Safer out of hours primary care

The death of a patient given an overdose of diamorphine by an out of hours doctor has raised questions about out of hours services. Paul Cosford and Justyn Thomas argue that wide ranging changes are required.

On rare occasions single catastrophic errors rightly lead to a complete review of a healthcare service. One such case is the death of David Gray, who was wrongly injected with 100 mg diamorphine by Daniel Ubani, a doctor based in Germany and providing out of hours primary care in Cambridgeshire. Dr Ubani had never worked in the United Kingdom, did not practise primary care in Germany, and was not familiar with local health care or with diamorphine. Yet he could fly in on Friday evening and work unsupervised on Saturday without routine access to patient notes.

Several investigations have followed,1,2 and the Care Quality Commission’s final report is due shortly. The recommendations so far aim to improve safeguards to ensure the competence of out of hours doctors and strengthen existing quality standards (table). However, we believe that wider changes to out of hours primary care are needed to systematically ensure quality and safety. The medical profession has a duty to lead these changes.

**The incident**

David Gray died on a Saturday afternoon, while Dr Ubani was working for an independent out of hours service provided under contract to Cambridgeshire Primary Care Trust (PCT). This arrangement has been common in England since 2004, when general practitioners were allowed to transfer responsibility for out of hours care to PCTs.3

The direct cause of death was the injection of 100 mg diamorphine, which the coroner deemed to be gross negligence manslaughter. He acknowledged mitigating factors (tiredness, lack of familiarity with local services, and less than adequate induction), but Dr Ubani had the British National Formulary to consult and instructions about opioids within the out of hours box, and he could have sought advice. The lesson is familiar—doctors must be aware of the limits of their competence and seek advice when reaching them. The mitigating factors described did not remove his responsibility.

**Events leading to the incident**

Dr Ubani made a critical and fatal error, but the chronology of events leading up to the incident (box) identifies several contributing factors. The effect of 100 mg diamorphine is basic knowledge for primary care doctors in England, and he was evidently not ready for the work he was to carry out. We must therefore examine the system that allowed him to practise in these circumstances.4,5

**Registration with General Medical Council**

Dr Ubani’s 1995 German certificate of training for general practice led to his acceptance on the GMC primary care register in 2006 under European Union Directive 93. This facilitates free movement of doctors in the European Economic Area and requires mutual recognition of their qualifications. Although it includes requirements for training programmes (aiming to ensure equivalence of a doctor’s competence), as applied in the UK, the GMC did not have to check Dr Ubani’s individual training, clinical skills, or language proficiency, which it does for doctors from non-EU countries.6 This is important given that Dr Ubani did not even practise primary care in Germany at the time.

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Observations and recommendations on out of hours care from coroner’s report, Care Quality Commission interim report1 and national report2

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<thead>
<tr>
<th>Recommendation</th>
<th>Coroner’s findings</th>
<th>Care Quality Commission</th>
<th>National report</th>
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<tbody>
<tr>
<td>Review GMC’s role in assessing clinical and language skills of EEA doctors</td>
<td>Yes</td>
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<td>Improvements to performers list</td>
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<td>PCTs to follow nationally set standards</td>
<td>Yes</td>
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<td>Yes</td>
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<td>More rigorous and uniform assessment of English proficiency</td>
<td>Yes</td>
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<td>Yes</td>
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<td>More rigorous assessment of clinical skills</td>
<td>Yes</td>
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<td>Yes</td>
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<td>National training and assessment programme for doctors qualified abroad</td>
<td>Yes</td>
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<td>Locum and session staff to have access to ongoing appraisal</td>
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<td>PCTs to consider all past applications to join a performers list</td>
<td>Yes</td>
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<td>Yes</td>
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<td>Improved exchange of information between PCTs and with GMC</td>
<td>Yes</td>
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<td>National database of doctors from abroad</td>
<td>Yes</td>
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**Induction**

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<tr>
<td>Higher quality induction</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Tailored induction for doctors new to UK general practice</td>
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<td>Yes</td>
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<td>High dose opiate</td>
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<tr>
<td>Withdrawal of high dose (100 mg) diamorphine from out of hours bags</td>
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<tr>
<td>Improved PCT commissioning and performance management of out of hours providers</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>PCTs able to add locally agreed quality indicators</td>
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*From the coroner’s summing up in public at the inquest into the death of David Gray.
Two lessons therefore arise. Firstly, either the EU directive or its implementation needs to change so that the GMC checks every doctor’s competence before registration. This is not to prevent the free movement of well qualified doctors but to recognise that healthcare systems differ across the EU, and that doctors’ competence is at least partly specific to the system in which they work. Secondly, GMC registration does not, of itself, assure current competence. As a minimum, references and professional appraisals should be used, and the introduction of revalidation is intended to help. For PCTs this case emphasises that, given the GMC’s currently restricted role, the onus for checking doctors’ competence rests with them.

Entry to PCT performers lists
Dr Ubani was put on the performers list of Cornwall and Isles of Scilly PCT in 2007, which allowed him to practise anywhere in England. The performers list system gives PCTs responsibility for monitoring the conduct and performance of general practitioners, with admission, suspension, and removal procedures intended to parallel those for doctors in secondary care.8

Dr Ubani had abandoned an application in West Yorkshire after failing an English language test but was accepted by Cornwall and Isles of Scilly with no language test, after it checked references, insurance details, a certificate of good standing, and GMC registration. Investigations into the case have recommended that PCTs fully check a doctor’s competence and language proficiency, applying strengthened national standards and protocols for sharing data on applicants.

However, another critical factor is that a doctor on one PCT list can still practise anywhere in England. Effective national standards must be accompanied by genuine local accountability, and this is not the case unless doctors are required to be on the performers list of the PCT where they work. If a doctor is not on the local list, the PCT medical director does not have the necessary leverage to ensure quality and PCT systems cannot be said to parallel those in secondary care. We strongly advocate that this change is made to the performers list system, with the extra provision that GPs should be able to enter more than one list if they have good reason.

Induction
According to the coroner, Dr Ubani’s induction was inadequate. It was done at short notice without protected time, he was not shown the palliative care box, and the outcome was not seen by the out of hours provider before he started work the following day. The lesson is clear: induction must be robust, pre-planned, and follow a standardised protocol. It cannot be relied on to confirm competence, but an experienced local clinician should carry it out and give an assurance of satisfactory completion before the doctor starts work.

Availability of high dose diamorphine
If 100 mg vials of diamorphine were not available in the out of hours bag, the fatal injection would have been much less likely. In 2006 the National Patient Safety Agency (NPSA) issued a Safer Practice Notice after reports of deaths from erroneous injections of high dose diamorphine.9 This notice required risk assessment of systems for storing and administering diamorphine, and included reference to out of hours primary care.

The coroner recognised that the provider was reviewing arrangements at the time, and immediately after this incident extra safeguards were implemented. Nevertheless, lessons are clear. High dose opiates should not be in routine out of hour bags, and NPSA safety notices must be robustly implemented and compliance audited. An extra safeguard is for providers to operate out of hours medicines management committees that regularly review the contents of drug boxes, taking into account emerging guidance and lessons from safety incidents.

Wider analysis of out of hours system
So far, contributing factors have been identified from analysis of the error and its antecedent causes. However, lessons should also be learnt from a wider analysis of the system within which errors occur.10 Such analysis shows that Dr Ubani was working in an environment that lacked some

### EVENTS SURROUNDING DR UBANI’S ERROR

- **November 2006:**
  Entered on GMC’s General Practice Register as a result of his right to practise in Germany, obtained in 1995
- **December 2006:**
  Applies to join performers list in West Yorkshire. Application abandoned because he did not pass the language test
- **May 2007:**
  Applies to join performers list of Cornwall and Isles of Scilly PCT. Accepted in July 2007
- **February 2008:**
  Engaged by locum agency to work in Cambridgeshire out of hours service for weekend of 16-17 February
- **15 February 2008:**
  Flies to Stansted during the morning, arriving at locum agency near Colchester at 2 pm. Given MIMS prescribing guide and satellite navigation system. Arrives at offices of out of hours provider in Ipswich at 6 pm, given computer system training and clinical induction. Travels to accommodation in Newmarket, arriving after midnight
- **16 February 2008:**
  Starts shift at 8 am. Patient’s partner calls the out of hours service at lunchtime, and Dr Ubani visits at 4 pm. He is told that the patient usually receives 100 mg pethidine for pain control and erroneously administers 100 mg diamorphine instead. Patient dies as a result
- **17 February 2008:**
  Concerns are raised with the out of hours service provider by the ambulance service that attended the patient. Dr Ubani is stood down and returns to Germany
- **March 2009:**
  Found guilty of causing death through negligence by court in Germany and receives fine and 9 month suspended sentence.
- **February 2010:**
  UK coroner concludes inquest with verdict of unlawful killing. Identifies cause of death as diamorphine poisoning, and states that this was “gross negligence manslaughter”
- **June 2010:**
  GMC strikes Dr Ubani off UK medical register.
Either the EU directive or its implementation needs to change so that the GMC checks every doctor’s competence before registration

**Characteristics of high quality service**

These analyses raise the question of what a safe and high quality out of hours service should look like. We know that local circumstances may require different solutions, and many places do have high quality care. Nevertheless, we need to ensure systematic application of the following principles, which should be embedded in national quality requirements for out of hours primary care.

Firstly, to overcome the lack of team structure, doctors should be part of multidisciplinary out of hours teams that include staff based at an out of hours centre and staff who visit patients who cannot attend the centre.

Secondly, systematic management safeguards should underpin such teams, including regular professional appraisals, audit of outcomes (for example, using the Royal College of General Practitioners Out of Hours Clinical Audit Toolkit), systematic feedback of information from patients and general practices, and structured team meetings at the start and finish of a shift. These could parallel pre-shift checklists and post-shift debriefing sessions in operating theatres, which have been shown to reduce mortality. They would ensure familiarisation with team members and their responsibilities, that mechanisms for obtaining patient information are in place, and that information on existing patients is handed over. Checklists could also be used to ensure that necessary equipment and drugs are available.

Thirdly, access to patient information must be resolved. It is simply unacceptable that the notes of patients who are known to their usual doctors are not routinely available to those treating them out of hours. This must be an immediate priority for the developing electronic medical record, and the summary care record would undoubtedly help.

Fourthly, doctors familiar with local health care should provide out of hours services, and the risky practice of bringing doctors from far afield to work short term shifts where they are unfamiliar with local health care should stop. This does not simply mean that GPs should be responsible for their own practice’s patients out of hours, since similar problems could arise through contracts with deputising services. Instead it recognises that to ensure patient safety, out of hours care should be provided by doctors familiar with local health care, working in formalised teams, with assurance that the service has the characteristics of high quality care. Many areas already operate such systems through cooperatives of local GPs, but crucially, it is not the case everywhere.

**Professional responsibilities and clinical leadership**

As a profession, we should not accept a system that allows incidents such as this in any part of the NHS. Paragraph 4/8 of the GMC guidance *Duties of a Doctor* is clear that all doctors have a professional responsibility to act if they have concerns about safety of their patients even when off duty. Local clinical leaders—for example, practice based commissioning leads, members of PCT professional executives, and PCT medical directors—are also well placed to ensure the adequacy of local out of hours care and lead any necessary changes. It is vital that the quality of out of hours care is part of the core task of general practice commissioning. National clinical leaders in the GMC, BMA, Department of Health, strategic health authorities, royal colleges and others must also advocate the changes necessary in this service.

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3. Primary Care Foundation. Improving out of hours care—what lessons can be learned from a national benchmark of services? Primary Care Foundation, 2010.

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