

# Medico-Legal Issues: a View from the Largest Acute Trust in England

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A meeting of the Society was held at the Royal Society of Medicine, 1 Wimpole Street, London W1, on Thursday, 12 March 2009. The President, Dr Robin Moffat, was in the Chair.

**The President:** A very warm welcome to all the guests here tonight. We have the past President of the Law Society here, so we had better watch out. He was Chairman of the Contentious Cases Committee, so be careful what you say tonight Stephen.

**Professor Smith:** Yes; I always am!

**The President:** Well, it is a very great privilege for me, a humble GP obstetrician, to invite Stephen Smith to talk to us tonight. He is the Principal of the Faculty of Medicine and Chief Executive of the Imperial College Healthcare Trust, the largest in the UK and an advisor to the MRC, the WHO and the Wellcome Trust. He has written 200 papers and in 2001 was awarded a Doctorate in Science. He is current Chair of London Genetics. He is a gynaecologist by training. He was Head of the Obs. and Gynae. at the University of Cambridge. He also held appointments at Addenbrooke's, the Edinburgh Royal Infirmary and at the Jessop in Sheffield. It is a very great pleasure for me to invite him to come up here now and address us on the **Medico-Legal Issues: a View from the Largest Acute Trust in England**. Have I got that right?

**Professor Smith:** Yes, that is correct.

**The President:** Is that what you are going to do?

**Professor Smith:** Yes, I am.

**The President:** Well then come and do it. (Applause.)

**Professor Smith:** Well, thank you very much and it is a great pleasure to be here. I always like it when they say you have written 220 papers: actually my post docs wrote quite a lot of those, not to mention all the other PhD students, and so on.

So what I thought I would do is introduce you to the largest acute Trust in the United Kingdom, explain why it is slightly different, but also to begin, as you say, with the fact that one day previously I was actually a practising gynaecologist. Therefore I can't remember a single moment in my professional life when at some stage Bertie, or one of his other mates, has not been crucially important to my continuing medical practice, not that as a gynaecologist, I think (looking at Lesley over there), I was any more litigious or incompetent than anybody else. But I can't actually remember a single working day when there wasn't some legal case being pursued against me or against the department or against the clinical facility.

I was for about 20 years a Professor in Cambridge, but for the last six of those I was also the Clinical Director of Obstetric Services, and, needless to say, our association with the legal profession was daily and quite close and, on one side anyway, was quite pleasant. With this new responsibility clearly medico-legal issues were on a slightly different scale and I thought it might be helpful if I introduced to you the structures which we have, because this is a unique organisational structure within the NHS. Then I will move on to the issues particularly relating to the legal system, because, as you will see, the size and nature of it requires us to function at a different level from a primary care Trust or a department.

We were established on 1 October 2007, but we actually only got (word of) our official designation on Friday (6 March 2009), and five organisations have now been given the sort of healthcare badge of being able to call themselves an Academic Health Science Centre. Imperial led this. We came up with the idea, we persuaded everybody it was a great idea and eventually five organisations have been allowed to have that designation. Imperial is the first Academic Health Science Centre. The other organisations are King's and UC here in London – there are three in London – Cambridge and Manchester, and you will notice that there is one university – and having been a Cambridge man for 20 years you can imagine how much pleasure this gives – which isn't there. Oxford is not part of that, and that is not of course because Oxford does not have outstanding research, it is because the organisation relationships between the university and the Trust are deemed by the international panel (not by me and hundreds of other people who know the real story) as not able to organise themselves in a way which provides for the interlinking between universities and the healthcare system. Now, you know better than I do that when it comes to issues around, for example, litigation, about governance, this is incredibly important.

So there are five centres – I doubt very much whether there will be very many more, because the purpose of these centres is to be globally competitive. At a time when the United Kingdom, with all honesty, has very few internationally global industries – we did have financial services (did?), we are quite good at aerospace, we are very good at media, we are very good at biomedicine and health, but it is beginning to get difficult after that to find where we can compete on the global stage. It was recognised quite rightly by Government that we needed to have one or two organisations which could genuinely compete with Harvard, Stanford, Yale and Hopkins. The system we eventually introduced is essentially based on Johns Hopkins, and we looked at the States, we looked at Holland, which has Academic Health Science Centres; we looked at France, Germany; we literally looked everywhere; but the one that best fitted, in our view, the United Kingdom was the Johns Hopkins system.

Now, there is an argument that when you have seen one Academic Health Science Centre you have seen one Academic Health Science Centre, and to some degree that is true. In the United Kingdom when we established the Health Service, we, I think probably unknowingly, set up a system which essentially put the hospitals at conflict with the universities. Unfortunately, after 1948, starting with a small letter in *Nature* in 1951 from Watson and Crick, there was a thing called the molecular revolution and, strangely, hospitals were rather ill-placed to pursue the molecular revolution. Fifty years later, when the whole of medicine has been transformed (not to mention the whole of life transformed) by the discovery of DNA, that relationship which had been rent asunder in 1948... There is a great story: the Vice-Chancellor of the University of Oxford was indeed Chairman of the local healthcare Trust, he was Chairman of the local hospitals in Oxford and in 1948, at the stroke of midnight, he was demitted from his post and the Oxford hospitals became part of the National Health Service. I think that is one of the best demonstrators of that divide which was artificially put in. Unfortunately, it has taken the United Kingdom 60 years to get back to understanding the relationships between universities and hospitals, and all of us who have worked in the system for 40/50/60 years would recognise that difficulty and the tensions between the two, which are almost wholly a consequence, we would argue, from the organisation structures which were put in place – not absolutely wholly, because there are other issues which are at stake.

So these centres have to be national centres for research, education and patient care, but they have a dual responsibility of serving the local population. In our case it is two to three million, roughly, in North West London, but it is important to reflect, particularly from the legal point of view, that we don't have a single PCT who gives us more than 10% of our business. So when the PCTs march into the room saying "You have to do..." this, that and the other, we go "Well, there is the other 90%", and something like 30 or 40% of our business comes from outside the patch of North West London, so there are all sorts of interesting contractual issues around that, and that is because if you are the largest (and we would argue, of course, the best) acute Trust in the United Kingdom, you will want to have patients coming to see you because of the complexity and because they choose to come because of the excellence of the service.

Now, the second point is crucial: how do you measure how safe a hospital is? That at the end of the day is what we are talking about. How we treat the patients is also important, but how safe is that hospital? For years Imperial College, through Brian Jarman particularly, who did the Bristol Inquiry, and the stats behind that, has been working on this concept of hospital standardised mortality rates. These are also now accepted by the Institute of Medicine in the US and the Commonwealth Fund and are genuinely recognised to be the benchmark across the world, and I am delighted to say that in the eighteen months since we have created this new entity we merged two NHS Trusts, we changed the organisational structure to put clinicians in the lead, clinicians in charge of the hospital – just imagine how scary that is – and we did it with the university actually taking a much more aggressive and integrated role with the Health Service. During that time, creating the biggest merger the National Health Service has ever seen, we improved our performance and our hospital standardised mortality rates went from 76 per 100,000 to 66 per 100,000. So there is something about the creation of this organisational structure which leads to, I would argue strongly, excellence in clinical care. But still remember, being best in Britain still puts you 20 to 30% behind the best in the rest of the world. So there is a difference between being very good and being the very best and that is what these organisations are about trying to create.

We are the largest Trust in England and also the largest acute Trust in the United Kingdom. I always get it – I must be very careful with Northern Ireland at the moment – I always get it from Northern Ireland individuals, who say they are the biggest Trust, but that is because they put Social Services in with the hospitals. In terms of acute Trusts we have a turnover of about £850–900 million, and when you put in the universities bit, which is about £220 million, it is a billion pound organisation comparable with the American equivalents at Hopkins, Harvard, Anderson, Sloan Kettery. In terms of league rankings, we are the third in Europe and eleventh internationally, but we are brought down actually by the life sciences at Imperial, which aren't as strong as they are at Cambridge, and therefore our medicine is extremely strong, and we have the highest research spend of any UK medical school. So when it comes to this international competitive business and when it comes to the product which we are offering our patients we believe we have a very strong position.

Now, I fully accept that as often as not for much of medical care patients couldn't give two monkeys about this stuff, but for the stuff that really matters, when you've had your heart attack, when you're needing catheterisation, when you've had your stroke, when you're needing the embolus removed from your middle cerebral artery, that's when it seriously matters whether you go to a decent place or a place which is second best, and those are life and death decisions and eventually they will be reflected in the medico-legal issues which are based around it.

The second thing we didn't want to do is to say it is all very well if everybody who walks into my hospital survives and everybody who walks into somebody else's hospital dies, or the population is so ill and the general practitioners are so poor – not that they are, they're absolutely fantastic, but if that was the consequence, if we sucked in all the money and if you could get into this sort of ivory tower of excellence, if you could, you know, battle your way in, sick and ill as you might be, that would be of no benefit if the overall population's health didn't improve. So a key feature of this entity and, to be honest with you, the only reason why the Government have allowed us to do this is that we have from the very, very beginning had a strong and close alliance with our Primary Care Trusts; indeed, our Primary Care Trusts are our strongest supporters. So when we go to Government to say "We want..." this, that and the other the first thing they do is ring up the PCTs and the GPs to say "You don't want this big, fancy thing, do you?" and, strangely, our great supporters in primary care say, "Yes, you're bloody right we do, because they provide the best outcomes for our patients and, furthermore, they're working with us to make sure when they don't need to be in the hospital they can get care close to home with outcomes which are commensurate with the best in the world." If you aspire to be the best in the world, in the end as long as you are spending reasonable sums of money (and we certainly do in the United Kingdom) you will get outcomes which are close to the best in the world, and we have got about 20 to 30% to go.

So we have a single research office; we have 80 or 90 people in there. We have a whole population base; as I say, it's about 2.7 million. We have AHSCs, Academic Health Science Centres; we work with charities, the Wellcome Trust, the British Heart Foundation, the Arthritis Research Campaign; we use the organisation who invented, if you like, anti-TNF alpha therapy for rheumatoid, for example; we work with our Trusts; we work with Chelsea, Westminster, the Brompton, the Marsden, and so on; but particularly, and more importantly, increasingly we work with the Primary Care Trusts. So we work as closely with Hillingdon and Brent as we would do with our local Trusts. So you have to, in our view, reduce – it is not unfair – you have to reduce destructive competition. So if you are wanting integrated care, which I think everybody accepts is the way forward, you have to have community, primary, secondary and tertiary care working together. You need to introduce some element of competition, because all of us, myself included even, get complacent if there is no competition; if I am not competing against one of my obstetric colleagues and if I am not better than somebody I lose the will to live; but if you make primary care compete with secondary care compete with tertiary care you get the worst of all possible worlds. Patients who should be treated are shifted through the system rapidly to the places that have the best results, with the best surgeons, the best nurses, the best managers. You get poor outcomes of course, and conversely you get tertiary centres doing stuff which frankly they don't need to do, you know. I am frequently asked "Imperial College..." – you know, Academic Health Science Centres – "...do you really need to do ordinary hernias?" Well, the answer, of course, medically is of course we shouldn't be doing ordinary hernias, but because the system firstly doesn't recognise the difference between community, primary, secondary and tertiary care and secondly, the tariff does not properly reflect that, we have to do that to maintain the business case, and that is where the system needs to continue to improve along the lines outlined in Ari Darzi's new Bill.

At the moment we do about 140 clinical trials. Now, clinical trials when I first started would be that I'd usually be at a conference, and, as Bertie knows, probably in the bar, and I'd meet with somebody from Roche or GSK and he'd say "You're the guy I've checked out who knows about menstrual dysfunction. We want to do a study on 90 patients. Have you got 90 patients?" "I've got bloody hundreds of patients." I'd then come to some sort of deal, we'll sort of recruit patients and there would be a sort of vague ethical committee approval. Now, you all know the world has changed out of all proportion to that. It now takes a minimum of 16 weeks to negotiate the contract. It then takes substantial management and investment of those, because, if you don't do it, you get sued. It has completely changed and we cannot and could not continue to behave in the amateur way we did. The other thing you do is you set up a charity and you become an advisor to the charity, and that money gets paid to the charity, therefore I am an advisor so I can get a salary out of the charity. That again is now not permitted. But, furthermore, you have to provide the appropriate facilities, the statistical support, the legal support, the legal advice, the management support, the management competency for doing these clinical trials. We currently have 140 trials on the books (85% of them sponsored by industry) so the College is sponsoring the other 15% and that means the College takes full and complete legal responsibility for those clinical trials, so if anything goes wrong the litigation falls back on the Trust. The trials are funded by industry, but industry will not continue to invest in the United Kingdom if the system is amateur. The biggest complaint about clinical trials in the United Kingdom from GSK, Pfizer, AstraZeneca and the rest is that the cost is too high, the quality is poor and the recruitment is derisory. The United Kingdom has the highest number of centres for international biomedical research who don't recruit a single patient to clinical trials. It is an absolute national scandal and a disgrace.

So you need to change the structure for the population, because diabetic patients, and obstetric patients, live at home not in hospital. They see their GPs, they go to their Primary Care Trusts, and that is where you need to recruit these patients. Patients, on the other hand, of course, love clinical trials. The acceptance rate of patients asked to go on a clinical trial is in excess of 80%, so if you take all of those patients who are asked "Would you like to be part of a clinical trial?" 80% say yes, and their satisfaction goes up, and therefore litigation declines. Satisfaction goes up for the obvious reason; they become a special patient; in effect, they get their own doctor, they get their own nurse, they get their telephone number, and a whole group of individuals are focusing on their needs and that has a direct effect on the litigation. We have lots of mechanisms to identify beds which are absolutely research beds, they're not NHS beds, and other bits which are NHS with the comment, "You can't put your research patient in there." "Why can't we? We have done it like this for hundreds of years." "Because it is not a system which is professional, it is completely impossible to manage, and you have to change, and, by the way, if you don't change, you'll be working in a different Trust." That's the bottom line. It's much, much harder than it used to be.

So how do we approach it? We have let the doctors – which is why I had the consultants on-side, by the way – take control again. Now, even though I am a doctor, that's a scary business. You know, you go through all of this and then suddenly get "Okay, you can control again", and then you think "Actually, was this a brilliant idea?" As a profession we're pretty individual, we're pretty hard-minded, so can we get them to work together? Well, we have created what are called "Clinical Programme Groups". They are led and organised by a doctor who was fully appraised; we had three days of appointments. We brought in an occupational psychologist, they did Myers-Briggs, and all the rest of it, and at the end of the first day the occupational psychologist we'd had in looked absolutely drained. I said "Would you like a cup of tea? You look absolutely drained; are you all right?" and she said no. She said, "I've had the most fantastic day." She had been occupationally assessing, I think it was, about 24 or 25 doctors, and I said "Well, you look dreadful" and she said "This has been the most fascinating day. I have never met a group of individuals who were so far outside of the normal parameters", and I said, "Well, they're doctors, of course they are", and she was astonished. Well, of course if you just think about it, if you are going to be the Chief Executive of GSK or BP or Shell, then you're a company man; you work for Shell, you want to make sure Shell is the best thing since sliced bread, and you know the way to get to the job is to say, "I'm going to do this for Shell. I think this is what we should do for Shell. I've been a Shell man all of my life." Can you imagine any doctor saying that? It's just completely different and she was reflecting on how that would work.

However, eighteen months later, I think it's been a great success. 80% of all healthcare expenditure is decided by doctors. So when drugs have to be prescribed – there are a few exceptions from the nursing point of view, an extremely important part of it – these are medical decisions. So if you have got financial difficulties, if you have got legal difficulties, if you have got patient perception difficulties, the only people who actually can change it are the clinicians, the doctors and nurses. It's not me sitting in my suit in an office telling them to be nicer to patients, it's doctors and nurses being nicer to patients and, as you well know, if they're nicer to patients they tend not to sue quite so much. I am sure there will be hundreds of studies in business schools all over the world on this, but I think that has been a very interesting change.

Our quality and safety is absolutely at the forefront. Imperial College invented Dr Foster. Brian Jarman is from Imperial College. We were the instigators of health statistics. We were the instigators of saying to consultants, "If you don't measure your performance, this is not the place for you to work. If you don't know how good you are, then you're not a proper doctor." Now, you can imagine there were one or two others who disagree. They're all now working somewhere else, because we absolutely will not compromise on the issue of quality and safety. Do we get it right the whole time? Of course we don't. Do we have disasters? Of course we do. But unless you're actually measuring as a doctor what you're doing I would strongly argue that that is not being a doctor. I have even stronger views about research and education and being a doctor, but I will come to that later.

So we have local accountability and responsibility. In other words, the Clinical Programme Directors have Chiefs of Service, and they have academic needs and educational needs. If you are the Chief of Service in surgery, say, or diabetes, or whatever, that clinician will be fully accountable for the finances, the legality, the professional activities through the Medical Director, the cleanliness of the ward. The fact that there are so many complaints; well those clinicians are now absolutely responsible, and that, we think, is quite a substantial change. Take note of the two words “accountability” and “responsibility”. It took us about six months, to actually get that right. There was one wonderful meeting, with I think the vascular surgeons; we had got all 25 of them present and we wanted to move them from here to there. This guy got up and said “Those bastard managers...” and he went on and on and on, and I got up and said, “I’m that bastard and I’m the Chief Executive and I’m a Professor of Medicine and don’t you ever talk to me again like that.” It’s the whole psychology of the change in that that is absolutely fascinating, and that was the sort of worst that we had. But it took them time to realise that if you are professional you are personally responsible and you are institutionally responsible for your actions. There are no managers you can blame, there is nobody else you can blame; as a professional our organisation makes it absolutely clear you are personally responsible for your actions (full stop), and I think that has quite an important effect on the issues we are here tonight to discuss.

So we have a new complaints early resolution process. We have a mechanism whereby they are dealt with rapidly. As you know, lots of the complaints are just that the Trusts never seem to take any action. We use patient feedback proactively, a very strong up-front programme. You know, in the past it was, “Oh, it’s only a couple of patients who complain.” That is completely the wrong attitude. If one patient complains you act on it, act on it hard and act on it fast, because if one is complaining there will be another 500 who aren’t complaining, and, yes, you have got to use little bit of judgment, but I would argue only a little bit. Although some complaints are vexatious, of course, and you have to identify those, most of the others reflect bits in the organisation where you think “Actually, that’s not so good”. So we try to have good internal surveillance and we try to limit surprises. So we want to know if something is going wrong as quickly as possible before we read it in the *Daily Mail* or it’s in the Sunday newspapers; I need to know; we need to know what is going on and what has gone wrong. So the whole idea is that if people make a mistake, don’t try and hide it, come and tell us so that we can do everything necessary, investigate, suspend if need be, take someone off work. How do we handle the people who are in difficulty? We do have a well trained workforce. The fact that our SHS and Rs are the best in the country shows that we have an absolutely dedicated workforce, but it has got to be clinically driven. There have to be clinically driven policies and procedures so that professionals can concentrate on the difficult bits, doing the neurosurgery, doing the cardiology; and at all times we take early legal advice on potential issues, so under no circumstances do we try to hide things under the carpet, and that goes all the way to the Board level.

So to the clinical input: we have lead clinicians for distinct aspects of governance, clinical experts for the serious untoward incidents. We have a programme which kicks into place straight away, and often when it happens and I am advised of a serious SUI the process has already gone into place. This is brought to the attention of the Boards; the SUIs are potentially discussed at every monthly Board meeting. We have clinical leads for the complaints investigation, and again the message from the top is "This is serious; this is important; you must take this seriously; do not brush the patients off" and so on. And again for the inquests, which are getting a little bit more serious, we have a lead clinician who reviews cases, with a trigger to a mechanism, and we then try to identify as quickly as possible future claims and the potential risk to the organisation, but always remembering that the thing that matters most is the patient. If we have done something wrong, if somebody has been harmed, then we must admit it quickly and make sure as best as possible it doesn't happen again. Our job as professionals is not to protect the organisation against those horrible people out there, the public, it is to try to get to the facts of the matter as quickly as possible, remembering at all times that our principal and only responsibility is to the patient.

So we receive complaints. It is common to get increasing complaints during a merger. I am delighted to say that we only had a 2% increase over that time. During that time almost all of our parameters of performance (and much of this is due to Anne), those dreaded ALE scores, which I of course thought was something to do with beer, they've got quicker by 10% since we brought the Trusts together. So there is something about the merger, there is something about aspiring to being better than we were, which has made, you know, simple statistics. Do we reply, do we respond quicker? Yes, we do. You know, one SUI from 25 per year becomes a claim, so we have all mechanisms of escalation. If we get one SUI, of course it is priced on distribution. If you suddenly get three or four, then that makes quite a difference and we have to respond to that, and we have decreased numbers of complaints and estimated costs over this time period, but our aims are to reduce claims with the same contributory factors, so where we see something which is happening time and time again, we are now actively trying to see ways in which we can reduce that activity.

Now claims, you know, in obstetrics and gynaecology, yes, of course it is the big one: you can see we have lots of claims, I am afraid, and you can see the cost to the Trust of those claims currently. The top three themes are the crucial points: treatment/diagnosis failed or delayed and accidents that may arise in personal injury. So it is, if you like, the bread and butter of an acute medical system, and our largest one, although Bertie might be able to change it, might be the £7.6 million birth injuries. We do, I think it is, 9,500 deliveries. The chances that we are not at any time going to be in some sort of litigious position in respect of obstetrics is non-existent. 9,500 deliveries is a enormous number and of course that comes with the dangers. We do have, you know, some of the best obstetric units in the country.

Communication, as the legal profession tell us, is absolutely crucial and is key to lessening litigation, so we do have to put in place mechanisms to help people to be more communicative with the patients. So we have a cautious (and that really means a sensible, honest) communication with family post event, so we try to get the families in, the relatives, to discuss with the clinicians as quickly as possible if something has gone wrong, and indeed one of the measures of that (and again it is usually management measurement) is that very few of the SUIs actually become complaints. So whereas an episode, a wrong operation or the removal of the wrong leg, or whatever, is an SUI, very few of those become complaints, and of course in a sense that is a measure of how well the – you don't want too many, but it is a measure of how well the organisation handles the business after some mechanism has gone wrong. We try to explain the process to both staff and patients and we establish points of contact. We have 11,000 employees, we have 850 consultants; the great issue from the patient's point of view is that you get faced with this massive blunt bureaucracy and you have got to have mechanisms whereby they can access telephone numbers at whatever time to be able to be absolutely clear that you are working with the patient to resolve whatever the problem was.

We inform staff at the start of the investigation. So, looking at the other side, how do we protect our staff, because as you well know these events are intensely traumatic to the individuals concerned? So they get told when there is the start of an investigation and documentation is potentially disclosable. We advise them from the very beginning how they might deal with it. Now, of course, most obstetricians have dealt with this on a daily basis, but if you are in those specialties which don't get sued a lot you don't know how to perform and behave, and, as you know, that can have quite a considerable effect on the outcome of the case.

We provide independent support for staff. We have a legal review of all documentation prior to its release. The legal briefings for staff are mock court sessions. We go into the whole bit of mentoring the individuals to be able to show as an organisation that we are not just hanging our staff out to dry or to hang, but we are there as a responsible employer to work with our professionals if they are in circumstances which have legal consequences, and we do all the stuff about debrief sessions and improvement plans.

At the end of the day, as you all know, if something goes wrong you have to own up to it, you have to understand why it went wrong, but every human response is to try and make sure it doesn't happen again. The second point is not to give false promises to politicians, you know, forever to stop Child P, or whatever it is (the last one). You know, who on earth seriously thinks that any system in the world can protect every child 100% of the time for every minute of every day? Who on earth would assume that that is a realistic proposition? We have got to be much more honest with the public and with the media and with our politician colleagues as to the reality of practical medicine.

So again we use the idea of learning opportunities. We fully appreciate that breach of duty and causation are immensely powerful learning tools. We have six-monthly reports to the CPGs for local review, so they get a list of all of it, and if something is blindingly obvious then, yes, of course we get them in, but they get that to review on a regular basis because of course there may be something they see and think, "Actually, if we change this, that might reduce that risk." And we have a Trust-wide review at the Governance Committee. The Governance Committee is chaired by Tom Legg, who is an esteemed legal mind I understand, and that Governance Committee is an extremely important Committee. In a new organisation, of course, where we have literally thrown everything into the air and redone them, the issues of governance are absolutely crucial – "Exactly whose responsibility is this at this particular time?" etc, etc. So we pay particular attention to governance.

We try to link contributory factors to risk assessment. When Richard Sykes was on the Board Richard used to go spare at the concept of risk assessment. You can't have risk assessment if you don't have opportunity assessment, so you have got to put the two together, and we try to get that in this. And, most importantly as an academic centre, we try to identify the research opportunities. So we are the National Health Service Safety and Quality Centre. We receive £6 million per annum to work on the issues of safety and quality, and that is why we were chosen by the WHO to be the lead centre for the checking off of patients that go to theatre. Now, unfortunately, we had a case where the wrong patient got the wrong operation, reported in the *Mail* on a daily basis. I think Claire and I were rung up usually about (what was it?) every hour at that time, Claire: "How could it be that the hospital which is the lead United Kingdom centre for the recognition of patients could operate on the wrong patient?" I said "Well, you have got a clue, because we did operate on the wrong patient" and maybe we needed it more than anybody else.

But it has been a fantastically interesting insight into the process. All of those assumptions which as an individual reflected my practice are not true for the rest of them. I didn't think there would be any discussion, I thought it was very simple. If you attack somebody with a knife or a laparoscope or you insert some unmentionable machine up somebody's unmentionable orifice I just simply assumed that, if you are the individual doing it, you are personally responsible for knowing whether that is the right patient, that is the right thing to be doing and that everything else is correct. Not at all. We had interesting discussions with our surgeons – "No, it's the anaesthetist's responsibility and if they're already asleep, maybe that's the anaesthetist". But then the anaesthetist "Well, yes, usually, but if I'm a bit pushed it might be ODA", and then ODA "Well, if I'm a bit pushed isn't it the Theatre Sister?" and then the Theatre Sister "Isn't it the ward who should have done it?" and, as you can imagine, what we unearthed is the learning opportunity; in other words, we unearthed a whole host of different practices. So in one theatre one consultant would take responsibility; in another theatre where they had been working together for 20 years the anaesthetist would take responsibility. Needless to say, when Claire and I oversaw this, petrification was a very close process. How could we, who are responsible for 850 consultants, responsible for tens of thousands of operations, how could we sign off to the Secretary of State and say "Yes, to the best of our ability we think this is safe" when actually what we had identified was a vast array of different performance and different behaviour?

So that WHO criteria, which some might argue is a little over burdensome, actually identified an unbelievably dangerous bit of medical practice. But once you address it, then you can begin to put things right. Will we not operate on the wrong patient again? Of course it will go wrong, of course something will happen. All we are trying to do, as in anything in medicine, is to reduce the probability. That it will happen is an absolute cert; it is an absolute cert something will go wrong. But have we got better mechanisms for trying to reduce that probability? Yes, and, hand on heart, as of March 1, Claire and I received an email from every single one of the clinical programme directors that, yes, they were signing off that all of their surgeons, all of their anaesthetists, all of their interventional physicians were compliant with the guidelines, and we check 10% of all of the activity at any time once a month to make that they are keeping to whatever they are supposed to do. That reduces, we hope, litigation. Do I actually think it will reduce litigation? I doubt it. Is it safer? Yes, definitely. So, as I say, those research opportunities are crucial.

So what I have tried to do is to describe the largest Trust in the United Kingdom, to show that it is different from before, but particularly, of course, in this environment, to focus on those medico-legal issues which, if we get it wrong, of course, have a massive impact on our patients and also on the National Health Service.

Thank you very much. (Applause.)

## **Discussion**

The President: Stephen says he will take questions now. Martin.

**Dr Mansell:** Martin Mansell, I am a Nephrologist at the Royal Free. About ten years ago at University College there was a Clinical Claims Review Group which had the basis to look at the claims as quickly as they came in from the outside solicitors and to try and take a view, “Yes, we made a mistake. We should bypass the lawyers (stop them from earning an honest living) and if it is money that is appropriate, then so be it.” Now, that was ten years ago. Does that model have any relevance to you, or is it really just too professional now to have a committee like that.

**Professor Smith:** Well, I would ask Anne to comment on that – because Anne is actually the one who deals with it.

**Ms Anne Mottram:** There is absolutely a place for having clinical leads in all of that and we have site specific leads, delegated down to clinical speciality leads. I think that we very much value the legal advice and support that we get from our advisors, who are Capsticks. We try to balance the advice legally and the clinical advice, too, and I am not sure we would have a separate group, we would prefer to see it almost as day-to-day work and to integrate it into normal decision-making processes.

**Professor Smith:** The other conflict, as you know, which arises is that often the Trust might say “Well, actually if we give them £10,000...” or whatever, “...it’s no problem”, and yet the professional concerned strongly feels that they didn’t do anything wrong and want to continue to pursue the case. So you do, get those sorts of difficulties.

**The President:** Dr Eddie Josse, chest physician, Police Surgeon.

**Dr Josse:** Eddie Josse, well described by our President. I was slightly worried by something that you said.

**Professor Smith:** Only one!!

**Dr Josse:** Slightly worried. You said that the individual doctor must take, and is taking, personal responsibility for mishaps, and so on.

**Professor Smith:** For their actions.

**Dr Josse:** For their actions, yes, okay, but you will know that healthcare professionals don’t work in a vacuum.

**Professor Smith:** Quite.

**Dr Josse:** A depends on B, who depends on C, who depends on D, who depends on A, and therefore you have institutional problems, and you identified one – operating on the wrong patient. Therefore, are you not being a bit harsh when you say the healthcare professional must take personal responsibility for his actions? I accept that there may be legal problems, but are you not ignoring your institutional problems?

**Professor Smith:** No. The managerial responsibility is to ensure that the mechanisms which are in place empower the individuals, to protect them and to make the right decisions. So you are absolutely right, there is a part of the mechanism which is part of the organisation, and that has to be as effective as possible. But, if I might take an example, if the patient's wristband is supposed to be checked it is perfectly reasonable for the organisation to say that every patient that goes into theatre has to have the wristband checked by the admitting nurse, the anaesthetist, whoever, and furthermore they have to have a box they tick which says "Yes, we checked..." this, that and the other. Now, that is, if you like, the managerial responsibility and we have to say six people have to tick each box. That is fine and that seems to me to be part of the managerial responsibility. If the individuals concerned do not do what the management advises them to do, if the management has provided them with sufficient training, sufficient reminders that, by the way, he shouldn't operate on the wrong patient and that is by checking the wristband, if those individuals don't do that, then that is their individual responsibility. The other danger, if you don't extend the importance of the individual, is that if you are the surgeon at the end of the day, whether one likes it or not, whether the patient is anaesthetised, whether there are 500 reasons, if you operate on somebody you are still personally responsible for what you do on that patient; the minute you cut the patient you are the person who is responsible, nobody else, not the organisation. The organisation can be criticised if we kept the person up all night or we did something which made it worse, but at the end of the day you, the surgeon doing the procedure, are responsible for that case and just because the anaesthetist is your mate and just because he put the patient to sleep before you had time to check, etc, etc, at the end of the day, that is the responsible of the individual. So I don't think it is an issue about being hard or soft, I think there are just some givens and you have to start with that given.

**The President:** The lady at the back.

**Ms Linda Lee:** Linda Lee. First of all I would like to say this on behalf of the legal profession – I am Deputy Vice-President of the Law Society – that we do compete globally and internationally for legal services. You might want to remember that –

**Professor Smith:** We'll rope you in.

**Ms Linda Lee:** My background is within claims for medical negligence and the thing that actually interested me is the amount of cash and that it's really an improvement in patient safety, and I wondered what work you had done to analyse what actually improved patient safety and whether that would be improvement across the board or whether certain departments do better than others.

**Professor Smith:** Yes. There are lots of things which the NHS Unit of Quality and Safety does, which was set up by Ari Darzi, who is now the Minister, so the first thing you can say is we got someone to be the Minister to herald safety and quality, which is part of the review. But you are absolutely right. The head of it is Charles Vincent and he is a psychologist. This is all about behaviour, practices, and the easy one is the operating theatre, so we have dummy theatres. We have all of the gizmos to have the theatres, and it goes wrong and who shouts at who or not, as the case may be, how the nurses interact with the doctors, how the junior doctors interact with the consultants. My one concern at that is that we're quite good at doing all of that. The second point is well, how many of our 850 consultants have actually been trained in it, and the answer is not very many. All the junior doctors will have gone through a process through the learning centres where they do all of that combined working, and so on. I am still not sure that we in the NHS do that enough to the others, and again, as you well know, the issues of safety and quality, particularly in the theatre, is based on the airline business from the famous two 747 crashes and you can do all of that role playing but I don't think we're hard enough actually. I have a private pilot's licence: I wasn't allowed to fly the plane unless I'd done twelve hours solo and seven landings, etc, etc. I think consultants should be exactly the same: you shouldn't do this type of anaesthetic if, once you are a fully qualified doctor, you haven't done something, which could be a simulation. If you talk to airline pilots they don't see simulation as a damned nuisance to be got through, they really think, you know, "Thank god I did it in a simulation and not in a real plane and landed in the Hudson", or whatever. So we do all of that stuff, but I don't think we do enough and I don't think we do enough across the patch once we have actually come up with the idea, and it is actually one of the reasons we set up an Academic Health Science Centre. British academics are absolutely brilliant, we are second only to the United States. The fact that we don't apply it to our own Health Service is *not* so brilliant. We're brilliant at sorting out the healthcare system in Botswana but bloody useless when it comes to Brent, and it is the same sort of argument: it's got to be a culture of safety and quality and, to be fair, the medical profession has been, I think, quite slow for us to pick up that this is a behavioural issue, the thing about working with the nurses, and so on. Who does eventually say (the classic one) "Who is in charge in theatre?" Now, 30 years ago we had a system that was very simple. There were two powerful people; it was either the surgeon who told everybody what to do or it was the theatre sister who told everybody what to do and you worked it out very quickly, you knew who was the boss, but one person was in charge. You go into any operating theatre anywhere in the United Kingdom and I challenge you to come out with that same feeling of who is in charge. It is difficult, but those are the sorts of challenges which I think we are facing. At the end of the day somebody has to be responsible, which comes back to my earlier point. Who it is I think we need to work on, but there is so much work (that) needs to be done in that area.

**The President:** You mentioned Shell, did you?

**Professor Smith:** I mentioned Shell just because it is a big multinational.

**The President:** Well, there is an ex-Shell man here.

**Professor Smith:** Oh, is there?

**The President:** Bill Gardiner.

**Professor Smith:** I also mentioned it because my brother was an ex-Shell man.

**Mr Bill Gardiner:** I am Bill Gardiner and I am a barrister and chemist and I am a non-executive Director of a very small NHS Trust, a tenth of the size, a Mental Health Trust, and I am a BP man, not Shell. The question I don't think will surprise you. I was struck by the power of the governance that you have been able to impose on the disciplines and the question is: is there critical mass; is there a scale factor in this? I will stop in a minute. My own Trust is so small that we lack managerial sovereignty and we do have the PCT on our back and the Strategic Health Authority on our back. The whole of your talk seemed to be about sovereignty and governance and I just wonder if you could tell us if it can be done for £300 million a year or it has to be a billion a year?

**Professor Smith:** Well, there are two issues of course. There is a difference between Foundation Trusts and NHS Trusts and obviously legally they have different positions. As you know, the Foundation Trusts have a little bit more flexibility and freedom, although David Nicholson has made it very clear that, if push comes to shove, they're still his Foundation Trusts, not Bill Moyes' Foundation Trusts. I think there is an issue over size. You know, we work very closely with the SHA, but we don't always agree. On the other hand, if we disagree, they have got a big headache. If they agree with us, then it is much better and things move more smoothly. We try not to disagree with the SHA and we do have lots of discussions with them and at the end of the day, you are right, I am actually answerable to the Chief Executive of the Strategic Health Authority. She occasionally reminds me of that, but not too often. I think size does make a difference. The other issue with size – and I take another analogy: drugs which are outside of NICE. I rather inadvisably at one moment said “We'll prescribe anything outside of NICE if we think it's the right thing to do”. Needless to say, it was on the front page of the *Telegraph* and now I am locked into prescribing everything, which Claire has to pay for unfunded by the PCTs, but either way that was quite a good exemplar: because of the size of the organisation I could – I had to have Board approval of course, but I could make a decision which went outside of the ordinary bounds, and firstly it was very popular amongst patients, but size allowed us to make decisions which were over and above what you would normally expect. So I think size probably does make a difference.

**Mr Garfield:** John Garfield, neurosurgeon, retired, old Mary's – you may remember it.

**Professor Smith:** I do; I'm still there.

**Mr Garfield:** European Working Time Directive. I am delighted that the President of the College of Surgeons has got front page billing today, as I imagine you have seen.

**Professor Smith:** Has he today? Yes, indeed.

**Mr Garfield:** If I understand it correctly, this doesn't just apply to junior staff but it applies to consultants. There is no way I could have kept a grip on my practice at the Wessex Neurological Centre if I was made to work under those conditions. Now, are we getting unnecessarily fussed about it or are you worried?

**Professor Smith:** Well, I mean, my institutional response is that I am legally obliged as the Chief Executive of the largest Trust to abide by the law and the law says that we have the European Working Time Directive. So my official response is very straightforward: the law is the law and I have to abide by it. Do we think that there are problems in that regard? Probably, yes. Do we think that the whole of Europe will impose it on the same date and with the same rigor that we do? Probably not. Does it make a difference to professionals? I think that is where the colleges need to make their play. If it is the case that something is dangerous to patients and reduces safety and quality, then first you have to prove it, and secondly, I think that is the role that the colleges would do. Formally speaking, I absolutely am not in a position to do that unless there is something which says that this is dangerous to patients, and for that I would need the colleges to stand up. Now, the College of Surgeons, as you rightly say, is pushing that case. What I believe personally I am more than happy to discuss around the dinner table.

**The President:** I wonder if I could ask you a question myself?

**Professor Smith:** Of course.

**The President:** When I first put my plate up many years ago it was quite usual to put “Physician, Surgeon and Accoucheur”, so I did 29 years in domiciliary obstetrics.

**Professor Smith:** Dangerous.

**The President:** Is it dead now?

**Professor Smith:** No, no, it is 2% – Lesley, you know the figures better than 1–2% of all deliveries are done at home. There is a drive to do more domiciliaries, but it is 2%, which is not an unreasonable number. It is nowhere near the Dutch, of course, but it is 2%.

**The President:** What about the morbidity and the mortality?

**Professor Smith:** Basically there are two things. Firstly, it is 2%, and secondly, that most of the big centres, ourselves included, provide low risk obstetrics, midwifery led facilities, right next to the sort of high tech stuff, so patients will come in both at the Mary’s site and at our Queen Charlotte site in Hammersmith who would never or may never need to see a doctor, they see a midwife the whole time and they have the pools and all sorts of mechanism, natural childbirth and all the rest of it. The crucial point is, of course, as Lesley says, if something goes wrong they can go next door. So the idea there is to try and provide an environment which is similar to home. I personally wouldn’t have ever had a baby at home because clearing up all the mess afterwards would have been quite beyond me. But that is another development. So almost all of the big units now provide two types of facility and you opt and you risk assess beforehand, and so on. As Bertie well knows, you still end up with obstetric catastrophes, but that is the nature of the game, I am afraid.

**The President:** Once in a while we get a really outstanding presentation to the Society, and this was one. We do thank you very much indeed Stephen. I would like to add a personal note: when you went on national television two or three weeks ago over the Ivan Cameron death, which was a very sad event, I thought it was masterly handled by yourself and I only wish that other hospitals would adopt the same attitude. So often they produce a junior bureaucrat who doesn’t really understand the issues. Is that fair comment?

**Professor Smith:** I think David Cameron and the family handled it exceptionally well.

**The President:** Yes. So did you. We are going to make you an honorary member because you have made such a deep impression tonight.

**Professor Smith:** Thank you.

**The President:** Not only that but we want to give you a little token of our appreciation.

**Professor Smith:** Thank you very much. (Applause.)