Infected Blood Inquiry

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The end of clinical freedom

The development of medicine as a "team sport".

An obstetrician and an anaesthetist specialising in obstetric care give evidence.

The basic code was that a blood transfusion should only be administered if there was a clear and definite benefit to the patient for doing so.

There was never a justification for giving every woman a unit of blood. Anaemia could be a problem in pregnancy but three or four iron tablets a week was usually enough to resolve the problem.

This also raises the issue as to whether NHS managers, including those with a clinical background, know how to operate a highly complex organisation like a hospital…

A Cochrane review had confirmed that increasing the dosage to three or four tablets a day had no additional benefit. "That was like pouring more water into an already full bucket".

Clinicians relied on implied patient consent to many procedures including blood transfusion. It was simply not practical to secure informed consent in emergency situations. Counsel asks how clinicians should deal with major obstetric haemorrhages. What was the most appropriate response? Our witness thought that the decision to transfuse during an operation was usually made by the anaesthetist rather than the surgeon.

In obstetric care the patient could have access to or even retain their clinical record.

There was no follow up of transfused patients. The post-natal check policy adopted at some centres had largely been abandoned…it was never very productive.

Health Visitors and GPs now handled post-natal care. Our witness had pioneered putting clinical guidelines on ward computers for junior doctors and nurses to access. It had worked well, and he had offered to franchise it all over the NHS for a modest fee.

However, the Department of Health had blocked the idea on the grounds that it would get in the way of the National Programme for Information Technology.

Local schemes would be a distraction they thought. Our witness claims that the national programme cost £12.4 billion and never produced any worthwhile benefits whilst slowing down the development of

local clinical guidelines. He is probably right.

As hospitals got more complicated and the working time directive began to be implemented our witness explains that it became increasingly difficult for patients to say; "*I am being treated by Dr X*." They were now being treated by the hospital or general practice.

Individual clinical freedom had been eroded. It was increasingly difficult for a clinician to argue that they had used their best judgement when thing went wrong. They were expected to provide some evidential basis for their actions.

In the view of our witness many thought that teams were safer for the patient than individual clinicians.

Trusts still did not give patients written information about blood transfusions.

These statements are listened to very closely by the Inquiry team and capture a profound switch in clinical practice over the past two or three decades.

Whilst every clinician would acknowledge the benefit of working closely with clinical colleagues of all disciplines the loss of personal clinical freedom [exercised responsibly] and the accountability that goes with it is a serious loss both to the profession, to patients and to the NHS.

This also raises the issue as to whether NHS managers, including those with a clinical background, know how to operate a highly complex organisation like a hospital with complex and fluid clinical teams. It sometimes results, as our witness puts it, in "clinical chaos".

Our witness from Anaesthesia takes the Inquiry through clinical care from his perspective.

He would never know if a patient was subsequently infected with Hep C after a blood transfusion. He agreed with colleagues that it was not practicable to secure meaningful informed consent in emergency situations.

This evidence goes to the heart of the Inquiry's purpose. Was it proper that Haemophilia centre directors and to a lesser extent Blood Transfusion leaders insisted on maintaining their individual clinical freedoms which resulted in such a high degree of clinical variation?

Would a more national approach have averted the crisis or at least reduced the harm to thousands of patients, is a question that the Inquiry will have to answer?

Clinical freedom as exercised by doctors in the early years of the NHS may be dying, but the alternative which stifles clinical judgement and initiative and reduces personal accountability could be worse.

The sheer complexity that multidisciplinary work generates increases the potential for clinical mistakes, misjudgements and omissions. Most hospitals are struggling to get the balance right relying on information technology to bind the professions together around individual patients.

This may be an old fashioned view but until the NHS learns how to operate effectively

with fluid clinical teams it may still be valid. I still vote for clear identifiable clinical leaders at the interface with patients.

There is not an exact parallel, but I am reminded of consensus based management teams created in the 1970s. It was great when it worked but a disaster when team work collapsed.

The teams gave way to general management and then to Chief Executives in order to clarify accountability.

Next two distinguished Haematologists from Newcastle and Oxford whose evidence is focused on clinical guidelines and audit. Regional and local transfusion committees had been required by DH circulars, but progress had been patchy.

Both thought that a Department of Health Circular was more powerful than a "Dear doctor "letter.

It empowered those clinicians who had to demand extra resources from managers.

By 2011 progress on implementing the Better Blood Transfusion circular had stalled as 42% of Trusts still did not have a blood conservation policy and a large number of Trusts still did not give patients written information about blood transfusions.

Perhaps because the risks were so small!

The risk of the transmission of HIV was less than 1 in a million; Hepatitis B was 1 in 20,000 and Hepatitis C less than 1 in 13,000. The benefits were clearly thought to be far greater.

Records at the Freeman hospital had been lost in a flood which impeded "look back" exercises. A problem now resolved with well backed up computer systems our witness explained [until they are hacked!]. Counsel works through the processes and protocols for checking the right patient got the right blood.

Returning to previous evidence our witness agrees that from the 1990 's medicine had become a "team sport".

Were guidelines followed. Well, most of the time!

They were after all guides not rules.