LETTERS

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GMC AND VULNERABLE DOCTORS

Doctors should be tried by a UK criminal court, not by the GMC

The General Medical Council's belated realisation that its processes may be too "blunt" is little comfort to those whose lives it has unjustly wrecked.[1]

Since being the subject of a complaint 15 years ago—of which no charges were proved—I have mentored and provided testimonials for around a dozen doctors referred for health and fitness to practise proceedings. Several themes recur.

Firstly, after referral doctors are presumed guilty until proved innocent. All employers must be told about the referral. Several doctors have had alternative jobs suspended or permanently terminated on hearing of a referral, irrespective of the final disposition. Many are suspended from practice even if the GMC does not suspend their registration.

Secondly, the tone and nature of correspondence to doctors is unhelpful and often hostile. This leads to a sense of paranoia and impending doom in even the most well balanced doctors.

Thirdly, the GMC seems to discipline a greater proportion of doctors than equivalent bodies in the US, Canada, and Europe. It also seems to be the most expensive regulator.

Fourthly, the GMC allows itself to be the conduit of internecine disputes between colleagues, or doctors and their employers, at whose conclusion the wronged party is rarely encouraged to redress the balance. This further ingrains disputes between different parties. For such disputes, if there is no direct patient risk or complaint, a mediated dispute resolution service would be preferable.

My observations lead me to conclude that it would be far better for doctors to be tried in a UK criminal court, with the inherent safeguards that have grown up over several centuries, than in the sketchily regulated courts convened by the GMC and its successor the Medical Practitioners Tribunal Service.

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1 Dyer C. GMC and vulnerable doctors: too blunt an instrument? *BMJ* 2013;347:f6230. (22 October.)

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INCIDENT REPORTING

A negative experience for most

Doctors may not report adverse events or speak up when they witness poor care because of fear of punitive action or lack of confidence that reporting will change anything.[1] Detrimental psychological effects associated with their patients experiencing adverse events may also deter reporting.[2] Negative previous experiences of incident reporting and investigations compound these effects.[3]

Berwick described a culture of fear in the NHS where "bad news becomes unwelcome and, over time, it is too often silenced."[4] An online survey of 1755 members and fellows of the Royal College of Physicians (mean age 47 years, 35% female) confirms this view (unpublished data).

Most who had used NHS incident reporting systems reported negative experiences. Only 21% noticed local improvements, 19% saw system change, and 14% had useful feedback; 25% had been involved in an incident that they should have reported but didn't. Reasons for not reporting included lack of confidence that anything would change, a view that it was an onerous process, and fear of punitive action.

Many reported psychological effects when their patients experienced adverse events. More than half had sleep disturbance or anxiety and in 63% it affected their professional confidence. A small but notable proportion (8% of our sample) had symptoms similar to those of post-traumatic stress disorder.

There are few formal mechanisms to support clinicians in these circumstances, and only 5.5% had a formal mentor. Most sought support from colleagues, friends, and family.

Other safety critical sectors (like aviation) recognise that frontline staff will speak up only if they feel supported and have confidence that they will be treated fairly, with reports used for learning rather than punishment. For the NHS, Berwick's recommendation to "abandon blame as a tool" would be a good first step in this direction.[3]

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1 O'Dowd A. NHS regulator plans to make it easier for doctors to raise concerns and break "mafia" code of silence. *BMJ* 2013;347:f6428. (23 October.)
2 Wu AW, Steckler R. Medical error, incident investigation and the second victim: doing better but feeling worse? *BMJ Qual Saf* 2012;21:267-70.
3 Sirriyeh R, Lawton RJ, Gardner P, Armitage G. Coping with medical error: a systematic review of papers to assess the effects of involvement in medical error on health care professionals' psychological well-being. *Qual Saf Health Care* 2010;19:e43.
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SCREENING FOR PRE-DEMENTIA

Dementia statistic is misleading

In their responses to Le Couteur and colleagues' article, Burns and colleagues state that fewer than half of people with dementia receive a formal diagnosis.[1] This commonly quoted claim is a misleading use of questionable prevalence data and needs to be challenged.

The statistic they refer to is an estimate that currently 46% of those with dementia in the UK have received a diagnosis.[2] It is based on extrapolation of 20 year old data by a Delphi consensus group that met in 2007,[3] and more recent research suggests that the prevalence of dementia is much lower than thought, so diagnosis rates are higher than this estimate.[4]

However, even if 46% is correct, it is misleading to state that fewer than half of people receive a diagnosis. Even if 54% of people with dementia in the UK are as yet undiagnosed, this does not mean that they will never receive a diagnosis, as Burns and colleagues imply. This misinterpretation of such an important statistic in the debate around the diagnosis of dementia is unhelpful and needs to be corrected.

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1 Burns A. Alistair Burns and 51 colleagues reply to David Le Couteur and colleagues. *BMJ* 2013;347:f6125. (15 October.)
2 Alzheimer's Society. Dramatic variation in dementia diagnosis across UK. 2013.
3 Knapp M, Prince M. Dementia UK. Full report into prevalence and cost of dementia. Alzheimer's Society, 2007.
4 Matthews FE, Matthews FE, Arthur A, Barnes LE, Bond J, Jagger C, Robinson L, et al. A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II. *Lancet* 2013; published online 17 Jul.

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Authors' reply

Brunet questions the validity of the dementia diagnosis rate, which is expressed as a simple percentage. The numerator is the annual return made as part of the primary care Quality and Outcomes Framework process and the denominator is the estimated number of people with the diagnosis (estimated prevalence). This figure is based on the best evidence of prevalence, which comes from the latest epidemiological information. The Cognitive Function and Ageing Study and European ALCOVE project (www.alcove-project.eu) have suggested that prevalence may be lower than previously thought. NHS England and the Department of Health are working with academic and clinical colleagues, together with the Alzheimer's Society and Alzheimer's Research UK, using the same Delphi technique as before, to establish a consensus on whether to amend this figure.

Regarding the stage at which the diagnosis is made, it may be cold comfort for people to know that a diagnosis will appear at some point during their illness. We should be moving towards timely diagnosis, when interventions and support for patients, families, and carers can improve quality of life for everyone. Whatever technical argument Brunet makes about when the diagnosis is made, to have fewer than half of people diagnosed at any one time (2012-13 figures out last week) is a cause for great concern.

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Competing interests: I am also professor of old age psychiatry at the University of Manchester, clinical director of Manchester Academic Health Science Centre (MAHSC), and editor of the *International Journal for Geriatric Psychiatry*; I have received payment towards travel expenses for the launch of Betrinac.

Full response with list of authors at: www.bmj.com/content/347/bmj.f5125/rr/670556.

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ADVANCE CARE PLANNING IN PRACTICE

Everybody's business

Mullick and colleagues provide an excellent overview of advance care planning, an area of practice that is rapidly growing in relevance and importance.[1] They focus on three main tools for advance care planning. However, advance care planning discussions can provide much more than documents recording a patient's preference, or other related legal documents.[2] Such discussions allow the development over time of a care plan that is mutually acceptable to patients, carers, and healthcare professionals. The process is dynamic and, however difficult, it is the responsibility of every healthcare professional who meets the patient.

Most people spend the last 12 months of life at home, and most end of life care in the UK occurs in generalist settings.[3] It therefore makes sense that GPs are key players in advance care planning. However, results of the recent King's Fund report into effective coordinated care for people with chronic and complex conditions suggest that many GPs fail to engage in the process even with financial incentives.[4] Huge challenges exist in current general practice that may explain this—conflicting demands and time pressures; lack of continuity, including the provision of out of hours services; and lack of adequate IT systems to allow effective communication of information.

Advance care planning should be part of routine care for the increasing numbers of patients who might benefit from it. The existing barriers in pressurised clinical practice must be dealt with. More research is needed to understand fully the experiences of patients with complex, chronic, life limiting conditions with respect to advance care planning and the challenges for healthcare providers and commissioners in delivering high quality, integrated care for these patients, so that we can move forward with solutions.

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END OF LIFE CARE

The buck stops here

Four months have elapsed since the report of the independent review of the Liverpool care pathway and the decision to phase out the pathway over six to 12 months.[1 2] I am probably not alone in hearing from across my region that the pathway is largely no longer being used, leaving a vacuum in end of life care for patients and professionals struggling with a loss of direction. With hindsight, announcing the pathway's planned demise before having appropriate replacement guidance in place may have been unwise—we are now seeing years of hard work in promoting good end of life care being undermined and dissipated.

However, this need not be the case if the medical profession were to engage seriously with these patients. The ultimate responsibility for the medical care of patients sits with their doctor. Sadly, I fear that some doctors who found the pathway a nuisance have used the findings as an excuse to disengage completely, while others who were more sympathetic have been put off by the difficult conversations rendered even more difficult by the furore over the pathway's misuse.

We still have a good tool, when used properly, and a mandate to continue using it for the time being. But even if the paperwork itself is not used, the principles underpinning the pathway remain sound. We know what good end of life care looks like and where we can access help to achieve that. But this care needs direction. Nursing colleagues in all settings should not be left floundering while waiting for whatever replacement guidance is on its way. Doctors must shoulder their responsibility for this area of patient care. The buck stops here.

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