

# Identifying and managing clinical responsibility

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**ABSTRACT** – Clinical responsibility is an area that requires extensive consideration and development to align with other changes in healthcare in the NHS. Increasing levels of litigation and investigation into the practice of medical practitioners have highlighted the need for clearer guidance for doctors. Using hypothetical case studies, this project explored the understandings and experiences of physicians and potential solutions in areas where there was ambiguity in clinical responsibility. In addition, existing policy and practice within trusts throughout the UK was analysed. The output from the focus group discussion and policy analysis led to the recommendations and guidance for doctors outlined in this paper, with the aim of illustrating the central themes that both doctors and trusts need to address in the future.

**KEY WORDS:** clinical responsibility, governance, handover, quality care, standards

## Introduction

Throughout the past decade, the delivery of healthcare in the UK has undergone a great deal of change. However, much of this change has not been supported by the simultaneous development of associated standards of good practice. This is certainly the case in relation to policy, standards, and practices

that clarify the clinical responsibility for doctors. The working environment for doctors has been affected by a number of external influences in medicine, including the European Working Time Directive (EWTD),<sup>1</sup> changes in training, and pressure to meet government targets. Extended roles for nurses and other healthcare professionals, multidisciplinary team-based working, and models such as Hospital at Night<sup>2</sup> may improve access and clinical care and facilitate compliance with rotas and service targets. However, these initiatives – coupled with the loss of the traditional hospital firm,<sup>3</sup> shift work for doctors,<sup>4</sup> and the movement of patients without knowledge of the team that admitted them<sup>5</sup> – mean that the line of clinical responsibility is becoming increasingly blurred. Little formal guidance from healthcare authorities has been provided.

Doctors are faced with numerous medicolegal, regulatory, and contractual factors in the environment within which they provide clinical care.<sup>6</sup> These responsibilities and accountabilities include:

- professional obligations stemming from regulations outlined in guidance from the Department of Health and General Medical Council (GMC), including revalidation and fitness to practice<sup>7–9</sup>
- other legal factors such as criminal law, data protection legislation, and statutory requirements relating to health and safety<sup>10</sup>
- patients' rights in relation to issues such as consent to treatment, confidentiality, and rights to complain<sup>11</sup>
- contractual obligations to employers, local protocols and guidelines, and trust disciplinary procedures
- clinical governance requirements, incident reporting, complaints handling, and appraisal<sup>12</sup>
- the need to maintain performance, train others, and supervise junior staff with working arrangements to meet health and safety, legal, and EWTD structures.

In 2004, the Medical Defence Union received a query that sought medicolegal advice about how a consultant physician should maintain their practice in the face of changes in the organisation of the process of care and external pressures, including financial, target, and workforce changes. Of particular concern was that these changes threatened the



Fig 1. Responsibility and accountability.

continuity of care of patients admitted to hospital, which made it difficult to follow advice given by the GMC and the Royal College of Physicians (RCP). The physician also raised their concerns with the RCP, and a project on clinical responsibility was initiated, in conjunction with other healthcare professionals and stakeholder organisations, to investigate whether it is possible to develop clearer guidance around clinical responsibility (Fig 1).

## Methods

A workshop on clinical responsibilities was held by the Clinical Standards Department at the RCP in September 2005. Participants were selected using purposive and theoretical sampling, with all attendees invited from key stakeholder organisations associated with management of clinical responsibility, including consultants, patients, junior doctors, nurses, radiologists, risk managers, hospital managers, legal advisors, and insurers.<sup>13</sup> The assembled group of knowledgeable informants provided a wide range of expertise and experience for the exploration of clinical responsibility policies and practices within hospitals in the UK.<sup>14</sup> Participants were divided into smaller focus groups with the aim of encouraging them to generate and explore their own questions and concepts and to develop their own analysis of common understandings, experiences, and potential solutions.<sup>15</sup> Hypothetical case studies that provide common examples of where problems are likely to arise, including failure to obtain the results of investigations ordered by another team (Case 1), failure to act on protocols (Case 2), inappropriate movement of patients as a consequence of bed shortages (Case 3), and problems arising from common list for investigations (Case 4), were used as prompts for the focus groups (Box 1).

In a second phase of the project, a selection of 50 trusts of varying sizes and geographical locations were asked to provide any information and policies they had developed around the management of clinical responsibility. From the analysis of the workshop discussion and information provided by trusts, specific recommendations and guidance were abstracted and grouped together to illustrate the central themes and concepts that require greater clarity around the management of clinical responsibilities.

## The need for clarity: areas in which clinical responsibility is uncertain

The four case studies highlighted a number of aspects of hospital management and clinical care that impact on clinical responsibility. In all four cases, the patients are not critically ill and the condition of many seems to be stable. Similarly, the problems that occur involve some degree of miscommunication on the part of the medical staff. Focus group discussion and trust policies highlighted a number of key areas in which clarity regarding clinical responsibility is lacking.

Clinical responsibility can become unclear from the very beginning of the patient journey.<sup>16</sup> Difficulties at admission are associated with the ordering and follow up of initial investiga-

tions, the location of admissions units, and the tracking of patients once they are transferred elsewhere in the hospital. Problems arise relating to lost, late, or inadequately reported patient investigations. Many doctors expressed dissatisfaction with this area of practice, including a lack of clarity around requesting, logging, reporting, and follow up of investigations.

The transfer and handover of patients throughout hospitals is often managed poorly and is a high risk area in which clinical responsibility remains unclear.<sup>4,17</sup> Hospitals and medical staff need to develop and agree transfer practices, including agreement of a clearly defined point at which the doctor ceases to be clinically responsible for a patient and the duty of care is handed over to another doctor.<sup>18</sup> Similarly, they need to develop criteria or transfer plans that specify how patients are selected for transfer.

The clinical responsibility for a patient continues right up to the point of discharge. Hospitals and medical staff need to ensure that a discharge protocol is in place and followed accordingly. Improved bed planning and management should help to alleviate many concerns associated with clinical responsibility, including those linked to admission, transfer, and discharge. The hospital's medical director and clinical director should be involved in the development of a process of bed planning and management that proactively addresses patient demand rather than reactively 'fire-fighting'.

Finally, the introduction of common (pooled) lists for invasive procedures – a relatively new practice in clinical care – raises specific concerns around clinical responsibility regarding the distinction between delegation and referral. Case 4 highlighted the need for any changes in the process of delivery of care (such as Choose and Book) to be underpinned by the development of explicit protocols within hospitals to clarify clinical responsibility. A number of recommendations for changes in policy and practice were developed and are outlined below. These recommendations are best practice, and it is acknowledged that time constraints and excessive workloads for clinical staff may often contribute to the issues that have been identified.

## Recommendations

### Investigations

- 1 Admission records should be structured so that the status of all planned initial investigations is clear. For each planned investigation, the admission record should state:
  - whether a form requesting an investigation was submitted and by whom
  - sample sent
  - results awaited
  - when the results were reviewed and by whom.
- 2 The results of all investigations should be documented in the record and any resultant action recorded.
- 3 At each clinical review, the status of all ongoing investigations and any action taken should be updated in the record. There should be a clear audit trail for all requests for investigations, including:
  - date and time request was made

- date and time investigation was completed
  - date and time investigation was reported
  - location or ward to which the result was sent.
- 4 A doctor who requests an investigation should ensure that explicit arrangements to follow up on the result are in place, including who should receive the results and who is responsible for interpretation, action, and communication with the patient.
  - 5 In the event that the result of an investigation falls outside

the accepted and specified 'normal range,' the department who carried out the investigation has a duty to report the result, as soon as possible, to an appropriate healthcare professional who has ongoing clinical responsibility for the patient. A back-up system that automatically reports on investigations that exceed a normal range should be in place.

- 6 For outpatient investigations and follow up, patients should be clearly informed of the investigations they need to

### Box 1. Hypothetical case studies.

#### Case 1

An elderly man is admitted to hospital with a chest infection. He has a history of myocardial infarction and heart failure and is on a combination of drugs that includes ramipril and spironolactone. Dr White sees him in the admissions unit on a Friday afternoon without the results of blood tests but finds no serious abnormality on examination. He is coughing up green sputum. The patient is clearly not well enough to be discharged home but causes Dr White no immediate anxiety. Antibiotics and physiotherapy are prescribed, and the patient is transferred to one of the other wards. A ward-based system is in operation at this hospital, and the patient is transferred to the nominal care of Dr Grey, who has finished work for the day and is not on duty over the weekend. The patient's condition causes the ward staff no concern, but on the Sunday evening, the patient has a cardiac arrest and dies. A postmortem examination is arranged, and it is discovered that the level of potassium in serum on admission was 7.8 mmol/l. This was not noticed by anyone in the admissions unit. Dr Grey was unaware of the presence of the patient on his ward. The pathologist's report suggests sudden death related to hyperkalaemia and acute renal failure.

#### Case 2

Dr White sees a patient with chronic obstructive pulmonary disease in the medical admissions unit. The patient is not in acute distress and Dr White considers she might be suitable for the early discharge scheme. This scheme is overseen by a team of specialist nurses who are employed by the local primary care trust (PCT) but who work to a protocol agreed between the hospital and PCT and that Dr White supports fully. The patient matches most of the criteria for the early discharge scheme except one – the partial pressure of carbon dioxide ( $p\text{CO}_2$ ) is 0.1 kPa above the threshold in the protocol. Partly because of pressure on beds, Dr White advises that this can be ignored and encourages the nurses operating the early discharge scheme to take the patient. All goes well for 48 hours, and the nurses visit and monitor daily. On the third day, the patient is less well (so the protocol would suggest readmission), even though the oxygen saturation remains higher than 90%. No beds are immediately available in the hospital, and the patient says that she does not wish to spend another three to four hours in the emergency department, so the nurses agree to continue looking after her. Later that evening the patient has a cardiorespiratory arrest at home and dies.

#### Case 3

Dr White sees a frail elderly woman in the medical admissions unit. She has a clinical diagnosis of acute pyelonephritis and has started treatment with amoxicillin and gentamicin. Her condition is stable and blood tests show normal serum levels of urea and electrolytes and a creatinine level of 99 mmol/l, with an estimated glomerular filtration rate (eGFR) of 51 ml/min (probably a considerable

#### Case 3 – continued

overestimate for this woman who weighs 40 kg). The patient is reviewed by Dr White's registrar the next day. There is a verbal report that *Escherichia coli* is growing in specimens of blood and urine, although antibiotic sensitivities of the organism are not established. The prescribed antibiotics are continued without change. The patient is much improved and is transferred that evening to another ward where she comes under the care of Dr Puce. Later that evening, one of Dr Puce's regular patients, who has complex needs well known to all the staff on Dr Puce's ward, is readmitted. The clinical site manager places the new patient on Dr Puce's ward but can do this only by transferring the elderly lady to one of the surgical wards. The patient is still logged as being under the care of Dr White, as the transfers have not been recorded on the patient administration system. Dr White's registrar has started night duty, and when Dr White enquires about the elderly patient's whereabouts, he is told that she has been transferred to Dr Puce, who of course knows nothing about the patient. The patient continues to improve on the surgical ward and only when she complains of vertigo five days later, after a long bank-holiday weekend, is she found to have gentamicin toxicity and acute renal failure.

#### Case 4

Your hospital runs three bronchoscopy lists – each performed by a different consultant. In the interests of efficiency and faster diagnosis, it is agreed that patients will be allocated to the next available list regardless of which consultant has seen the patient. Two thirds of patients are day cases and one third inpatients. An agreed protocol specifies that a history and examination proforma must be completed and that certain tests must always have been done and seen to be normal. Mr Smith arrives for his bronchoscopy and Dr White reviews him briefly, looks at his notes, and prepares to obtain consent. Dr White notes that Mr Smith is not one of his patients, that the reason for the procedure was doubt about the appearance of the left hilum on the chest radiograph ordered in the clinic, and that the patient had no other symptoms or signs to suggest malignancy save for being a smoker. The chest X-ray had been done as part of an anaesthetic check before a hernia repair. Dr White feels the chest X-ray is probably not abnormal and then observes that the electrocardiogram (ECG) is abnormal. Dr White knows that his colleague Dr Brown would want the procedure done and Dr White is aware that his own criteria for the procedure are more conservative than those held by Dr Brown. Dr White is also aware that the abnormal ECG means this procedure carries an increased risk – perhaps an increase from a mortality of 1:6,000 to 1:4,000. Dr White explains to Mr Smith that there is an increased risk but that Dr Brown is worried that a tumour could be present. Dr White does not tell the patient that he would not have referred or recommended the procedure himself. Mr Smith signs the consent but dies during the procedure.

undergo using a management or treatment plan or letter. The responsibilities of the patient in regard to their investigations need to be clearly communicated.

### *Movement of patients and transfer of care*

- 7 Hospitals and medical staff should develop and agree criteria for the transfer of patients that allow continuity of safe and appropriate speciality care. Explicit arrangements regarding clinical responsibility should be made, agreed, and documented when a doctor is providing cover for a colleague.
- 8 The patient record should document where the patient has been moved to after leaving the emergency admissions unit, including any subsequent moves, and the location should be updated on the patient administration system. In addition, the name of the doctor who takes on or retains overall clinical responsibility for the patient should be noted prominently on the record.
- 9 Patients should not be transferred to a doctor who has not been informed about the transfer. Handover is a two-part process: one doctor must agree to the transfer and the other must agree to accept the patient. The duty of care of the transferring doctor is not relinquished until the patient or transfer has been accepted by the other doctor. This needs to be logged and recorded, including the time, date, and acceptance of transfer.
- 10 If a patient is managed outside the local agreed care pathway, including transfer or discharge protocols, the doctor needs to ensure they can justify their clinical decisions. If an individual doctor is unhappy with the hospital protocols, agreed local pathways of care, or transfer arrangements, they must ensure their concerns are documented formally.

### *Bed management*

- 11 Hospitals need to reassess their bed base regularly and adjust it according to demand.
- 12 Bed management requires the identification of patients who can be transferred or discharged early in the working day. A predicted discharge date for each patient should be recorded on their admission and updated each day to facilitate this process.

### *Delegation or referral*

- 13 Protocols should be developed for common (pooled) procedure lists and shared patient care to reflect the different clinical responsibilities of doctors. These protocols need to consider that different doctors have different thresholds when making clinical decisions.
- 14 Protocols and patient notes need to specify whether the procedure has been delegated or referred to the second doctor:

- delegating – the second doctor accepts and assumes that all of the risks have been considered and discussed with the patient; in this instance, the second doctor is undertaking the procedure but the delegating doctor retains clinical responsibility
- referring – the second doctor must reassess the need for the procedure (balancing the risk, safety, and benefit of the procedure) and discuss it with the patient; in accepting the referral, the second doctor also accepts clinical responsibility.

- 15 A doctor or other healthcare professional should not undertake a procedure or investigation if they feel that it is inappropriate or represents an unacceptable level of risk to the patient.

### *Medical record*

- 16 Investigations, referrals, and reports from other consultants, subspecialties, and departments should all be included in the one unified set of notes.

Medical directors noted that they receive very few untoward incident reports regarding clinical responsibility concerns and transfer issues. Doctors should complete an untoward incident report for every case in which care is compromised as a result of inadequate transfer or handover.

### **Conclusion**

Management of clinical responsibility is an area of healthcare that requires extensive consideration and development to come in line with other large-scale changes across the NHS. Increasing levels of litigation and investigation into doctors have highlighted the need for clearer clinical responsibility guidance for doctors. Areas of concern or ambiguity in clinical responsibility cross from admission through to discharge. All of the issues identified require a common approach by trusts, hospital management, and medical staff to develop and agree various protocols and policies to address not only the issues identified but a larger unified approach to the management of clinical responsibility.

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