Personal paper: The scapegoating of a consultant orthopaedic surgeon

Dorothy H Crawford

At the end of last year Mr Anthony Percy accepted libel damages of £125 000 from the Mirror Newspaper Group in an out of court settlement. The *Daily Mirror* had called him Dr Dolittle—accusing him of failing to do everything he could to find a bed for a patient with a head injury. Dorothy H Crawford analyses how Mr Percy was driven to clear his name.

At 9 30 pm on 28 March 1995, Mr Anthony Percy, senior consultant orthopaedic surgeon at Queen Mary's Hospital NHS Trust, Sidcup, arrived home after a long day in the operating theatre. Two journalists appeared out of the darkness from behind his garden hedge. They snapped his astonished face, told him that he had been severely censured, and asked him if he was going to resign. The next day the *Daily Mirror* dubbed Mr Percy "Dr Dolittle." So began a long and painful drama which threatened Mr Percy with the loss of his job and his reputation.

The story began on the night of 6 March 1995 when Malcolm Murray was involved in a road traffic accident. He arrived at Queen Mary's Hospital unconscious and in urgent need of a bed in an intensive care unit in a hospital with specialist neurological facilities. No such bed was available locally or in the whole of the London area. Much frustrating telephoning followed. After contacting 20 neurosurgical units a bed was found at Leeds Infirmary. The patient eventually departed on a 200 mile journey in a helicopter at 6 30 am on 7 March. He was operated on immediately but died the next day.

Mr Percy was the consultant on call that night. From his home he spoke to the junior doctor at Queen Mary's Hospital three times on the telephone. They had extensive discussions, and he gave advice and support. The junior doctor was entirely in control of the situation. He did not ask him, nor did Mr Percy deem it necessary, to go into the hospital.

Such regrettable incidents occur and under other circumstances may have gone unnoticed, particularly as there was no evident misconduct. An influenza epidemic had closed the Brook Hospital where local neurosurgical referrals usually go, and it was subsequently established that the patient's death was not the result of the delay. He had sustained irreversible brain damage caused by the accident. But at the time several similar events made the availability of NHS beds a hot news item. The press thought that it had the then secretary of state for health, Virginia Bottomley, on the defensive. Also, local political interest was aroused by the expected and vehemently opposed announce-

ment of the closure of the Brook Hospital. Concerns were expressed at a high level and questions were asked in the House of Commons. An inquiry was set up in two parts: at Queen Mary's Hospital and at regional level. The health secretary promised to publish the findings.

The local inquiry team was headed by Mr Colin Campbell, chairman of the trust, and swiftly completed its task. On 18 March a draft report was sent to the chairman of the then South East Thames Regional Health Authority, Mr Williams Wells, who was conducting the inquiry at regional level. The local report highlighted the independent review of specialist neurosciences services undertaken in 1993, which recommended six referral centres in south east England in a "hub and spoke model." "It is clear that no such model yet exists," the local report said, "there is...no regional or central point to call."

No criticism of Mr Percy

What then happened only became clear when Mr Percy took the Mirror Group Newspapers to court for libel. Mr Charles Gray QC, Mr Percy's counsel, told the court that the local hospital's report contained statements from all concerned and made no direct criticism of Mr Percy. The junior doctor who dealt directly with the patient strongly supported Mr Percy's role. But after discussions between Queen Mary's Hospital and Mr Wells significant alterations were made. Although Mr Percy was not named in a discussion of consultant cover, the emphasis had shifted from the non-availability of specialist neurosurgical beds in the draft to local management issues in the final version. A new section headed "Duty consultant orthopaedic surgeon" appeared.

Mr Wells sent the results of the regional inquiry to Mrs Bottomley on 24 March. Quoting from their correspondence, Mr Gray said that her response, while making no reference to the bed shortage, asked, "What about the consultant refusing to appear?"

From here Mr Percy became the focus of attention. Acting on an agreement with Mr Wells, the chairman of Queen Mary's Hospital wrote a letter of censure to

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Mr Percy. But Mr Percy denies ever receiving the letter. "They just didn't have the guts to send it to me," he said.

Both reports were published on 29 March. But it was the night before this that Mr Percy was confronted by the journalists at his home. They knew that he had been censured when even he did not. How did they come by this information? Clearly there had been a leak, and investigations by Mr Percy's counsel discovered that the Department of Health had telephoned certain daily newspapers, evidence that was produced in court. Presumably this was the origin of the *Daily Mirror's* "Dr Dolittle" article. "It was devastating to see my face on the front page under those head-

lines," Mr Percy said. "I was made a scapegoat and I felt completely betrayed."

Mr Percy sued for libel and won £625 000—among the highest sums ever paid in libel damages. The Mirror Group Newspapers appealed and when the case was settled out of court Mr Percy was awarded £125 000. This is not important to him and his family; the important thing is that he cleared his name. And in pursuing litigation against the media he exposed a coverup. "I'm very pleased we did it. We established that I was not to blame. We stood up against the lot of them and won. That is very satisfying. People sitting in offices in Whitehall can't just blame doctors for inadequacies of provision. They are the providers; they are responsible."

Primary care: opportunities and threats

What the changes mean

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This is the first of a series of six articles discussing the imminent reforms in primary care

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Primary care in Britain could change considerably from 1998. Now, the first contact with the NHS for most patients is through one of a handful of independently contracted partners in a small, local general practice surgery. From next year a wide range of pilot schemes in each district might offer patients something radically different: primary care from a salaried general practitioner in a large unit run by an NHS trust or other provider. These and other big changes in primary care look set to be piloted, even if the government is replaced this spring. This series of six articles will debate the opportunities and threats to the NHS posed by these latest plans.

After seeing your general practitioner, having an hour's session of physiotherapy, and getting your eyes tested you might make a dental appointment—all without leaving the primary care centre. The following week you could go to your local big pharmacy store to buy some shampoo, drop in your holiday photographs for processing, see the asthma nurse, and then collect your medicines. Many of us in Britain are used to one stop shopping; we could soon be getting one stop primary health care, or even a combination of the two.

Opening up the primary care market to new providers—including NHS trusts and private healthcare providers as well as other commercial companies—is just one of the British government's latest ideas for reforming the NHS. The proposal appears in *Choice and Opportunity* (box 1),¹ a white paper published at the end of last year to put flesh on the bones of the primary care bill that is currently going through parliament. Two other white papers have followed, one of which also relates specifically to primary care (box 2).² The other is a general mission statement for the whole NHS that does not say anything very new (box 3).³

This series of articles will concentrate on the proposals for primary care, but it will also consider the

Box 1—Choice and opportunity. *Primary care: the future*¹

The white paper published November 1996 heralds the legal changes contained in the primary care bill:

- Encouraging voluntary evaluated pilot schemes of new ways of delivering primary care
- Allowing new providers of primary care—NHS trusts, private healthcare providers, large retailers (pharmacy chains, supermarkets)—to run pilot studies
- Introducing new ways of paying for primary care:
 - More salaried GPs
 - Practice based contracts
 - Primary care centres
- Letting health authorities recruit and decide on distribution of GPs

opportunities and threats that these latest reforms might present for the whole NHS.

Reforming primary care

Unlike other recent reforms in primary care the new proposals will not make general practitioners alter their clinical behaviour. Doctors will not have to run extra clinics or meet new targets for tests and treatments. Instead, the reforms focus on the organisation of primary care—who delivers it, where it happens, and how its practitioners can be trained more appropriately. The idea, says the government, is to make the NHS more responsive to patients' needs and more accessible.

But why should primary care need reforming now? After all, it has been subjected to almost constantly imposed change over the past seven years, and general practitioners have not, on the whole, enjoyed this. Nevertheless, further change has seemed increasingly inevitable, if only to rescue primary care from the low morale and falling recruitment rates afflicting general practice.⁴ Recognising this, the health secretary has lis-

Box 2—Primary care: delivering the future²

The white paper published December 1996 recommends more detailed and broad change beyond that requiring legislation:

- Restating core values for primary care:
 - Quality
 - Fairness
 - Accessibility
 - Responsiveness
 - Efficiency
- Developing the primary care team—for example, expanding nurse prescribing
- Strengthening other partnerships—for example, with community health (optometrists, pharmacists, chiropodists, etc) and community care providers (mental health teams, etc)
- Developing professional knowledge for all primary care staff:
 - Multidisciplinary education
 - More formal continuing professional development
 - More relevant vocational training for GPs
 - Summative assessment for all GP registrars⁹
 - Improved GP retainer scheme and access to retraining
 - More support for underperforming GPs
 - More use of clinical guidelines
 - Multidisciplinary audit
- Doubling of government funding for research and development in primary care
- Informing the public more effectively on health and health services
- Strengthening the infrastructure of primary care:
 - More flexible funding of primary care premises
 - More permanent funding for out of hours services
 - Extending NHS pension scheme to cover non-medical primary care staff
 - Better communication between practices (among those in same purchasing groups) and between primary and secondary care

tened to general practitioners nationwide and has considered their suggestions and pleas for putting primary care right again.

The consultation document resulting from this listening exercise reassured general practitioners' leaders when it was published last summer.⁵ For the first time in years the government had promised negotiated change in the NHS: change based on the knowledge and desires of people working in the service. This winter's white papers, the final result of all the consultation, have gone even further towards evidence based policy making by insisting that new ways of delivering primary care are piloted and evaluated properly.

Overall, the white papers avoid telling general practitioners and health authorities exactly how to run primary care. They moot many possible models for delivering and organising care but lay down few rules. Indeed, they relax several of the rules that currently govern who can provide primary care and where it can be provided.

The main changes for GPs

Change could start right at the beginning of a doctor's life as a general practitioner, during vocational (postgraduate) training, and could particularly affect where that training takes place.

Box 3—The National Health Service: a service with ambitions³

The white paper published December 1996 is a mission statement for the whole NHS, expressing broad aims to:

- Provide a responsive service that gives patients the health care they need and want
- Provide a seamless service in the NHS, removing many arbitrary organisational boundaries that may hamper care
- Provide more information for patients and the public on health and health services
- Achieve high levels of training and skills throughout the NHS
- Encourage knowledge based decision making, both clinical and organisational

Places of work

The government says that general practice registrars should spend longer (more than a year) in practice based training. This is part of a wider plan to make vocational training more relevant and useful, say ministers. This could mean more community based posts for registrars such as those already established in south London.⁶

Once trained, general practitioners wanting to work in inner cities would probably encounter most change. The new legislation abolishes central planning of the general practice workforce and expects health authorities to match the number of general practitioners to the needs of the local population, an aim that has often proved difficult to satisfy in inner cities. Group practices would not be affected much; existing partners would still have prime responsibility for appointing general practitioners and filling vacancies.

Single handed practices (most of which are in inner city areas) could find recruitment more difficult, however. At present health authorities have to fill vacant single handed posts at the third attempt, even if no candidate fully fits the job description. Under the new proposals doctors would be appointed to such posts only if they met the required standard. Patients finding themselves without a permanent doctor because of this might be able to go to a new kind of service, a primary care centre.

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The nature of the new primary care centres is still unclear, but they could be run by a range of providers including NHS trusts, private healthcare providers, and other commercial companies. They would probably be staffed by a multidisciplinary workforce including salaried general practitioners and might be sited in hospitals, supermarkets, or purpose built premises. The big risk, says the BMA, is that such centres could threaten the general practitioner's economically and clinically vital role as the gatekeeper to secondary care.⁷

Communication, education, and research

Even when new general practitioners have settled into substantive posts, in whichever setting, they might encounter further organisational change (box 2). For example, the government has suggested ways to improve communication within and outside primary care (such as closer working with other disciplines throughout primary and community care, and greater use of information technology and telemedicine when dealing with secondary care services). The politicians also expect general practitioners and other primary care professionals to get even more involved in clinical audit, evidence based practice, and continuing professional development. All three white papers emphasise these aims but none offers additional funding to pay for them.

Two aspects of primary care have, however, been promised more money. The first of these is research. The government says it will double its funding for research and development in primary care from about £25m to £50m a year, taking it from around 7% of the total NHS research and development budget to around 14%. Much of this will be aimed at practice based research supported by local networks and mentors.

The second area that is promised more money, or at least more secure and permanent funding than now, is out of hours primary care. Over the past year many schemes—mainly large cooperatives run by practices—have been set up to deliver out of hours care without exhausting overloaded general practitioners.⁸ These schemes have depended on one-off grants; the white papers pledge regular funding for them.

In summary, the general practitioners of the future should be able to work in a variety of settings. This would probably mean greater job mobility and less job security—but they might be better trained and less tired. Would this make their patients happier?

How primary care might change for patients

Most primary care would still be delivered in local surgeries and health centres, mostly run by group practices. But patients might also have the option, within the next couple of years, of seeing NHS general practitioners in large primary care centres, in accident and emergency departments, in community hospitals, and perhaps even in shopping centres.

Patients would be more likely than now to see non-doctors at any given consultation. The government wants nurse practitioners and other staff (such as pharmacists and counsellors) to expand their roles. Patients needing continuing care in the community, for instance for mental illness, might be more able to see someone from a specialist team if the government's desires for more seamless care (which are somewhat vague) succeed (box 3).

One of the biggest threats posed by these expansive proposals is that care might become impersonal. Patients could find that whoever they see in one of the new primary care settings does not know them very well, if at all. In time, better information technology in the NHS might mean that clinical records could be called up on screen in any consultation and any setting. This would not, however, compensate for the loss of the personal doctor-patient relationship that the old style of general practice is so good at fostering.

As well as better information technology for staff, politicians want more (and more effective) written information for patients. This should cover health, illnesses, and treatments. Primary care staff are also expected to tell patients how and where to find other local services such as social services and those offered by voluntary organisations, as part of a broad attempt to provide more integrated care.

To sum up

The latest reforms could alter British primary care profoundly. But the white papers are so open ended that only time, and a wide range of pilot schemes, will tell. Which of the schemes are endorsed will depend heavily on how the pilots are evaluated and which outcomes (those affecting services or patients) are given most weight. As yet, no criteria for these evaluations have been suggested.

If all goes as intended, planning for pilot schemes should start this spring for implementation in April 1988. Not even a change of government at the forthcoming general election would halt the programme. Although it has promised to block one proposal—the provision of primary care by private companies—the opposition Labour party broadly supports the reforms.

1 Secretary of State for Health. *Choice and opportunity. Primary care: the future*. London: HMSO, 1996.

2 Secretary of State for Health. *Primary care: delivering the future*. London: HMSO, 1996.

3 Secretary of State for Health. *The National Health Service: a service with ambitions*. London: HMSO, 1996.

4 General Medical Services Committee. *Medical workforce: task group report*. London: British Medical Association, 1996.

5 Bogle I, Chisholm J. Primary care: restoring the jewel in the crown. *BMJ* 1996;312:1624-5.

6 Carnall D. Training for excellence in the inner city: an interview with Richard Savage and Clare Vaughan. *BMJ* 1996;313:544-6.

7 Hallam L. Out of hours primary care. *BMJ* 1997;314:157-8.

8 Beecham L. GPs seek amendments to primary care bill. *BMJ* 1997;314:233.

9 Beecham L. GMS endorses registrars' recommendations on summative assessment. *BMJ* 1996;312:126.