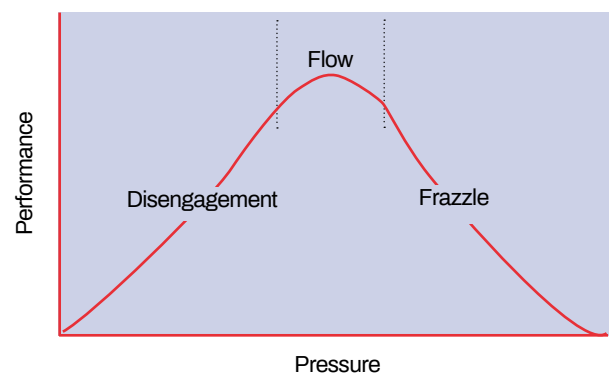
I also think that, with such a dynamic situation, there need to be high-quality cognitive aids, both on a national level and in each department, that give people clear and — as much as possible — unambiguous guidance about diagnosis, treatment, etc. The final thing — and this is something my own board and emergency department have already put in place — is pre-emptive psychological help for staff, involving occupational psychologists to provide support with no stigma attached.

IS PRESSURE ALWAYS A BAD THING FOR CLINICIANS?

We all need pressure to perform well, to make the right decisions, to communicate, to lead a team. What happens physiologically is that, as pressure increases to a certain level, we get low-level release of cortisol and adrenalin and that acts to motivate us, to arouse us, to stimulate us and actually move us into a zone of high performance, or *flow*. Pressure at the right level is very positive in terms of performance.

But when pressure becomes excessive we move from that zone of flow to the zone of *frazzle*. That results from cognitive overload and a perception that what we face is insurmountable, i.e. our appraisal of the situation is that it poses a potential threat. That results in increased release of adrenalin and cortisol and pushes us into the zone of frazzle, or compromised performance.

It's an issue for us in helicopter retrieval and an issue for me in mountain rescue; the environment we're working in can really compromise our performance. Being cold, wet or it being windy,



“I think it’s vital to maintain rostering systems that allow sufficient rest periods”

and also trying to operate and perform to a high level in a noisy vibrating aircraft — all of these add to the pressure. And if we are not prepared, if we are not used to working in these types of environments, then it will result in compromised patient care. It's easy to think of extreme situations an EM specialist might be involved in, but all doctors can feel overwhelmed and frazzled.

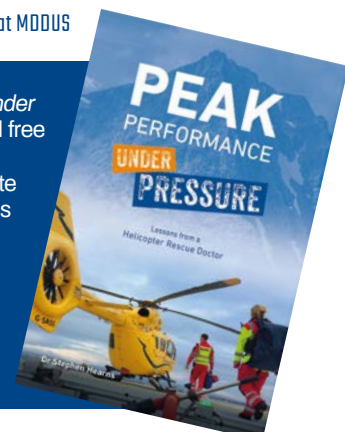
YOU SPEAK IN YOUR BOOK OF “OWNING THE PRESSURE”. WHAT DO YOU MEAN BY THAT?

Pressure can be good but you need to take time to prepare your team when you have the opportunity, to minimise the impact of the pressure they are going to be under, especially with something like the COVID-19 situation. That is the idea of actively trying to own the pressure — because in high performance we need a degree of pressure, and if we can prepare in the cold light of day then we will stay in the zone of flow and avoid frazzle.

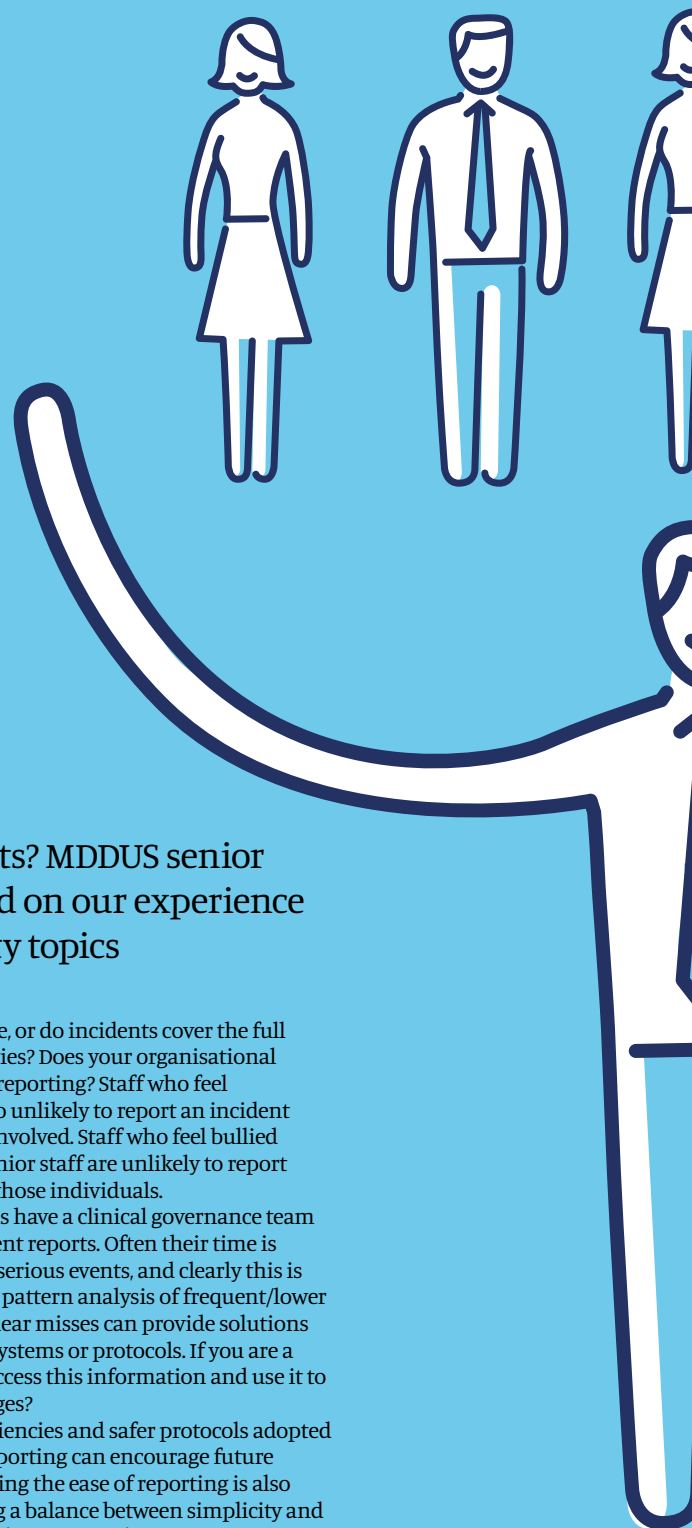
Jim Killgore is an editor at MDDUS

To order a copy of *Peak Performance Under Pressure* with a 20 per cent discount and free UK delivery for MDDUS members, go to www.classprofessional.co.uk and quote the discount code: **MDDUSPEAK20**. This offer is valid until 30 June 2020.

Check out further content and links from Stephen Hearn at www.CoreCognition.co.uk and on Twitter [@StephenHearns1](https://twitter.com/StephenHearns1)



CREATING POSITIVE CHANGE



Is your team truly learning from adverse incidents? MDDUS senior risk adviser Liz Price offers some reflections based on our experience in working with hospital doctors on patient safety topics

ALL secondary care teams should be following nationally-led and organisationally-driven systems of reporting and learning from adverse events. In theory, these should be effective in reducing risk, but in practice there are often process failures. And with under-reporting common, it becomes impossible to maximise the value of the exercise.

The most common factor in under-reporting is that the incident isn't perceived as "adverse". At MDDUS training events, we often hear comments such as: "there's no point in reporting incidents as you never get any feedback and nothing changes", or "my colleagues don't always report incidents as there is a worry that we won't be supported".

If you want to start a conversation in your team — at all levels and including clinical governance leads — below are some starting points.

HOW ARE EVENTS TARGETED FOR ANALYSIS?

Consider the effectiveness of your incident reporting processes. If you are a clinical lead, does the team understand what a reportable incident is? Are different teams reporting into the same multidisciplinary process? Does everyone understand the purpose of collecting, and the process that follows?

Are low-level incidents, near misses and 'good catches' being collected as well as more significant incidents for thematic review? Capturing such incidents can help identify training needs and reduce unnecessary follow-up activities.

Leads, and the clinical governance team, should also consider who reports incidents. Are the same people

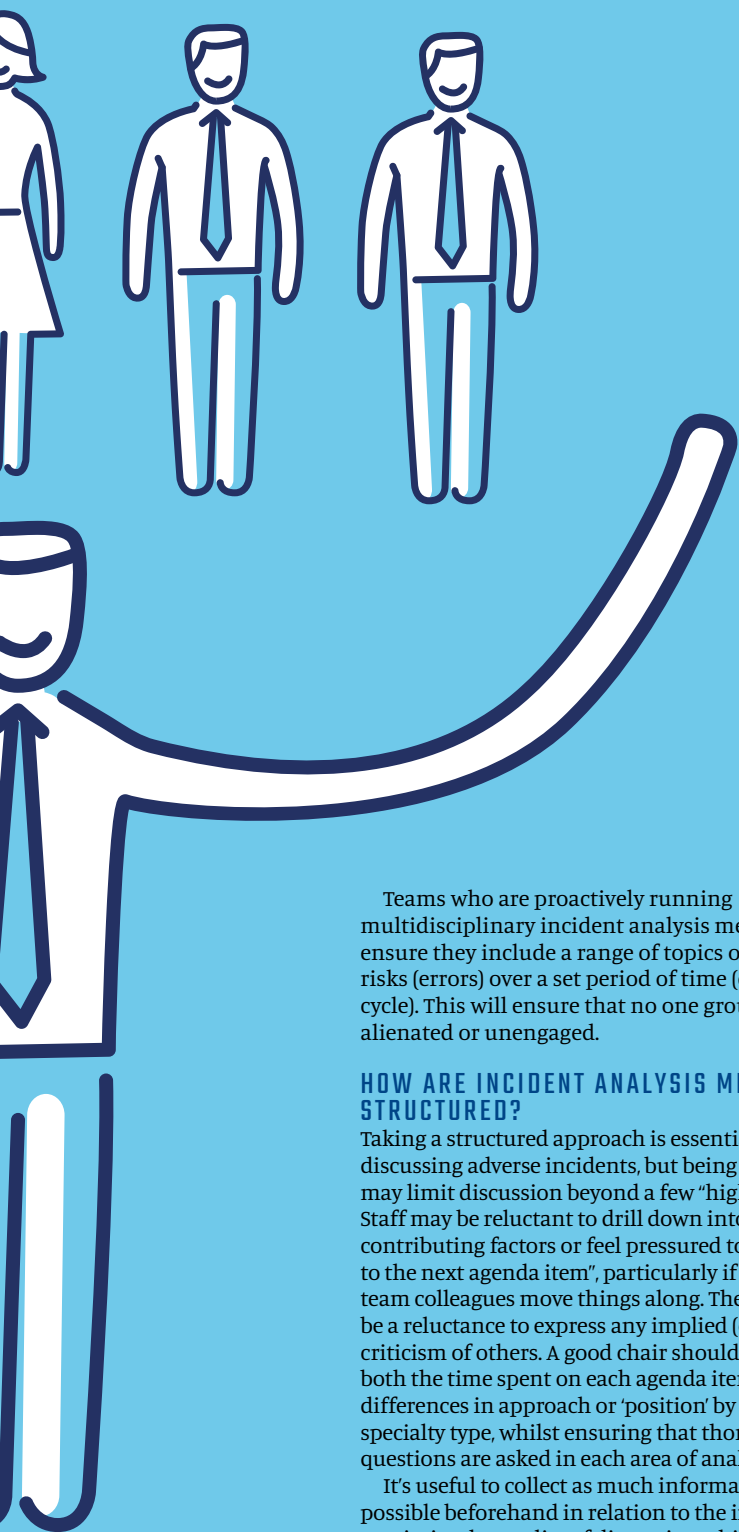
reporting all the time, or do incidents cover the full range of team activities? Does your organisational culture support self-reporting? Staff who feel unsupported are also unlikely to report an incident in which they were involved. Staff who feel bullied or intimidated by senior staff are unlikely to report incidents involving those individuals.

Most organisations have a clinical governance team who deal with incident reports. Often their time is taken up with more serious events, and clearly this is important. However, pattern analysis of frequent/lower level incidents and near misses can provide solutions to improve routine systems or protocols. If you are a team lead, can you access this information and use it to create positive changes?

Highlighting efficiencies and safer protocols adopted as a result of such reporting can encourage future engagement. Reviewing the ease of reporting is also important: achieving a balance between simplicity and gathering sufficient data is crucial.

WHO IS INCLUDED IN INCIDENT ANALYSIS?

Some clinical incidents may be too sensitive for wider team discussion. But if incidents involve non-clinical systems — or patient-related processes in which admin actions are required — a suitable admin team member must be involved to ensure that any changes are sensible and do not create additional risks. Alternatively, outcomes can be shared via team meetings or other agreed channels. Either way it is important to ensure changes are properly understood (and embraced) by the wider team and other stakeholders, such as other departments, locations or relevant patient groups.



Teams who are proactively running multidisciplinary incident analysis meetings should ensure they include a range of topics or potential risks (errors) over a set period of time (e.g. a year cycle). This will ensure that no one group feels alienated or unengaged.

HOW ARE INCIDENT ANALYSIS MEETINGS STRUCTURED?

Taking a structured approach is essential when discussing adverse incidents, but being too structured may limit discussion beyond a few “high-level factors”. Staff may be reluctant to drill down into other contributing factors or feel pressured to “move on to the next agenda item”, particularly if more senior team colleagues move things along. There may also be a reluctance to express any implied (or implicit) criticism of others. A good chair should manage both the time spent on each agenda item and any differences in approach or ‘position’ by profession/specialty type, whilst ensuring that thorough questions are asked in each area of analysis.

It’s useful to collect as much information as possible beforehand in relation to the incident(s) to maximise the quality of discussion. This could include detailed written statements, copies of current policies or other records.

ARE STAFF SUPPORTED AND IS THE MOST COMPREHENSIVE LEARNING EXTRACTED?

In many cases only superficial learning and training opportunities are identified through analysis. What went wrong may be put down simply to: “the process or protocol wasn’t followed” or “the junior doctor should have asked for advice from a colleague at the time of the incident”. Subsequent learning is then noted as: “the protocol should be followed in these circumstances” or “in future a consultant should be contacted if a patient presents in this way”. Such

conclusions may be true but unless “why” questions are asked many incidents are more likely to reoccur.

This is because in most scenarios there will be other underlying factors that contributed to the adverse incident, ranging across:

- People — the specifics of the patient or team member involved.
- Activities — the task(s) or process that the individual (or team) were engaged in at the time.
- Environment — the setting or situation within which the incident occurred.

There is evidence that asking “why” five times is the optimal strategy to achieve deeper learning and a root cause.

Exploring the contributory factors more fully should lead to findings such as: “the protocol was not followed because the individual was under too much pressure” or “the consultant was not contacted because the junior doctor was too scared to approach them”. In the latter, asking why is likely to identify whether the junior doctor needs support to be more assertive, or whether the consultant needs to adjust their manner or response to interruptions or contacts.

Identifying such underlying issues can often be challenging but failure to do so will likely lead to future incidents.

ARE OUTCOMES BEING MAXIMISED?

To ensure that any lessons learned from incidents are properly cascaded, a mechanism should be agreed through which staff not directly involved in an incident are updated. Any amendments to protocols or systems should include clear information about the efficiency, effectiveness or patient safety gain from the proposed change, as this is likely to encourage future compliance.

Sometimes, research or audit is required to assess the extent of any issues identified, or further training will be necessary to support improved practice. It is important to agree a timescale within which this should be completed, and to appoint an individual to make sure it happens and report back.

Once complete, an anonymised written record of the analysis — including insights gained, lessons learned and actions agreed — should be generated and retained securely. It is often useful to share this with the patient as part of a complaint response to show evidence of quality improvement. Where an event led or could have led to patient harm, an incident review can be used by doctors in appraisal/revalidation as evidence of reflective practice.

Doctors at all stages in their career have a responsibility to engage fully in patient safety initiatives and use whatever influence they have to effect positive change.

Liz Price is senior risk adviser at MODUS

NATIONAL GUIDANCE

- Scotland: tinyurl.com/td98qkl
- England: tinyurl.com/w6py8uo
- Wales: tinyurl.com/s9bdmvc
- NI: tinyurl.com/rccxozf

HERNIA REPAIR

DAY ONE

Mr K is 51 years old and works in finance. He presents to his GP with an abdominal bulge in the left groin and pain, especially on bending or lifting. He is diagnosed with an inguinal hernia and referred to a surgical unit.



WEEK 12

Mr K is admitted to hospital and undergoes a laparoscopic inguinal hernia repair, using surgical mesh. He is discharged after two days, with advice on pain relief.



WEEK 16

The patient re-attends his GP complaining of persistent pain and some swelling in the left groin. He is referred back to the surgical unit. An MRI reveals no problem related to the mesh and no recurrence of the hernia. The surgeon advises Mr K that there appears to be some fatty infiltration of the inguinal canal (cord lipoma) and this may be causing discomfort but she would be reluctant to embark on further surgery. She refers the case to a senior colleague.



ONE MONTH LATER

Mr K is admitted for surgery and signs a consent form. Mr J undertakes open groin surgery and excises a small but elongated cord lipoma. The patient is discharged the next day but on follow-up reports that the pain has in fact grown worse. Subsequent treatment including steroid injections and neurectomy are ineffective in relieving the pain. Mr K finds sitting for any long period uncomfortable and his mobility is reduced. He is later referred to a pain clinic.



WEEK 20

A consultant surgeon reviews the MRI and in discussion with the patient advises open groin surgery and removal of the cord lipoma. Mr K agrees but requests a private referral to avoid having to wait. The consultant contacts a colleague – Mr J – who agrees to undertake the procedure. Mr J's secretary contacts Mr K offering an appointment to discuss the treatment but the patient (wanting no further delay) opts for a quick admission.

A letter is sent by solicitors acting for Mr K claiming clinical negligence in Mr J's treatment. It alleges that the patient was not informed he would be undergoing open surgery, nor was there discussion of the procedure's risks/benefits. Mr K claims that he would not have undergone the operation had he been fully informed.

MDDUS acting on behalf of Mr J reviews the case and commissions an expert report from a consultant surgeon.

In his response, Mr J states that in the letter from the referring NHS surgeon it was clear that the proposed treatment had been discussed and agreed with the patient prior to his requesting private care in order to avoid a prolonged wait. Mr J had offered to see Mr K in clinic to further discuss the operation but the patient opted for direct admission to the surgical unit.

Mr J states that his usual practice on the day of surgery is to have a quick word with the patient to ensure understanding of the procedure and to answer any last questions. The records show that a surgical consent form was signed but the operative method is not detailed, nor is there any record of benefits and risks discussed.

The surgical expert opines that the decision to undertake open exploration and removal of the cord lipoma was appropriate. He notes that a consent form for the named procedure was signed but there was an assumption that Mr K was aware he was undergoing an open procedure and fully understood the risks/benefits. The expert states that, in his view, this constitutes a failure of informed consent and a breach of duty of care by Mr J.

In regard to causation (the consequences

of the breach), the expert acknowledges that it would be up to a court to decide what Mr K might have done had he been fully informed about the open procedure and its associated risks. Had he chosen more conservative treatment Mr K would still have endured persistent chronic pain.

MDDUS decides to settle the case, with Mr J's agreement, for a modest sum.

KEY POINTS

- Ensure the patient understands what treatment is being proposed – this is the essence of shared decision-making.
- Record what was discussed with the patient in regard to consent.
- GMC guidance, *Consent*, states that the treating doctor has responsibility to discuss agreed plans with the patient. Always confirm consent, never assume.

IT'S THE SMALL THINGS

Deborah Bowman

Professor of Bioethics, Clinical Ethics and Medical Law at St George's, University of London

WHEN I first became interested in medical ethics, it was an issues-led field that was predominantly concerned with 'big questions'. The relatively few books that existed had titles such as *Matters of Life and Death*. There were no syllabi nor any agreed curriculum content, but the lectures I attended were commonly concerned with a triad of abortion, euthanasia and reproductive ethics. These are, of course, important. Yet, early on, I became interested in the intersection of ethics and the small things. For example, those precious initial moments in an encounter that set the tone and allow for trust, dignity and humanity to flourish, how we adapt in pressured environments to queries or interruptions, how constructively we can disagree and the tone of our communication with others. I wrote a lot about the "ethics of the everyday", largely absent from curricula and textbooks, but integral to healthcare.

I have been thinking a lot about the small things and the big challenges that they can present for staff and patients. A few weeks ago, I received a letter from 'the NHS'. It advised that an appointment had been booked across the road from my office for breast screening. The letter explained why this appointment was valuable, talking about age, risk, early detection and improved prognosis.

As some readers will know, this letter was received by a woman who no longer has breasts and, so far, has received two and a half years of treatment for breast cancer. I was, in a response that is increasingly familiar when I think about illness, both rational and emotional. I appreciated that it was an automated letter and no one's fault or responsibility. I understood that for many, the letter would be welcome and the ease of a pre-booked appointment appreciated. In a complex and resource-constrained system, it isn't efficient or perhaps even possible, to identify those who might be considered exceptions.

Yet, I was also upset. The letter was a stark plunge into dark places. Its unexpected arrival was an unavoidable reminder that I was relatively young when diagnosed, that I had late stage disease with a poorer prognosis, that I was physically different from most women, that I was frightened about the future, that I felt ashamed about perhaps having 'missed something' before I was diagnosed and that maybe I should have been more



"The letter was an unavoidable small thing; a consequence of the complexities and challenges of running a national screening system"

alert to avoid being in this position in the first place.

I knew enough not to do anything immediately but to sit and process my response; to attend both to the rational and to the emotional. After a few days, I began to wonder about the member of staff who would take my call when I rang to explain that I would not be attending the appointment. He or she would have no idea about my circumstances, or that I have deliberately avoided having any clinical care at my own hospital. Rather, I'd encounter someone likely to be working in a pressured environment and juggling myriad demands.

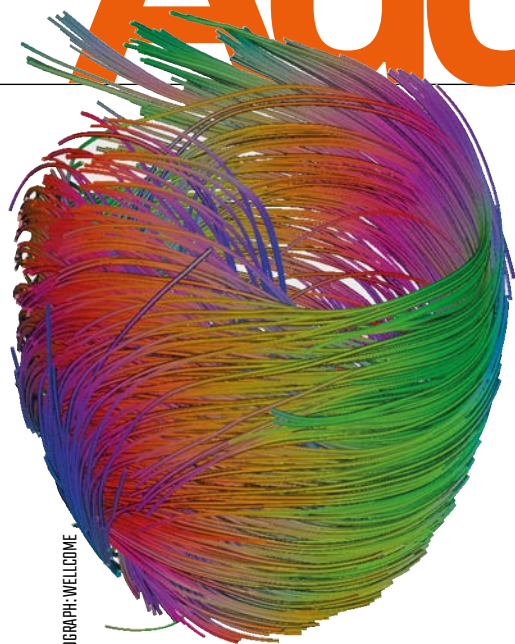
I wanted to explain why I wasn't coming, but I knew I needed to do it in a way that was calm, factual and kind. I understood that the person I contacted was not responsible for, or even aware of, my personal response. I rehearsed the

conversation. I debated whether to go over to the Breast Centre and speak to them in person whilst at work, or whether it was better to make a telephone call from home. The task hung over me and I was apprehensive when I passed the unit as I walked through the hospital. I knew though that this 'small thing' was no one's fault and I had to acknowledge that truth in my response.

Eventually, I rang the unit. It was not the conversation for which I hoped. I was reminded by the staff member that screening slots are precious and, although it was a fortnight until the pre-booked appointment, asked why I had waited a few days to get in touch. I was asked twice if I was "sure" even as I explained that I have had a radical bilateral mastectomy. No one knew whom I should contact to avoid being invited to future screening in the hope that I could save the NHS time and resource by preventing further letters and pre-booked appointments.

When I put down the phone, I reflected on "the small things". The letter was probably an unavoidable small thing; a consequence of the complexities and challenges of running a national screening system. However, the response of another person to my call was a small thing that could have been different. The conversation, imbued with officiousness, irritation and misunderstanding, reflected ethical choices. It could have made all the difference. There was nothing "small" about it.

Addenda



PHOTOGRAPH: WELLCOME

OBJECT OBSCURA

Heartstrings – digital image

THIS swirling arrangement of cardiac fibres in the left ventricle was produced using a type of MRI known as diffusion tensor imaging (DTI). The non-invasive technique tracks the diffusion of water molecules in the myocardium, revealing valuable information about the structure of the heart in a non-invasive way. It allows scientists to model the structure of cardiac muscle cells and how certain pathologies, such as ischemia, can cause this to change.

BOOK CHOICE

The Body: A Guide for Occupants. By Bill Bryson

Transworld, hardback, £25.00 2019

Review by Dr Greg Dollman, *Insight* editor

I MUST admit I was a little sceptical at first. How could anyone, even Bill Bryson, keep me engrossed throughout nearly 400 pages of a lay description of the human body? There are only so many “we blink fourteen thousand times a day” and “the body makes millions of red cells every few seconds, and discards one billion every day” facts that I could appreciate. I was wrong. Within the first few pages, Bryson describes the human body as “a warm wobble of flesh” and I was hooked.

The chapters whistle-stop their way through the anatomy and physiology of the body, reminding us how we come to be, what makes us who we are and how we live — marvelling at what ‘goes right’ and considering what can go wrong.

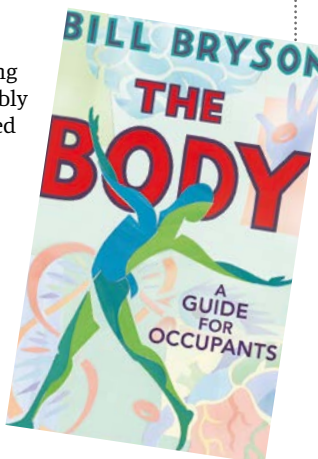
Bryson’s descriptions are witty and astute: he observes that, considering the nature of the skin’s stratum corneum, “all that makes you lovely is deceased”, and explains how we are infected with viruses and colds on being “exposed to others’ leakages and exhalations”.

The Body surely contains something for everyone. There are the bizarre facts (Bryson notes the difference in bowel transit times between men and women), the ‘pub quiz’

facts (the record for staying awake is 11 days, 24 minutes), the history lessons (pioneers of medicine along with the ‘firsts’), refresher courses on immunology, microbiology, nutrition (you name it, it’s mentioned) and of course the references (over 40 pages of them).

I anticipate that experts will note factual inaccuracies, unsurprisingly given the volume and detail within the book. Remarkably, however, Bryson provides considerable facts and figures, in a very entertaining format, for a non-medical audience.

The Body provides a comprehensive account of something that I know reasonably well and yet managed to keep me turning the pages — and smiling while I did (contracting the orbicularis oculi muscle in each eye to make them sparkle, as Bryson tells us).



FILM CHOICE

Dark Waters

Directed by Todd Haynes, UK 2020. Starring Mark Ruffalo, Anne Hathaway

A SHOCKING true story of corporate greed wrecking untold environmental damage is at the heart of this legal thriller. Ruffalo stars as real-life corporate defence attorney Rob Bilott, who went from advising businesses on how to pollute legally to suing one of the world’s largest chemical companies, DuPont, for dumping toxic sludge into a small town river.

Ruffalo puts in one of his best performances yet as the determined lawyer who responds to a plea for help from a West Virginia farmer whose cows have been dying in mysterious circumstances. At great personal cost, Bilott doggedly investigates DuPont and uncovers a corporate cover-up that is breathtaking in its disregard for the environment and the health of the town’s people and animals.

This is a story that deserves to be widely told and, while it is often intense and infuriating, director Todd Haynes never lets the story drag.

VIGNETTE

Margaret Fairlie (1891-1963)

First female professorial chair in Scotland

DUNDEE prides itself as a city of discovery and in recent years has worked hard to honour those of its citizens who have contributed to that name. Today in Slessor Gardens, behind the imposing Caird Hall, you will find a walkway paved with bronze plaques. Amongst these is one to Margaret Fairlie. As well as a short biography, the plaque depicts less obvious clues about her life and career — a frame of sea holly and wheat, a glimpse of the Eiffel Tower and a stylised atomic structure of radium.

Margaret Fairlie was born in Angus and grew up on a farm near Arbroath —hence the plants framing her plaque. She studied medicine at the University of St Andrews and University College, Dundee, graduating during the First World War. After holding various clinical posts in Dundee, Perth and Edinburgh, she worked at St Mary's Hospital in Manchester, where she received much of her specialist training. She returned to Dundee in 1919, where she would spend most of her remaining career. There, she ran a consultant practice for gynaecology, and the following year started teaching at the Dundee Medical School.

In the mid-1920s, she joined the staff of Dundee Royal Infirmary and in 1936 was promoted to Head of Department of Obstetrics and Gynaecology. Her appointment, however, was not met with universal approval, and one male colleague was disgruntled that the post had been awarded to a woman.

Although a gifted and diligent teacher, she also pursued an active clinical career. In addition to her core work at the infirmary in Dundee, Fairlie was visiting gynaecologist to all the hospitals in Angus and in the north of Fife. Like all in her specialty, she

dealt with patients across a wide age spectrum and enjoyed all aspects of it. As an obstetrician, she helped set up Dundee's first antenatal clinic. One matron asked her: "Do you think if all the babies you delivered were laid top to tail they would reach from Dundee to Perth [some 22 miles]?"

"Yes — and heading for Scone [another 2.5 miles]!" was Fairlie's quick reply.

As for her interest in the novel treatment of gynaecological malignancy, this was sparked by her visit in 1926 to the Marie Curie Foundation in Paris where she learned about the clinical applications of radium — hence the Eiffel Tower and atomic structures on her bronze plaque in Dundee. On her return, she pioneered its use in Scotland and conducted careful long-term follow up of her patients. Thirty

At the time of her retirement in 1956, she remained the only female Scottish university professor

years later she would remark: "One aspect of my work which has given me especial satisfaction and delight has been my continuity with the patients who attend the radium follow-up clinic... some of whom have been coming for twenty years... The atmosphere at this clinic is one of trust, gratitude and mutual affection."

Her students, her colleagues and her patients found much to praise, but perhaps her main claim to fame was to become Scotland's first female professor. This, however, was not straightforward. In 1936 her appointment as head of department



should have almost automatically made her eligible for the chair in obstetrics and gynaecology. However, it took the University authorities four years to come to terms with appointing a woman. Perhaps she was a victim of the political difficulties ongoing between Dundee and St Andrews Universities at the time, but it is also thought that the then Principal of St Andrews was particularly averse to the idea of a woman professor.

She was finally appointed to her chair in 1940, with the strong backing of the Directors of Dundee Royal Infirmary. At the time of her retirement in 1956, she remained the only female Scottish university professor. It would be another two years before the University of Edinburgh would appoint its first woman to a chair and a further 22 years before Glasgow would follow suit.

In her retirement Margaret was a keen gardener and an enthusiastic traveller. It was while in Florence in the summer of 1963 that she took ill for the last time. She returned home

and was admitted to her former hospital where she died soon after. Today there is that bronze plaque on Dundee's Discovery Walk, which includes words from one of her patients: "She gave me the will to live." Surely no higher tribute could be paid to a practitioner of medicine."

Allan Gaw is a writer and educator from Scotland

SOURCES

- Baxter K. University of Dundee Archives.
- Richardson S. Glasgow Herald, 20 April 1956.
- Obituary. Glasgow Herald, 13 July 1963.



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