Witness Statement Ref. No. 306/ 1

NAME OF CHILD: RAYCHEL FERGUSON (LUCY CRAWFORD)

Name: Ian Carson

Title: Dr.

Present position and institution:

Retired
Non-Executive Chairman, Regulation and Quality Improvement Authority (RQIA)

Previous position and institution: Medical Director, Royal Belfast Group of Hospitals

[As at the time of the child's death]

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 2000 – October 2012]

Special Adviser to DHSSPS on Clinical Governance (part-time secondment from Oct 1999 to July 2002). Nothing outside my role as Deputy CMO up to my retirement in April 2006, and my appointment as Chairman, RQIA (June 2006 to present date).

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

No previous statements in relation to these children apart from Witness Statement 077/ 1

OFFICIAL USE:
List of previous statements, depositions and reports:

Ref:	Date:	

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached

I. QUESTIONS IN RELATION TO YOUR QUALIFICATIONS, EXPERIENCE AND CAREER BACKGROUND

(1) Please address the following questions with regard to your qualifications, experience and occupation/post as of April 2000:

(a) State your medical and professional qualifications, and the date on which they were obtained.

MB, BCh, BAO (1968); FFA RCSI (1972); MD Hons (1974)

(b) State the date of your appointment to the role of Medical Director and provide a description of all of the professional posts held by you before and since that date, giving the dates of your employment in each case.

Medical Director (Royal Group of Hospitals & Dental Hospital HSS Trust): April 1993 – July 2002
Pre-registration House Officer (RVH): Aug 1968 – July 1969
NI Postgraduate Training Scheme (Anaesthetic rotation): Aug 1969 – July 1974
Assistant Professor, Stanford University Medical Centre, USA: Aug 1974 – Sept 1975
Consultant Anaesthetist, Cardiac Surgical Unit (RVH): Oct 1975 – July 2002
Deputy Chief Medical Officer, DHSSPS: August 2002 – April 2006
Non-Executive Chairman, Regulation & Quality Improvement Authority (RQIA): June 2006 – to date.

(c) Describe the duties which you were required to undertake in the role of Medical Director and please arrange to provide the Inquiry with a copy of your job description for that time.

I do not have a copy of the Medical Director Job Description on my appointment in 1993. However, I do have an unsigned copy of a letter from the Chairman (Sir George Quigley) dated 22 January 1993 on my appointment; and an extract from a document signed by Sir George on 29 July 1992 which I think he circulated to Medical Staff Committees, in which he describes in general terms the 'Post of Medical Director'. I think that the appointment was initially for "3 years renewable".
The HPSS Management Executive did not issue *'Professional Responsibilities'* for Executive Medical Directors until 4 Oct 1995 as a Supplement No.2 to METL 2/ 94.
By 1996 the post was beginning to develop and I worked with the Director of Human Resources to modify the job description and make it reflect more accurately the nature of the post. I have made available to the Belfast Trust a copy of the Medical Director job description dated 7 March 1997 that outlines in detail the breadth of responsibilities.

(d) Please explain what responsibility, if any, you had for clinical governance (or for ensuring compliance with clinical governance standards) at the Royal Belfast Hospital for Sick Children, and if applicable, outline how you exercised this responsibility?

Arrangements for clinical governance in the RBHSC were the same as arrangements elsewhere across the Trust.
I took responsibility for the development and introduction of Clinical Governance in the Royal Group of Hospitals and Dental Hospital Trust. This drew heavily on developments that were taking place in the NHS in England *("A First Class Service: Quality in the new NHS"*) and on my experience and contacts with Trust Medical Directors working in the NHS. There was no statutory framework or guidance in place in Northern Ireland at that time.
I introduced *"Clinical Governance:* a framework for continuous improvement in quality of clinical services and the maintenance of high standards of care within the Royal Hospitals Trust" in April 1999.

(e) In any case where a patient had died at the Royal Belfast Hospital for Sick Children, and where that death was unexpected and unexplained, what were your particular responsibilities, and where did those responsibilities derive from?

The responsibility for individual patients would reside with the doctor under whose care that patient was being treated. In a hospital, this responsibility would usually be that of a consultant under whom the patient was admitted (or referred to by a general practitioner). This professional responsibility is clearly defined for all doctors in the GMC's document *'Good Medical Practice'.* For hospital consultants it is also explicit in their contract of employment.

Should a patient die, and where that death was unexpected or unexplained, the initial responsibility would be with the consultant to consider the issues relating to, or contributing to that death. This would have been a convention that was a common professional practice for many years. It would involve the consultant convening an early meeting with nursing colleagues, any junior medical staff involved. An early/ immediate decision of the consultant would be whether in his judgement the death needed to be discussed with/ referred to HM Coroner's office. In the Royal Hospitals, if HM Coroner was notified, this would have been brought to the attention of Dr George Murnaghan (and latterly Mr Peter Walby), either by the consultant or a senior member of the medical team involved, or by HM Coroner.

If the consultant considered that any adverse event had contributed to the death of the patient, it would be expected that the matter would be brought to the attention of the Clinical Director.

At that time, deaths whether expected or unexpected or unexplained, were not formally brought to the attention of the Medical Director unless there was serious concern that patients' lives were at risk, or there was a complaint in regard to the doctor/ doctors involved that would be likely to result in disciplinary procedures being considered.

(2) Have you ever received any form of advice, training or education in order to inform you of the appropriate approach to fluid management in paediatric cases and if so please state,

(a) Who provided this advice, training or education to you?

(b) When was it provided?

(c) What form did it take?

(d) Generally, what information were you given or what issues were covered?

I would have received education in fluid management of children as part of my postgraduate anaesthetic training in the 1970s. I am unable to recall the detail.

(3) Have you ever received any form of advice, training or education in order to inform you of the issues relating to hyponatraemia in paediatric cases and if so please state,

(a) Who provided this advice, training or education to you?

(b) When was it provided?

(c) What form did it take?

(d) Generally, what information were you given or what issues were covered?

I do not recall receiving any specific advice, training or education in relation to hyponatraemia in paediatric cases. I was aware of the guidelines issued by the DHSSPS in August 2002. I retired from clinical practice in July 2002.

(4) Prior to April 2000, describe in detail your experience of dealing with children with hyponatraemia, including the

(a) Estimated total number of such cases, together with the dates and where they took place. Not known

(b) Nature of your involvement. Not known

(c) Outcome for the children. Not known

Prior to April 2000, in my practice as a consultant anaesthetist, I do not recall dealing with any children diagnosed with hyponatraemia.

(5) Since April 2000, describe in detail your experience of dealing with children with hyponatraemia, including the

(a) Estimated total number of such cases, together with the dates and where they took place. Not known

(b) Nature of your involvement. Not known

(c) Outcome for the children. Not known

Since April 2000 I do not recall dealing with any children diagnosed with hyponatraemia. I retired from clinical practice in July 2002.

II. CLINICAL GOVERNANCE AT THE TIME OF LUCY'S DEATH

(6) By April 2000, specify the steps that had been taken at the Royal Belfast Hospital for Sick Children to implement a clinical governance and/or risk management strategy?

The development and implementation of 'clinical governance' and risk management strategies were Trust wide. Arrangements in the RBHSC were no different from those conducted within other Clinical Directorates, and responsibility for local implementation lay with the management team in the Paediatric Directorate.
While some elements of governance and risk were in place, even before the Trust became a legal entity, it was recognised that arrangements required further development, organization and resources. In many aspects there was an absence of regionally approved guidance.

(7) If a clinical governance and/or risk management policy was in place at April 2000, describe the key components of the policy, and please make arrangements to ensure that the Inquiry is provided with a copy of the policy.

The development of policies and arrangements for clinical governance and risk management were incremental over the years.

- In 1995 with the appointment of the Trust's Health & Safety Manager, reporting initially to Dr G.Murnaghan. IR1 Incident reporting commenced shortly thereafter, and the Trust's first Health & Safety report covered 1995/ 96. IR1 reporting at that time, and the associated form, was designed to address compliance with Health & Safety guidelines and legislation. Clinical incident reporting did not commence until about April 2000.
- In November 1997, in keeping with the introduction of new GMC Performance Procedures, I introduced *"Medical Excellence* – Maintaining good medical practice: the conduct, health and performance of doctors working within the Royal Hospitals Trust".
- In 1998, following the retirement of Dr Murnaghan, there was an opportunity to introduce new arrangements with the appointment of two new part-time Associate Medical Directors (Dr C.Mulholland – Clinical Standards; and Dr P.Walby – Clinical Performance). Responsibility for risk management transferred to Dr A.Stevens, Director of Occupational Health & Safety (to whom the Health & Safety Manager now reported).
- In April 1999, I introduced *Clinical Governance*: a framework for continuous improvement in quality of clinical services and the maintenance of high standards of care within the Royal Hospitals Trust. The Trust's first Clinical Governance Report and action Plan were published in September 2000.
- In April 1999, the Trust's first Clinical Risk Manager was appointed, reporting to Dr Stevens, and clinical risk reporting commenced about April 2000.
- In March 2000, in keeping with the developing clinical governance agenda, the Trust introduced *Risk Management Strategy*, A Strategy for Effectively Managing Risk. I believe that there were policies for risk management in place prior to 2000.

Copies of these documents should be available from the Belfast Trust.

(8) By April 2000, what were the arrangements for critical incident reporting within the Royal Belfast Hospital for Sick Children? Please make arrangements to ensure that the Inquiry is provided with a copy of any relevant policy or procedure?

See 7 above.

(9) By April 2000, were medical and nursing staff in the Royal Belfast Hospital for Sick Children trained in relation to the reporting of critical incidents? If so, please describe the training that had been provided and the form that this training took.

Awareness sessions and training were delivered across the Trust, initially by the Health & Safety Manager, and subsequently by the Clinical Risk Manager. I am unable to describe the detail and form of this training.

(10) Was Lucy's death reported in accordance with the arrangements for critical incident reporting? If so, please address the following:

I do not have this information. This would be better referred to the Belfast Trust.

(a) Who reported her death for the purposes of those procedures?

(b) Who was the report made to?

(c) When was the report made?

(d) What information was reported?

(e) Was the report made orally, or in writing? If a report was made in writing, or if a record was made of the report, please arrange to provide copies of the documentation to the Inquiry.

(f) What steps were taken on foot of the report?

(g) If a report was not made in accordance with the extant procedures for critical incident reporting, please explain your understanding of why this omission occurred.

(11) By April 2000 what clinical governance or other processes were available within the Royal Belfast Hospital for Sick Children to facilitate investigation or review of a death, where that death was considered to have been unexpected, unexplained, or where there might have been concerns that it had arisen out of an adverse clinical incident.

See 7 above.

(12) Was Lucy's death investigated or reviewed under any of the processes set out in your answer above? If so, outline the nature of any investigation or review which took place and the conclusions that were reached. Please arrange to provide to the Inquiry copies

of any documentation arising out of any investigation or review which was conducted in relation to Lucy.

I am not aware of any other investigation, other than that conducted by HM Coroner.

(13) If no such investigation or review took place, please explain on the basis of your understanding, why this omission occurred.

My understanding is that the circumstances that contributed to Lucy's death occurred in Sperrin Lakeland Trust.

(14) From your perspective as Medical Director at that time, what steps would you have expected senior medical staff in the Royal Belfast Hospital for Sick Children to have carried out in order to investigate the circumstances and cause of Lucy's death?

i. To inform the referring clinical colleagues in Sperrin Lakeland Trust.
ii. To inform the office of HM Coroner.
iii. To inform the office of the Associate Medical Director (Clinical Performance) in the Royal Hospitals Trust.

(15) By April 2000, was there any guidance available for medical staff working in the Royal Belfast Hospital for Sick Children dealing with referral of cases to the Coroner, and the information to be provided to the Coroner? If there was, please arrange for the Inquiry to be provided with a copy.

I do not recall whether there was any formal policy issued by the Royal Hospitals Trust prior to April 2000, giving guidance to medical staff dealing with referral of cases to HM Coroner. Certainly there was instruction at annual induction of new staff on the reporting of deaths to the Coroner.
Undergraduate medical students had teaching on this subject as part of their course in Forensic Medicine. The booklet containing the *Medical Certificate of Cause of Death* has guidance on reporting deaths to the Coroner.
All doctors should be aware of the guidance in relation to the coroner contained in the GMC's *Good Medical Practice* May 2001.

(16) By April 2000 did the Royal have a transfer policy in place with regard to the transfer of patients to and from other hospitals? If so, explain what the policy was with regard to the transfer of a patient's case notes and charts, and please make arrangements to provide the Inquiry with a copy of this policy.

I suspect that there was a policy in place with regard to the transfer of patients to and from other hospitals, as the Royal Hospitals Trust was the regional centre for many specialist referral services. I do not recall the detail, and suggest that contact is made with the Belfast Trust.

III. STEPS TAKEN BY YOU FOLLOWING THE DEATH OF LUCY CRAWFORD

(17) Were you notified of the death of Lucy Crawford? If so, when were you notified, who notified you and for what purpose?

I am unable to recall any notification to myself as Trust Medical Director, at or around the time of Lucy Crawford's death in the Royal Belfast Hospital for Sick Children in April 2000. Please refer to my Witness Statement 077/ 1.

(18) If you were notified of the death of Lucy Crawford, what were you told about the cause of her death and/or the circumstances of her death? Again, indicate who gave you this information and the date you were provided with it.

I am unable to recall any notification to myself as Trust Medical Director, at or around the time of Lucy Crawford's death in the Royal Belfast Hospital for Sick Children in April 2000. Please refer to my Witness Statement 077/ 1.

(19) If applicable, starting from the time at which you were first informed about the death of Lucy, outline chronologically all of the steps that you took in the exercise of your responsibilities in order to address any matter associated with the treatment and death of Lucy. For the avoidance of doubt you should refer to all discussions, investigations or inquiries which you raised or undertook, all reports that you made, as well as any steps taken by you to obtain any relevant documentation.

I am unable to recall any notification to myself as Trust Medical Director, at or around the time of Lucy Crawford's death in the Royal Belfast Hospital for Sick Children in April 2000. Please refer to my Witness Statement 077/ 1.

(20) Please account for any steps taken by you (or insofar as you are aware, your colleagues) to contact the Sperrin Lakeland Trust to establish what had happened to Lucy, and to ascertain whether that Trust was investigating her death? If no such steps were taken, please explain why this omission occurred.

I am unable to recall any notification to myself as Trust Medical Director, at or around the time of Lucy Crawford's death in the Royal Belfast Hospital for Sick Children in April 2000. Please refer to my Witness Statement 077/ 1. I am not aware of what steps were taken by colleagues in the RBHSC in contact with Sperrin Lakeland Trust.

(21) Were you provided with a copy of the post mortem report produced by Dr. O'Hara?

Not that I can recall.

If so, please address the following matters:

(a) Was any consideration given by you (or insofar as you are aware, your colleagues) to contacting the pathologist (Dr. O'Hara) to obtain clarification from him in relation to his findings? (Ref: 013-017-061)

(b) Were any steps taken by you (or insofar as you are aware, your colleagues) to challenge the findings of post mortem report produced by Dr. O'Hara?

IV OTHER MATTERS

(22) Have you learned any lessons or changed any practice arising out of any involvement you had in the processes of investigation into the treatment and death of Lucy Crawford, or any other matter related to her death? If so, fully describe the lessons that have been learned or the changes in practice which have occurred.

Systems and processes underpinning the development of clinical governance and clinical risk management continued to develop in the Royal Hospitals Trust up to and beyond my departure as Trust Medical Director in July 2002, e.g. the introduction of Root Cause Analysis training in 2003, and drawing on the experience of developments in the NHS in England etc.
More significantly, in Northern Ireland, the DHSSPS issued the consultative document, *Best Practice, Best Care* in April 2001. This was followed by the introduction of legislation, the *Health and Personal Social Services (Quality, Improvement and Regulation) Order 2003* which established a statutory 'duty of quality' and a formal framework to underpin the introduction of 'health and social care governance'.
Many other regional initiatives have subsequently been introduced e.g. new systems to assist with the prevention, recognition and management of poor performance of doctors, including appraisal, new guidance on consent for post-mortem and consent for treatment, new guidance on records management, new guidance on adverse event reporting, new proposals for reform of the Coroners Service, and review of Death Certification (ongoing), etc.

(23) Provide any further points and comments that you wish to make, together with any documents, in relation to:

(a) The cause of Lucy's death; No further comments.

(b) The role performed by you, the Royal Belfast Hospital for Sick Children or any other body when reviewing or investigating issues relating to the cause of Lucy's death; No further comments.

(c) The procedures which were followed when reviewing or investigating issues relating to the cause of Lucy's death; No further comments.

(d) Lessons learned from Lucy's death and how that affected your practice;
Nothing further to the comments in 22 (above).

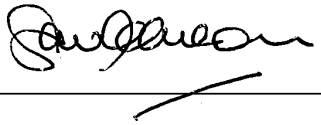
(e) Any other relevant matter.

The Inquiry into Hyponatraemia-related Deaths is rightly focusing in on the clinical and governance arrangements and systems that existed at the times of the children's deaths, on the learning from and sharing of information, within and between hospitals.
During the Inquiry to date, there has been considerable attention paid to the performance of individual doctors (and nurses) responsible for direct patient care. As far as it concerns doctors, this is a complex and difficult area – in the 1980s and 1990s the General Medical Council's performance procedures were extremely complex to interpret and apply, and the NHS disciplinary procedures were cumbersome and fraught with legal barriers. Thankfully most doctors deliver a high standard of care, and serious underperformance is uncommon.

For Trust Medical Directors, particularly for those involved in 'first wave' trusts, these problems posed major challenges. Many commentators considered the task to be an 'impossible challenge', and given the relationship between clinicians and health service managers, the culture faced by medical managers was a difficult one.

Prof. Sir Liam Donaldson, while regional general manager and director of public health in the Northern and Yorkshire Regional Health Authority recognised these problems and forecast difficulties ahead. His publication in the British Medical Journal (Vol 308) 1994; 1277-82 is relevant, informative, and has a bearing on events experienced by Trust Medical Directors working in the HPSS in Northern Ireland between 1993 and 2003.

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed:  **Dated:** 13/12/12

PERSONAL AND CONFIDENTIAL

Dr I W Carson
Clinical Director
ATICS Directorate
Royal Victoria Hospital
BELFAST BT12 6BA

22 January 1993

Dear

You will know that you have been appointed as Medical Director and Deputy Chief Executive of the Royal Hospitals Trust. May I offer you warmest congratulations and all good wishes.

This is a demanding and challenging assignment to which my colleagues and I have every confidence you will bring precisely the right qualities. The Group is at a critical stage in its history. New patterns of care are proposed for the Greater Belfast Area which would significantly affect the Group. We have to develop a considered response which shows an openness to change where change denotes improvement but also identifies those respects in which change would be detrimental - not just to the Group but to the interests of patients and to Northern Ireland's ability to provide adequately for its health needs into the long-term future.

It is clear that we have not yet managed to provide a secure financial base for our activities. There is no escape from doing so. Until then, we shall be dogged by recurrent crises. Not only will this render us unable to switch sufficient attention to enhancing our reputation as a centre of excellence but it will steadily erode the foundations on which that reputation is built. Difficult decisions have to be made right away to stop the slide into major deficit and recover lost ground and a better way forward for 1993/94 has to be found.

I look forward to your playing a very significant role in all these matters. We need to find means of aligning every single individual in the Group - and particularly, of course, the doctors as key players on the hospital stage - with well thought out corporate objectives for the whole Group and also to find means of seeking from each their own regulation of their own

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activities in ways which ensure that each unit and department makes its planned contribution to corporate objectives.

None of this is easy. I believe that it calls for excellent two-way internal communications so that people all over the place feel that they can cause things to happen and are responsible for what happens.

The Board of the Trust knows the difficulty of the task and will be anxious not only to have your input to its consideration of all these issues but also to give you all possible support as you play your part in tackling them.

I should welcome the opportunity for a chat with William McKee and yourself when that is convenient for you.

With all good wishes.

Yours sincerely

DR W G H QUIGLEY
Chairman

12. Post of Medical Director

It may be helpful if I venture to set down here the kind of profile I presently have in mind for the Medical Director. A person with exceptional leadership qualities. Capable of shaping a vision for the Group, which is not just that person's vision but reflects the climate of collegiate creativity which the Medical Director deliberately promotes and then has the ability to harness to productive ends. Sensitivity to the new environment in which the Group will be operating and the ability to articulate the vision in terms of all the factors that comprise that environment. Excellent interpersonal skills, which are exercised not merely within the Group but at all the many interfaces which the Group has with purchasers and the community (medical and otherwise). The Medical Director has to be a realist, capable of coming to terms with the fact that hospitals, like all organisations, live in an age of limits and constraints and that, having pushed out the limits as far as possible, the objective becomes the achievement of the best possible solution within those limits. The Medical Director has to be able at one and the same time to empathise with colleagues and to avoid the temptation simply to act as their representative and spokesman. As a full member of the Board of the Trust, the Medical Director must ensure that fellow-directors are seised of all the considerations which the Medical Director is uniquely equipped to present. The Medical Director must also, however, like them, share fully the responsibility to take into account other considerations and arrive at decisions which in all the circumstances are best for the Royal Group of Hospitals. The Medical Director may on occasion have to espouse decisions which are unpalatable for that Director (and, in all probability, for fellow directors as well). The person must therefore be someone who commands the total respect of medical colleagues, someone whom they are prepared to trust to have done the right thing for the Group even when it does not accord with their own views. This is one of the points at which the Medical Director's leadership qualities will be tested - in a willingness, once decisions are taken after full consultation and debate, to stand shoulder to shoulder with the Chairman and Chief Executive in mobilising the full energies of the Group to achieve successful implementation.

13. I hope that these indications are helpful: it is never easy to draw such a portrait and if colleagues feel that I have gone astray, I shall be only too happy to discuss any points with them. They reflect my strong feeling that the Trust's Medical Director has an indispensable contribution to make in shaping - in the new environment - a patient-centred institution, driven by the imperative of clinical

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excellence and supported by an organisational structure and systems (information, finance and the rest) which are so secure and apt for their purpose as to be virtually taken for granted.

14. Key role of Hospital Council

The Hospital Council - along with the Board of the Trust will be the forum where key issues are identified and decided or prepared for decision by the Board. I appreciate greatly the nature of my own relationship with the Council and its individual members since I became involved with the Group. My own impression is that excellent foundations have been laid in recent years and that the Council has developed steadily in cohesion and corporate effectiveness, thanks to the impressive work of the Unit General Manager, the Unit Clinician and their colleagues. Clearly, however, it will be necessary to keep the machinery under review in order to identify if there are changes which can beneficially be made.

15. This note reflects ambitious objectives. I appreciate that, in this year of transition to full Trust Status, there are inevitably uncertainties. But I would encourage the Council not to let the uncertainties deter it from pressing on with the change process. The more quickly we chart our course, the longer the period we have for adjustment to whatever change is necessary in the interests of the Group as a whole - and the less painful, therefore, that adjustment is likely to be.

16. I have addressed this note to the Members of the Hospital Council but I am content that you should disseminate it individually or collectively within the Group in any way you may wish to do.

George Quigley

W G H QUIGLEY
29 July 1992

Management Executive
Provider Development Directorate

Chief Executive of each HSS trust
Chief Executive/ General Manager of each Board
Unit General Managers
Trust Medical Executive Directors

4 October 1995

Dear Colleague

HSS TRUSTS - ROLE OF EXECUTIVE DIRECTORS WITH PROFESSIONAL QUALIFICATIONS

1. The Management Executive letter (METL 2/94) which issued on 18 May 1994 outlined the background to the composition of HSS trusts and gave guidance on the role of the social work executive director in particular. Supplement 1 to the letter, issued on 20 June 1994, concentrated on the role of the nurse executive director. The annex to this letter concentrates on the role of the medical executive director and thereby completes the guidance on the role of the professional executive directors.

2. The material contained in the annex to this letter, which has been drawn up in liaison with medical colleagues, should be associated with the earlier material. Through the issue of this guidance the Management Executive intends that the executive directors will thus provide the trust with the necessary professional advice and expertise which will be required to ensure the effective and efficient delivery of all its functions.

3. This letter is being copied to a wide range of interested bodies and any enquiries about its content should be addressed, in the first instance, to Joyce Cairns, Provider Development Directorate, Tel.01232 524244.

Yours sincerely,

JOHN MCGRATH

Health and Personal Social Services Northern Ireland
Dundonald House, Upper Newtownards Road, Belfast BT4 3SF. Tel: 520500 Fax: 524073

SUPPLEMENT No.2 TO METL 2/94

MEDICAL EXECUTIVE DIRECTOR - PROFESSIONAL RESPONSIBILITIES

1. The Health and Personal Social Services (Northern Ireland) Order 1991 and the more recent Health and Personal Social Services (Northern Ireland) Order 1994 enable HSS trusts to provide a wide range of health and personal social services either directly or by purchasing services from the private and voluntary sectors.

2. In considering the complex issues that are likely to be involved in exercising these duties, powers and responsibilities, a trust will wish to have access to the highest quality of professional advice that is available. This factor will be an important consideration for a trust in demonstrating its commitment to high quality services and will serve also to allay fears and concerns about the principles and practicalities of delegation.

3. The medical executive director will play a full role in the general management of the trust. This will include sharing in corporate responsibility for policy-making, decision-taking and the development of the trust's aims and objectives. In addition, however, the Management Executive expects such a director to have three specific areas of responsibility : professional standards and practices; oversight of clinical functions discharged by the trust; and, management or development issues relating to medical services generally.

4. Whilst the Management Executive does not intend to be prescriptive about the specific activities undertaken by the executive director in pursuance of their general or specific management responsibilities, it will expect the postholder's role to be set out in such a way that it covers the following clearly and unambiguously:

   a. responsibility for giving advice and assistance to the trust in determining its policies and strategies for medical services and for executing those strategies;

   b. advice to the trust on medical workforce policy including staffing levels, changes in working patterns and skill mix which will ensure the delivery of effective and efficient clinical services to the patient;

   c. responsibility for medical staffing issues including :

      - discussing and agreeing job plans with consultants
      - ensuring that junior doctors hours of work comply with their Terms and Conditions of Service
      - appointments procedures
      - disciplinary matters;

d. guidance in the selection of clinical directors, supporting them and leading them in managing particular services with budgetary, information and quality responsibilities;

e. advice and assistance to the trust in determining its expenditure on clinical services;

f. advice to the trust on professional medical issues;

g. ensuring that professional standards are maintained in the provision of medical services within the general guidance issued by the Department of Health and Social Services and within the terms of contracts with purchasers;

h. contributing to and ensuring that an appropriate system of clinical audit is in place for assessing and reviewing the quality of services provided;

i. the co-ordination and promotion of high standards at all stages of medical education including :

- undergraduate education in association with the Dean of the Faculty of Medicine;

- postgraduate education in association with the Postgraduate Dean; and

- continuing medical education and development where appropriate in association with other clinical professions;

j. encouragement of the development of evidence-based clinical practice and research;

k. the promotion of a multidisciplinary approach to clinical services;

l. the encouragement of the development and maintenance of relationships with the voluntary and private sectors in fostering constructive and collaborative working relationships;

m. providing leadership on medical standards, by ensuring that effective procedures are developed for dealing with clinical complaints and clinical risk management, and monitoring these procedures;

n. liaison with key doctors outside the trust, including GPs and other medical directors;

o. taking responsibility for some aspects of the public image of the trust, dealing with media and the local community particularly where clinical matters are to the fore.

Doctors with problems in an NHS workforce

Liam J Donaldson

Abstract

***Objectives*—To describe the incidence, nature, and implications of serious disciplinary problems among the medical staff of a large NHS hospital workforce.**

***Design*—Descriptive study with analysis of case records.**

***Setting*—Northern Health Region, an administrative area within the NHS covering a population of three million.**

***Subjects*—Forty nine hospital doctors: 46 consultants and three associate specialists.**

***Main outcome measures*—The nature of the problems encountered within the doctors' practice, and the types of action taken by the employing authority.**

***Results*—Over a five year period concerns serious enough to warrant the consideration of disciplinary action were raised about 6% of all senior medical staff (49/850). Ninety six types of problem were encountered, and were categorised as poor attitude and disruptive or irresponsible behaviour (32), lack of commitment to duties (21), poor skills and inadequate knowledge (19), dishonesty (11), sexual matters (seven), disorganised practice and poor communication with colleagues (five), and other problems (one). Twenty five of the 49 doctors retired or left the employer's service, whereas 21 remained in employment after counselling or under supervision.**

***Conclusions*—Existing procedures for hospital doctors within the NHS are inadequate to deal with serious problems. Dealing with such problems requires experience, objectivity, and a willingness to tolerate unpleasantness and criticism. Because most consultants' contracts are now held by NHS trust hospitals, however, those who had developed skill over the years in handling these complex issues are now no longer involved.**

Introduction

Concerns about the conduct or performance of doctors come to the public's attention in one of two main ways. Cases of alleged serious professional misconduct heard by the General Medical Council usually receive wide coverage in the media. Similarly, when a doctor comes before the courts, at an inquest, in a professional negligence action, or on criminal charges, the public is often given insights into wider issues surrounding standards of clinical practice.

Less prominence has been given in public to discussing doctors as employees of the NHS and how problems arising within their practice are dealt with. Formal procedures exist which allow an employer to deal with issues of professional competence and conduct among hospital medical staff. In the past, comparatively few cases have come to light in this way. Two explanations are often put forward for this—firstly, that there are in fact few serious problems and, secondly, that serious problems are much more common than is officially acknowledged but that employing authorities avoid facing up to them because of the complexity, time, money, and acrimony involved.

I report my experience of a consecutive series of cases over a five year period in which serious allegations were made about the conduct, competence, or performance of NHS hospital doctors within a large medical workforce.

Methods and background

STUDY POPULATION

The Northern region covered a population of about three million. Northern Regional Health Authority, which planned and provided health care for this population, was one of 14 similar authorities into which the NHS in England was divided geographically and administratively.

At the time of the study, regional health authorities held the contracts of employment of hospital consultants, associate specialists, senior registrars, and registrars working in hospitals within their jurisdiction. This role was consistent with a regional health authority's responsibility to plan the size and distribution of the medical workforce within its boundaries in response to clinical and training needs, as well as to changing patterns of care and new developments.

In the future the new statutory entities, NHS trust hospitals, created as part of the NHS and Community Care Act 1990[1] will be the employers of almost all the consultants and associate specialists formerly employed by the regional health authorities and will have the responsibility of dealing with allegations of the kind described here.

At the midpoint of the study there were 790 consultants, 60 associate specialists, 170 senior registrars, and 254 registrars employed by the region. None of the senior medical staff had yet transferred their contracts to NHS trust hospitals.

CASES ASSEMBLED

I have assembled all cases in which serious concerns had been expressed (or existed) about a hospital doctor employed within the period of June 1986 to June 1991. By serious I mean concerns about the doctor's conduct, competence, or performance sufficiently grave to warrant disciplinary or other formal action being considered as an option by the person raising the concern. In most instances, the person reporting the concerns (doctors, managers, or health authority chairpeople) brought the case to my attention with the approval of colleagues and with substantial supporting evidence. Action was never taken precipitately because of concerns expressed by only one person, who may have had antipathy towards the doctor concerned.

Serious cases entailed a single major incident (or occurrence), a longstanding problem, or a cumulative

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[illegible]

series of incidents. Other cases came to notice with some regularity, which after discussion were not considered to raise serious concerns. They are not described here and were dealt with by informal counselling regionally or locally. Nor are problems of ill health described here. These were dealt with within the region by treatment, care, or retirement if appropriate.

DATA EXTRACTED FOR ANALYSIS

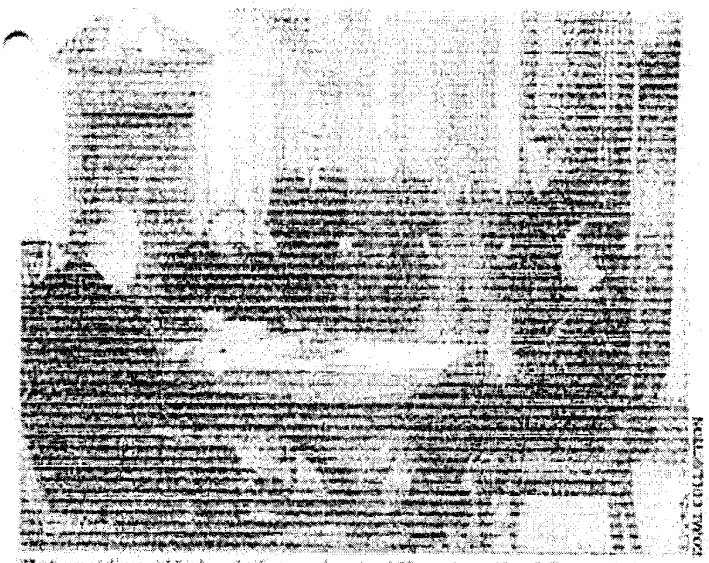
A confidential file on each of the cases was held by the regional medical officer. The following data were extracted for analysis: sex, age, grade, specialty, the details of the concern(s) or allegation(s) and when they first arose, whether there was a history and when it began, a synopsis of the problems and issues which were established after investigation, and the outcome of the case. Great care has been taken in extracting and presenting the data to ensure that individual doctors and patients cannot be identified. This has meant excluding or modifying certain aspects of the case descriptions but not so as to distort their fundamental substance.

FORMAL DISCIPLINARY AND OTHER RELEVANT PROCEDURES

The duties and powers of an NHS employer of hospital doctors in relation to disciplinary matters are set out in various circulars and procedural notes which are linked to terms and conditions of service for medical staff.[1] There is thus a formal contractually based framework through which an employer must approach a problem arising from a doctor who is an employee. Broadly, disciplinary problems or allegations must nationally be placed in one of three categories before they are dealt with.

The first category is personal misconduct, which encompasses behaviour unrelated to clinical skills. Examples of personal misconduct would be assault, sexual harassment of colleagues, fraud, or theft.

The second category is professional misconduct, which is behaviour which arises during the exercise of clinical skills. Examples would be breaches of confidentiality, sexual intimacy with a patient, rudeness and insulting behaviour towards patients, or disruptive or seriously uncooperative behaviour towards colleagues.



The figure of disconsolate Sir Lancelot Spratt in the series of "Doctor in the House" films may have been a figure of fun, but in reality such a figure can completely destroy the framework of a department

The third category is professional incompetence, which is inadequate or poor performance in exercising clinical skills or professional judgment. Examples of incompetence would be failure to examine patients properly, neglecting to carry out proper investigations before initiating treatments, persistently poor record keeping, or making technical errors in carrying out operations.

Personal misconduct is dealt with by the employer's internal disciplinary procedure, which also applies to other groups of staff; such cases may involve the police from an early stage and later the General Medical Council. Professional misconduct and incompetence are dealt with by procedures unique to medical staff. Again, some cases of this kind may involve the General Medical Council.

The most serious cases in the latter category are those in which the regional medical officer judges that the issues of professional conduct or competence, if proved, could result in the doctor's dismissal and on which he or she gives advice to the regional health authority chairperson accordingly. In such cases, the procedure is a modified form[2] of that described in a circular which was first issued in 1961.[3] It entails the presentation of evidence to a form of tribunal at which there is legal representation of the doctor and the employing authority. Until 1989 there was no formally defined method for dealing with less serious cases involving concern about a doctor's professional conduct or competence or for those in which a doctor was failing to fulfil contractual obligations. New procedures were introduced in 1990,[4] however, which entailed peer review-type mechanisms, one of the outcomes of which was advice to the employing authority about how to proceed.

Another procedure exists for doctors in whom the concerns about their professional conduct or competence seem to arise from ill health or related factors. This procedure is set out in a circular dealing with the prevention of harm to patients, often colloquially referred to as "the three wise men" procedure.[5] Cases of this kind are not included in this report.

Results

The cases of 49 career grade doctors came to my attention as possible serious breaches of conduct during the five year period. Forty three doctors were men and six were women; 46 were consultants and three were associate specialists.

At the time of referral six doctors were aged under 40 years, 18 were 40-49 years, 19 were 50-59 years, and six were 60 years and over. Table I shows the specialties in which they worked at the time the problems arose. The age and specialty of the consultants in the study was not significantly different (χ^2 test) in either case from what would have been expected given the distribution of age and specialty of all such doctors employed at the time.

Table II shows the types of problems. There were more problems than individual doctors because in most cases there was more than one reported incident or area of concern.

FORMAL ATTITUDE AND DISRUPTIVE OR UNCOOPERATIVE BEHAVIOUR

The commonest problems encountered concerned doctors' behaviour or attitudes towards patients or professional colleagues. This category was diverse and difficult to deal with. It included many examples of consultants who were aggressive or rude to both patients and staff. For example, one consultant regularly arrived late for clinical sessions and then was abrupt and unsympathetic to patients as well as rude, demanding, and condescending towards the nursing staff concerned. There were other cases in which one

TABLE I—*Specialties of senior hospital doctors about whom there were serious concerns*

Specialty	No of doctors (n=40)
Anaesthetics	7
General medicine	4
General surgery	4
Geriatrics	4
Obstetrics and gynaecology	5
Other medical (including paediatrics)	6
Other surgical	9
Psychiatry	11
Radiology	1

TABLE II—*Nature of problems among senior hospital doctors*

Problem	No of problems
Punctuality and disruptive or irresponsible behaviour	32
Lack of commitment to duties	31
Badly exercised clinical skills and inadequate medical knowledge	19
Dishonesty	13
Sexual overtures or dealings with patients or staff, or both	7
Disorganised practice and poor communication with colleagues	3
Other	1
Total	99

doctor's behaviour led to a complete breakdown of relationships within the clinical team, in one instance preventing discussion and planning of leave arrangements let alone clinical matters. As a result at certain times of the year the clinical workload could not be covered because no previous arrangements had been made with the hospital management or clinic staff to cover annual leave. In other situations, personal animosity was such that abusive comments were made to other doctors, managers, nursing staff, and even patients by one consultant about another. Other doctors in this category caused a great deal of disruption by repeatedly refusing to participate in any team development plans or persistently failing to comply with decisions or policies that had been democratically agreed.

There were also cases of grossly irresponsible behaviour. For example, in one instance a doctor had compromised hospital standards and possibly placed a patient in jeopardy by contaminating a clinical area in pursuance of a purely personal objective. The incident necessitated the service being closed for a time. In another case a surgeon was in the habit of leaving his patients during operations to demonstrate to staff the use of theatre instruments which were unrelated to the procedure in hand.

Many of these problems were long standing, and we were often surprised by the willingness of the doctor's professional colleagues to tolerate the difficulties that ensued for such long periods of time. In these cases the judgment about when behaviour becomes so unreasonable that it should form the basis for disciplinary action is a difficult one. Sadly, we did not encounter many serious problems of this kind which could be resolved by counselling or informal means. Behaviour that is persistently disruptive or apparently stems from immature attitudes and reactions proved almost always refractory to such interventions. Of this group, six out of 15 stayed in post after counselling, with varying degrees of monitoring or supervision being required. The remainder opted for early retirement or left the authority's employment.

LACK OF COMMITMENT TO DUTIES

The issues found in this category were varied, but three cases illustrate the kinds of problems encountered. One consultant's pattern of work meant that he started and finished work earlier than any of his colleagues, he exceeded his annual leave entitlement, he refused to respond to emergencies while on call at home, and saw far fewer patients than other consultants in the same specialty in the same hospital. Another consultant missed clinical sessions without notice or explanation or was persistently late for them, refused to handle extra work while colleagues were on leave, and systematically took the busiest on call days as annual leave or to attend professional meetings out of the area. A third consultant was never available in the hospital during one half day paid session a week and recorded above average amounts of time each week as devoted to administration. In 10 cases the lack of commitment to duties was explicitly linked to private medical practice. For example, one consultant carried out extensive private work during the normal working day, but NHS work was undertaken only at the beginning and end of the day, at times which were inconvenient for junior staff and disruptive to hospital ward routines. Another consultant continued to undertake private practice while on sick leave from the NHS.

Just under half (six of 14) of these doctors opted to take early retirement or left. The remainder stayed in post, and their work programme and commitment was kept under review.

POOR SKILLS AND INADEQUATE KNOWLEDGE

The third largest category of problems were those of poorly exercised clinical skills or inadequate medical knowledge. These included high levels of complications after surgery, displaying a lack of knowledge of the effects of drugs currently being prescribed therapeutically, and the incorrect use of clinical instruments. In one case the clinical practice and opinions of one consultant were so distrusted by junior medical staff (having been found on many occasions to be in error) that they were reluctant to approach him when a problem arose with which they needed help, preferring instead to seek help from any of the other senior medical staff.

Five of these 12 cases were resolved by the doctor concerned opting for early retirement. The remainder stayed in post after counselling, with close monitoring of, or restriction to, parts of their practice.

DISHONESTY

The cases of apparent dishonesty included a number of false claims for expenses and the non-declaration to the NHS hospital of private patients seen within the hospital. In other cases some of the doctors were less than honest in their work practices. One consultant had falsified work returns about the number of patients seen to conceal a clear shortfall in workload, while another had knowingly given incorrect data to a drug company during a drugs trial.

Three of the five doctors in this group took early retirement or resigned. Cases were referred to the General Medical Council or the police as necessary.

SEXUAL BEHAVIOUR

In a few cases the problems raised about the doctor's practice concerned sexual matters. In this group the history of incidents was long standing, ranging from two to 20 years.

The behaviour of one consultant had repeatedly distressed his female patients. He regularly took an inordinate amount of time to carry out internal examinations. Lengthy pelvic and breast examinations were carried out on patients with conditions such as varicose veins in which arguably such procedures would normally be omitted. The doctor concerned also questioned such patients in detail about their sexual histories and proclivities. On one occasion (observed by nursing staff) the doctor carried out a lengthy vaginal examination with his head under a blanket. He

justified this approach as dulling all perceptions except that of touch.

Another doctor regularly insisted on examining female patients with upper abdominal symptoms by palpation through their breast tissue. The manner in which the breast was massaged and manipulated caused distress to patients and to the nursing staff who observed the examinations. The same doctor was reported to use a great deal of sexual innuendo in history taking with female patients. As a result nursing staff never left him alone with female patients, and additional staff were deployed in outpatient clinics so that he was never without a chaperone.

In each of these cases there were also complaints about conduct in relation to female members of staff—for example, suggestive comments or a physical approach.

In all such cases the patients were convinced that the doctor's actions had sexual overtones, and the nursing staff also considered that the practice or behaviour was improper. In some cases of this kind complaints were made initially by the patients, relatives, or staff, but when this happened none would pursue them formally because when it was explained that they may have to appear before a hearing and possibly be asked questions, they were unwilling to take the matter further.

All but one of the doctors in this group took early retirement.

DISORGANISED PRACTICE

Some doctors ran their practices in a disorganised way. Their record keeping was extremely poor, and letters about patients referred for consultation were never sent or were too late to be of help to the general practitioners. All the doctors in this group remained in post after counselling.

OUTCOME OF THE CASES

Table III shows the outcome of all the cases described in the previous sections. Over half of the doctors (25/49) whose performance or conduct had been a cause for concern either retired or resigned, some presumably to work elsewhere. Most of the others continued in post after counselling and were kept under observation.

Discussion

My experience of dealing with the most serious problems of conduct and performance among hospital doctors in NHS employment in a health region provides, to the best of my knowledge, the first published report which has attempted to quantify such problems in a large medical workforce in Britain.

I must anticipate and accept the criticism that I have identified only a proportion of the cases which actually existed. I have made no mention of junior hospital doctors. We only occasionally became aware of problems in these grades. My strong impression was that such problems were not always properly dealt with locally or reported to the regional authority. The attitude taken was often that the problem was best resolved by the junior doctor concerned leaving at the end of the contract. As far as the consultants and associate specialists were concerned (who formed most of the cases reported here), however, my extensive contacts with senior doctors, health authority chairpeople, and health service managers in the region at that time meant that almost all the names of doctors that eventually arose formally were already known to me through this informal network as people who had been giving rise to concern over a period of time. Thus, I believe that the number of cases involving senior medical staff reported here, which represented 8% of the workforce, is a reasonable estimate of the size of the problem.

TABLE III—*Outcome of cases of disciplinary action against doctors*

Outcome	Non-GP doctors (n=49)
Retained as employee after counselling or under supervision	21
Retired	16
Left to work elsewhere	8
Other	4

CLASHING RACKS

Among managers I found general resentment arising from the perception that doctors are so heavily protected and that they seem to be privileged compared with other groups of staff. On many occasions I was told by those making the referral of their reluctance to report problems because they thought that nothing could or would be done or because of the tendency in such cases for early involvement of defence societies and their lawyers. Moreover, whereas doctors' colleagues were often willing to report concerns confidentially and informally they were extremely reluctant to go on the record. Some considered that this would amount to disloyalty; others feared giving evidence in a hearing or believed that defamation actions would be launched against them.

The most difficult and time consuming cases to resolve were those in which a doctor's attitude and behaviour were disruptive or highly unreasonable. So serious did this become in some of the cases I describe that clinical departments were almost brought to a standstill. The resulting poor communication, the absence of teamwork, the atmosphere of hostility, and the poor morale could not, in my view, have been other than detrimental to patient care.

During the course of handling these cases, on numerous occasions I have heard doctors' colleagues ask, "Why can you not just get rid of him?" A similarly pragmatic approach was often advocated by newly appointed non-executive directors of health authorities, who, seeing the problem for the first time, were incredulous that the delivery of a service could be allowed to be so severely damaged for so long by the behaviour of one or two individual people working within it. Judgments about poor attitude and unreasonable behaviour are difficult to convert into evidence which could sustain an action for professional misconduct or incompetence. In several cases the problems remained and were little improved by the process of investigation and counselling.

PROBLEMS OF DEFINITION

It might be thought that apparent failure to fulfil work commitments would be a more straightforward issue to resolve. On the contrary, in my experience establishing precise contractual responsibilities within the scope of terms of conditions of service for hospital doctors, even with the advent of job plans introduced as a component of the 1990 NHS reforms,[4] is extremely difficult in practice. It often proved impossible to overcome the counterarguments of the doctors' trade union or legal representatives that the actual commitment being made technically fell within the scope permitted by the minimum requirements laid down nationally. Yet the cases concerned were regarded as particularly serious and blatant by the doctors' peers. Without a more explicit form of contract for hospital doctors it will not be possible to deal with problems like this simply and effectively.

The cases that particularly concerned me was the small but worrying minority in which there were sexual communications to doctors' relationships with patients. The behaviour concerned never presented itself as

flexibility, less confrontation, and more openness, as well as striking an appropriate balance between professional self regulatory and employer based mechanisms for dealing with problem doctors. Moreover, more varied retirement and other exit options must be created to enable doctors with problems to depart with dignity when the circumstances are appropriate. Without all this patients and the quality of their care will suffer as they have done in the past because of a reluctance to face up to difficult issues.

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Treating childhood asthma in Singapore: when West meets East

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Though Western medicines and ideas about asthma have become popular in many Asian nations, local beliefs about treatment prevail. The multiracial society of Singapore shows a variety of beliefs about causes of asthma attacks (for example, the balance of yin and yang) and types of treatment—herbal remedies, inhaled versus eaten medicines, the influence of Ramadan. Many of the cultural practices mentioned are probably preserved among south east Asian minorities residing in the United Kingdom. Eastern treatments typically take a holistic approach to asthma and do not ignore the psychosomatic component of the disorder.

As in most Western countries, asthma is increasingly common in many Asian nations. Its prevalence during childhood (5-17 year olds) in Singapore is 12% among Chinese communities, 19% among Malays, and 15% among Indians (unpublished data). In recent years Western medicines and ideas about asthma have become popular, but despite this trend local beliefs about treatment prevail. Some of these sound implausible, but others hint at underappreciated differences in the pathogenesis of asthma between Asians and white people.

Singapore is a multiracial society, consisting mainly of Chinese (76%), Malays (15%), and Indians (6%). These main racial groups are culturally diverse, as are their beliefs in traditional medicine. The Chinese in Singapore originate from southern China and belong mainly to the Cantonese, Fukien, and Teochew dialect groups. These dialect groups share the same written language and have common traditional beliefs about illnesses and their cures. The Malays in Singapore are also a heterogeneous community, with main origins from Javan and Bawean provinces of Indonesia. Like the Chinese, they share distinct beliefs about diseases and their cures.

This article reviews some of the local beliefs about asthma reported by the parents of children attending the respiratory clinics of the National University Hospital of Singapore. Although this report is based on our experience with childhood asthma, these local beliefs apply to asthma as a disease entity and are not unique to childhood asthma.

Inter-racial differences in food induced symptoms of asthma suggest unexplored processes that cause changes in bronchial reactivity and the expression of atopy

Causes of asthma attacks

Central to understanding on how to treat asthma in our cosmopolitan community is to realise that eating is the most important national preoccupation. Beliefs about what foods should or should not be taken during illness are often held with great conviction and are considered just as important for recovery as the doctor's prescription. Although some families' concern with food becomes obsessional, it would be counterproductive to dismiss such ideas on the grounds that medical evidence is lacking or because they are difficult to explain.

Whereas many Western people with asthma identify pollens, grasses, and moulds as important precipitants of symptoms, aeroallergens are less frequently implicated in equatorial climates where exposure is often perennial. Although viral infections are often recognised as precipitants of wheezing, the most common answers to "what makes your child's asthma worse?" are cold fruits, cold drinks, ice cream, and chocolate from the fridge. It is difficult to understand the basis for this purported effect of all things cold on asthmatic