LIFE AND DEATH **Iona Heath**

Falling through the gaps in care

The gap between hospital and home is unsustainable and, for the sake of our frailest and most vulnerable patients, it must be closed

The stresses of yet another reorganisation of the NHS, combined with the Nicholson challenge of achieving £20bn in "efficiency" savings by 2015, are widening pre-existing faultlines at an alarming rate. Patients are already falling through the resulting gaps and seem likely to do so in increasing numbers unless those in power are prepared to make the necessary effort to understand more clearly what is going on and to stop fiddling while the NHS burns.

There are gaps between specialists and generalists, between the provision of physical and mental healthcare services, and between financial and clinical imperatives, but perhaps the biggest gap exists between two different sorts of bed, the one in hospital, the other in the patient's own home. Services have become ever more centralised in large hospitals as a direct result of the trend to increasing specialisation among hospital doctors, combined with the evidence that, for patients lucky enough to have only one condition, care in a specialist unit provides better outcomes. So more and more patients find themselves at an ever greater distance from any form of inpatient care—and the further away, the less familiar and more intimidating the hospital becomes. And it also becomes harder for relatives and friends to visit and provide comfort, support, and love.

The centralisation of hospital services makes clear economic sense when the need is to deliver complex procedures involving expensive technology and sophisticated specialist skills. However, the *Hospitals on the Edge?* report from the Royal College of Physicians tells us that nearly two thirds of people admitted to hospital are over 65 years old and that people over 85 account for a quarter of all bed days.[1] The older the patient, the less likely they are to have a single condition, and the less easily they fit into the intensely specialty based hospital service. As the report puts it, "Patients who do not fall neatly into any organ-based specialist remit may become 'lost' in the system or at least 'neglected.'"

Expensive and frightening technology and specialist intervention are essential but amount to only a small part of the totality of healthcare. The gap between home and hospital has become too great, and general practitioners and other primary care clinicians are struggling with the consequences. Take my personal test cases. The first is a fiercely independent but frail older woman who has lived alone for many years and takes pride in her ability to do so. She reluctantly accepts some homecare services but is completely undone by a bout of severe diarrhoea. She cannot get to the toilet in time and soils her furniture and her carpets. She is no longer strong enough to clean up after herself. She needs someone to nurse her intensively for a few days and to restore her lost dignity. To the general practitioner the only option is almost always to admit her to an acute hospital, which neither she nor the hospital staff need or want and which may, in reality, fail to provide either of the things she needs. My second exemplar is an elderly man already past the average expectation of life. He may have had a stroke or he may have cancer, but he is not interested in any added time. His wife is already dead, and he would gladly swap the marginally improved outcomes of a centralised specialist service for care in a familiar setting where he can be visited easily by those who still love him. Yet it has become almost impossible to offer such an option.

Despite the apparently deliberate policy of centralisation, there has been much simultaneous talk of care closer to home, which paradoxically suggests change in a precisely opposite direction. Yet little has materialised for those who most need it. Has it just been empty rhetoric—a comforting mantra along the lines of motherhood and apple pie? Or an ingenious smokescreen for inappropriately early discharge of the most frail? At present the policy has no substance.

"More and more patients find themselves at an ever greater distance from any form of inpatient care—and the further away, the less familiar and more intimidating the hospital becomes"

Innovative solutions are urgently needed, or perhaps a reinvigoration of the old and much valued solution of the small community hospital. In the shadow of the Francis inquiry into failings at Mid Staffordshire, we are obliged to ask ourselves serious questions about the survival of compassionate care in the increasingly pressured environment of an acute hospital, particularly for frail and confused patients. It should be much easier to provide such care in smaller hospitals embedded in local communities and with staff shared with local general practices. Lines of communication would be much more open, and local people would be in and out. Primary care staff, doctors, nurses, and others would need to be given the opportunity to extend their skills and be resourced to do so, but every patient would be one less in an expensive and dangerous acute hospital.

It is just possible that, in the end, Andrew Lansley's NHS "reforms" will be deemed to have played a useful role. Not at all for the reasons he anticipated but because the destructive disruption that is being visited on the health service in England seems to be bringing some sad truths into painfully clear focus. The gap between hospital and home is unsustainable, and for the sake of our frailest and most vulnerable patients it must be closed. The rebirth of local community hospitals has the potential to provide a constructive, compassionate, and even cost effective means of doing this.

Iona Heath is a retired general practitioner, London iona.heath22@yahoo.co.uk

References are in the version on bmj.com.

Cite this as: *BMJ* 2012;345:e7863

ETHICS MAN **Daniel K Sokol**

How good a doctor do you need to be?

If doctors have a duty of care, they must act with adequate skill. But what does that actually mean? Case law offers some guidance

In 1954 John Bolam was a psychiatric patient at the now defunct Friern Hospital, London. To treat his depression the medical team administered electroconvulsive therapy, a relatively new treatment at the time. As they did not give Bolam a relaxant drug before the treatment, nor adequately restrained him during it, he sustained fractures of the pelvis.

In his directions to the jury, the judge in a trial of the medical team stated the principle now widely known as the Bolam test: "A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art."[1]

After retiring for 40 minutes the jury found that the medical team had not been negligent.

The Bolam test applies not only to treatment but also to diagnosis, advice, and the provision of information about risks.

Medical experts commonly disagree, but disagreement is not proof of negligence. The "responsible body of medical men" can be a small group, as long as it is responsible or reasonable. The key question that lawyers ask their medical experts is not, "What would you have done?" but "Would any reasonably competent doctor have acted in this way?" And in that question the relevant time is not now but the time when the act or omission took place. What is negligent today may not have been 10 years ago.

If the doctor is a specialist, then he or she must be judged by the standard of a reasonably competent specialist. The law does not expect excellence, merely competence. And for the junior doctors reading this, the expected standard of skill is that expected from someone holding your post in the hospital. As harsh as it may sound, no distinction is made between foundation year 1 doctors on their first day and those on their last day.[2]

Doctors are often worried about making mistakes, but an error of judgment may not be negligent, even if it causes harm. The relevant question is, "Did the doctor in reaching this decision display such a lack of clinical judgment that no doctor exercising proper care and skill could have reached the same decision?"[3]

Since its inception in the 1950s the Bolam test has come under fire from scholars. With the rise in patients' rights, some people have considered the test too deferential to the medical profession, too tolerant of views at the fringes of accepted practice, and too vague in its definition of a "responsible body" of medical opinion.

In Bolitho *v* City and Hackney Health Authority in 1998 the House of Lords modified the Bolam test.[4] The court held that, in rare cases, a defendant will be found negligent even if a body of professional opinion supports the practice. When? If it can be "demonstrated that the professional opinion is not capable of withstanding logical analysis." The law adapted to the ethical climate by putting medical opinion under legal scrutiny.

The former lord chief justice of England and Wales Harry Woolf wrote in an article in 2001 that the expression "doctor knows best" should now be followed by the phrase "if he acts reasonably and logically and gets his facts right."[5]

When I sat on a clinical ethics committee a few years ago we received occasional requests from clinicians who wanted to try novel procedures on desperately sick patients. I remember observing one operation in which the trauma surgeon, seeing that the patient was haemorrhaging uncontrollably, attempted a rare procedure he had read about in a case report the previous month. In such cases the issue is whether the clinician acted reasonably in the circumstances. In Hepworth *v* Kerr in 1995 an anaesthetist deliberately reduced a patient's blood pressure to provide the surgeon with a blood-free operating field.[6] As a result the patient developed anterior spinal artery syndrome. The court held that the anaesthetist was negligent in exposing the patient to an unnecessary and foreseeable risk of major organ underperfusion.

"The expression "doctor knows best" should now be followed by the phrase "if he acts reasonably and logically and gets his facts right"

In Waters *v* West Sussex Health Authority in 1995, however, a neurosurgeon who used a novel approach to correct a prolapsed thoracic disc was not found negligent, despite the patient's subsequent paraplegia.[7] The surgeon had encountered a problem with the standard method and decided to alter his drilling angle, performing a laminectomy to relieve some pressure on the spinal cord. The court found that the surgeon did nothing that unreasonably increased the risk to the patient or that was contrary to reasonable professional opinion.

A solicitor once told me that he enjoyed clinical negligence because there were only three cases to remember and all of them started with the letter B. Two of those were Bolam and Bolitho. The third, Bailey, concerns the causation of harm.

Daniel K Sokol is a barrister and honorary senior lecturer in medical ethics, Imperial College London
daniel.sokol@talk21.com

1 Bolam v Friern Hospital Management Committee [1957] 1 WLR. 582.
2 Wilsher v Essex Area Health Authority [1986] 3 All ER 801.
3 Hughes v Waltham Forest Health Authority, *The Times*, November 9, 1990, CA.
4 Bolitho v City and Hackney Health Authority [1998] AC 232 HL.
5 Woolf H. Are the courts excessively deferential to the medical profession? *Med Law Rev* 2001;9:1-16.
6 Hepworth v Kerr [1995] 6 Med LR 39.
7 Waters v Health Sussex Health Authority [1995] 6 Med LR 362.

Cite this as: *BMJ* 2012;345:e7858