National Association of LINks Members (NALM)—Oral evidence (QQ 123–139)

Evidence Session No. 3. Heard in Public Questions 123 - 139

THURSDAY 7 JULY 2011

Members present

Baroness Young of Hornsey (Chairman)
Lord Cotter
Lord Eames
Lord Foulkes of Cumnock
Baroness Henig
Lord Hunt of Wirral
Baroness Scott of Needham Market
Lord Skidelsky

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Examination of Witness

Witness: **Ruth Marsden**, Vice-Chair, National Association of LINks Members (NALM).

The Chairman: Good morning, Ms Marsden, and thank you very much indeed for coming to give evidence to the inquiry. It seems like you are a long way away down the room, so perhaps it would be helpful if members of the committee could say their names when they speak. I shall just give the usual housekeeping notes. Members' interests are recorded in the Register of Lords' Interests and a list of declared interests is on the Witness Table. The session is on the record. It is being webcast live and will be accessible via the parliamentary website. You will receive a copy of the transcript of the session to check and correct, and this will also be put on the parliamentary website. Please would you begin by stating for the record your name, your official title and your organisation? If you wish to do so, you can make an opening statement.

Ruth Marsden: Thank you. My name is Ruth Marsden. I am vice chair of the National Association of LINks Members. LINks are the current statutory model of patient and public involvement in health, but under the Health Bill soon to be changed to HealthWatch.

The Chairman: Thank you. As you will be aware, various concerns have been raised with us about the free movement of health professionals. Apart from language, which

we will come to later, what concerns have been expressed to you by patients about the free movement of health professionals, and do you have specific examples of incidents that have given rise to concerns?

Ruth Marsden: Perhaps I should make it clear that in all the work I do I am unpaid and, as such, I am not beholden or on anyone's choke chain. Therefore, patients and clinical colleagues can speak freely to me. The first thing I would raise is the changing nature of healthcare practice where issues of language competence are relevant. I come from Yorkshire, up there where the sheep cough. It is a pretty far-flung empire. We butt on to north Yorkshire and the area is virtually the size of Belgium, so there is an increasing dependence on technological aids such as Telehealth, where the patient is monitored by a programmed gizmo placed at his or her bedside. There is very little actual face-to-face, personal, hands-on contact with a health professional except when an emergency kicks up. You do not have the visual signals that would enable you to attune to the nuances of language and situation and that assist all conversations. That is a particular issue in the background to language.

The out-of-hours service is another example whereby typically the attending practitioner, if he attends—he may be a contacting practitioner and ring the patient—has no background notes, so he knows nothing about the clinical context or circumstances of the patient with whom he is communicating. That conversation is the sole tool for getting to the bottom of the circumstances for triaging and deciding clinical priority. Being able to communicate effectively and understanding the signals of those situations and their context is critical. This sort of thing matters in a variety of areas.

My particular forte and clinical interest is radiology, although I am not a medical practitioner and never have been. Radiology is increasingly reliant on voice recognition systems for the dictation of notes. You have to educate the system to the voice, which can operate effectively within a certain window of recognition. Let me give an example. You have probably heard it, but I will cite it because it is valid. Through this system, notes have been downloaded where the clinician said that the patient is suffering from phlebitis, but it came through as flea bites. There is a significant difference.

The Chairman: Thank you. As you were speaking, I wonder whether some of these issues also relate to doctors based here in the UK who have a range of accents as well as EU doctors.

Ruth Marsden: They do indeed. I think it is the Princess Royal who tells the story of Lord Mountbatten who, when the war in the east had ended, went to visit a hospital of Australian prisoners of war. He came to a bedside and said, "Cheer up, my man. You did not come here to die". The Aussie said, "Nah, I came yesterdie". It is perfectly correct. There are so many situations where misunderstandings are possible. In this context it is not critical, but in healthcare it is critical. The margin for error is very small.

Baroness Henig: In written evidence, the Patients Association has said that fundamental to patient confidence is the knowledge that regulators are able to take all the necessary action to assure themselves that the professionals who are being registered are suitably competent to practise. How do you think patients' concerns can most effectively be overcome, and would regulatory changes themselves be sufficient?

Ruth Marsden: I am neither a lawyer nor a bureaucrat, but my reading around the subject leaves me with no optimism that regulation will solve the problem. The current situation is as full of holes as a doily, and I do not really see the ability, certainly not anything like

immediately or in the short term, to address these issues. But you are right when you say that patient confidence is paramount. I am constantly struck by the lack of communication between patients and doctors. I hope I am reasonably savvy about these things, but when it comes to my own situation, I am similarly guilty of it. You almost expect the doctor to be a mind reader. You say, "I don't feel so clever". What does that mean? Have you had a big gas bill? It can mean a range of things. Patients have to have confidence in a doctor's ability, and currently in 99.9% of cases they have it. But we do not want it to be unjustified blind faith.

The Chairman: We can move on now to language testing.

Lord Eames: So far I have found your answers absolutely fascinating. In a sense, there is an overlap of many of the things we want to raise with you, of which this is an example. I would like you to talk to us about what happens at the time of professional registration. To what extent is the sort of problem you have highlighted, the lack of confidence, simply because of inadequacy in language and in understanding language? Is it sufficiently highlighted at the point of professional registration, which in a sense is the beginning of a process? A medical professional often works well after registration. Is there a case, such as that raised in the Green Paper, for strengthening attention at the point of registration to the language that will be used in the area where the professional is going to work? People have told us that afterwards it is too late. Does that make sense?

Ruth Marsden: It does. The simple answer is yes, there is a case. Let me instance a couple of things. My previous professional life was spent in engineering. On one occasion we had a cohort of air force guys from the Middle East who came to us for their engineering degrees. Theoretically they were English-speaking, but their country had sent them to Scotland to learn English, and they then came down to Hull for their training. You can imagine the sort of "Casey's court" that this created. In the healthcare context, I am aware of a trust with a nursing shortage that sent for a cohort of nurses from, I think, the Philippines. I might be wrong about the Philippines, but they were certainly from the Far East. Although these nurses were theoretically English-speaking, in order to attune them to the sort of patient clientele with whom they would interact they were shown endless episodes of "Coronation Street". That raises the question of what the level of understanding in the parent country is of the sort of English that will be required.

Lord Eames: In the light of that reply, from your experience what problems could arise if an employer subsequently has questions about the competence of a medical practitioner on the basis of language?

Ruth Marsden: There are concerns and it is difficult to see how it is done. In my experience, these things devolve to the human resources arm of the organisation or trust. That is very rule orientated and administrative in its ethos, when it might be a question that is much better dealt with by clinical colleagues, the clinical area lead or clinical peers. But there is not really a mechanism for doing that.

Lord Eames: Should there be?

Ruth Marsden: I would like to see it taken into consideration. Many of my consultant colleagues in radiology, for example, attend the main conferences that are held annually all around the world, in Chicago, Amsterdam or wherever. They meet a huge range of colleagues from many other countries. Once they meet these individuals, they know what their language competence is in the space of three-quarters of an hour over a cup of coffee. They are the best judges because they are

first real people in the scenario. But how we bring these two together and whether the law permits it, I am not qualified to say.

The Chairman: You mentioned earlier that both patients and clinical professionals speak to you quite openly and in a way that perhaps they would not with others. Do you have any specific examples from either of those bodies of people of language skill issues that relate to the EU?

Ruth Marsden: Yes. I cannot remember which EU country it was, but it concerned nurses working on dedicated medical elderly wards. I would not like to convey that the patients were in their dotage because the cut-off age was 65, so I would be swept off to a ward like that whether it was for bunions or brain surgery just on the grounds of age. These were not people in their dotage, but it was a medical elderly ward.

There was an incident when a patient was feeling very unwell and rang for the nurse. The patient said, "I am feeling faint". The nurse misunderstood and thought the patient was feeling afraid, and started to minister the soft and fluffy side of things rather than addressing the patient's fluid levels, BP and other clinical signs. Another instance, although I have forgotten what the patient said, was when a nurse misunderstood and wires were crossed so that reassurance was not given.

Lord Skidelsky: One suggestion has been made that a European professional card should be introduced. Do you think that that would do any good?

Ruth Marsden: The short answer is no, I do not. If you drill down and ask me why, I can only say that I have looked at the assurance provided by cards in other contexts and considered the loopholes that have been discovered—the ability to sell cards on and adulterating them. There is also the issue of how current the card is. Mention has been made on several occasions of continuing professional development. Medical practice moves extremely fast. What is current now may in three months' time no longer be state of the art, or at least not in all disciplines. I attend conferences quite often for the sake of genning up. I also quite often go to conferences as a presenter and speaker on issues related to patient care in the clinical environment. At the end I am given a certificate of competency that represents "n" number of CPD points. I have quite a portfolio of them, but that does not make me competent to practise professionally.

Lord Skidelsky: Can I ask a follow-up question? I want to put to you an old-fashioned view that I heard a lot in my parents' time. Although a certain doctor's science might not be right up to date, that doctor has very good intuition and is capable of listening to what the patient says. The doctor treats the patient first; that comes before the disease. Do you think there is too much reliance on science in the medical profession and not enough reliance on a doctor's judgment and ability to listen?

Ruth Marsden: I see where you are going and the answer is yes. There is a balance between soft care and establishing rapport because that is part of the communication required. But for persons who are not indigenous to the country, that in itself can bring problems. I am mindful of certain clinicians I know who are not from this country who present immaculately. They are beautifully turned out, extremely polite and wholly respectful. In a social sense, that is delightful, but to the ordinary patient they often seem remote, distant, insular and almost superior. There is a question of perception. Communication in terms of getting under the skin or under the radar of an individual in a holistic way is important.

Although primarily I am waving the flag for the patient, I am mindful that in this discussion we need to be fair to practitioners as well. They are nuanced and dimensioned people who are at a loss if

they cannot find a fit in their environment and with their own clinical teams. An example of this is that a workstream I have been involved with for a long time is chaired by

one extremely senior professor and attended regularly by another, albeit in a different discipline. Fairly frequently, these two profs fight—not physically, but there are spats and sparrings. That is because they spend the whole of their professional lives giving out to critically sick people, many of whom are on a one-way street and for whom they are fighting desperately to gain a bit of extra time. It is hugely stressful. If these professionals have to have a steam-blowing session—they do, and it is healthy and better than hitting the ketamine or whatever—what about the more junior practitioners, particularly those who do not feel as "at home" in the broadest sense with their clinical colleagues? The potential for isolation and the sense of confusion and stress are greater, and that means a troubled doctor. A troubled doctor can be dangerous.

The Chairman: Are there any mechanisms currently available, or which should be available, to address that part of a doctor's training? Part of what Lord Skidelsky is saying is that it is not only what is on the piece of paper that matters. How else can these sorts of issues be addressed?

Ruth Marsden: I would like to rewind the clock a little. Currently, medical training and education give less scope for this. People are pushed through even faster. There is less elbow room for the element of puppy walking, one could call it, or the working under mentorship that used to be available. I know the deaneries themselves are under pressure and have funding issues on patient involvement. Ring-fenced budgets are anathema; "ring-fencing" is a dirty word. There are now negotiations to get deaneries 'protected' budgets, purely so that training, in its whole sense, can be safeguarded. But the simple answer is that there is less room than ever to, as we call it back home, let the dog see the rabbit—to get the feel for the situation and those sorts of issues.

Lord Foulkes of Cumnock: Coming originally from the north-east of Scotland, I had better keep my accent under control so that everyone understands the question. As you know, the whole concept of the free movement of health professionals depends on the automatic recognition principle. I saw that you were sitting in earlier when we heard from Mr Faull in Brussels. You will have heard concern expressed by the General Medical Council when we heard from them last week and I put that concern to Jonathan Faull. Do you think that we need to look again at this automatic recognition of qualifications and credentials?

Ruth Marsden: Yes, I do, out of fairness to both the patients and the practitioners themselves. We are not whiter than white ourselves; there are gaps in our country in the radiology modalities, for example. One can be an ultrasound practitioner simply by buying the kit from the advertising pages of the trade press, popping on a white coat, erecting a sign and getting cracking. In a sense, that is perhaps not too dangerous because I do not think that anybody has ever been dopplered to death. But we are not watertight ourselves in every respect.

Lord Foulkes of Cumnock: We seem to have a more rigorous system of registration, certainly of doctors and probably of nurses. Those are the two key health professions.

Ruth Marsden: They are, but I alluded a moment ago to the trade press, to which I subscribe for reasons that I will not bore you with. The agony pages, if I can use the general vernacular, of those publications not infrequently have advice on litigation: how to avoid it, how to head it off or see it coming, and what to do when you have colleague issues. It is out there.

Lord Foulkes of Cumnock: If someone comes over here from a country with a really dodgy qualification and someone dies as a result, is it not a bit too late to have litigation?

Ruth Marsden: The distress lasts long and the redress is long in coming, even if it could make restitution, which, too often, it cannot.

Lord Foulkes of Cumnock: Do you think this committee should press for changes in the automatic recognition of qualifications?

Ruth Marsden: Yes, I do. It is a matter of patient confidence. You know how the 99% of good news never gets regarded, but the 1% of bad news resonates around the world and is deeply damaging.

The Chairman: Finally, from the patient's perspective, does the current regulatory framework offer sufficient clarity to patients? What do you think of the idea that healthcare professionals should be treated separately from other professions?

Ruth Marsden: In terms of how much it reassures patients, I fear that the simple answer is that the average patient has no cognisance of these regulatory mechanisms. In a way, it is right that they should not, because if it was on the front burner of their thinking all the time, that would flag up for us that there were issues. Somebody said to me not very long ago that if you go into the average waiting room in a hospital, so long as you are wearing a white coat and swinging a stethoscope you can get somebody into a cubicle and to undress at the drop of a hat. That is the extent of the 'trust', and so it should be.

The Chairman: Obviously people are in a vulnerable position and want to be able to feel that they are in the hands of somebody who is trustworthy. But that has to be backed up, as you say, not only by their experience but by the experiences of others. Of course, the press and the media play a part in that.

Ruth Marsden: Whatever we have, it must be real, both to those whom it governs, the healthcare professionals, and to the patients that it safeguards. There is indeed mileage in separating doctors and nurses from the generalised batch of pharmacists, vets et cetera.

The Chairman: That is an interesting point, because the term "healthcare professionals" covers pharmacists, doctors, nurses, midwives et cetera. There can also be life and death situations caused through inadequate regulation of pharmacists. Unless colleagues have anything else to add to add, it just remains for me to thank you very much indeed for giving us your time. It is important for us to hear different perspectives of people involved in the provision of healthcare. Thank you very much indeed.

National Association of LINks Members—Written evidence

1. All health professionals need to be essentially 'bi-lingual' in that they talk to each other in terms of anatomy, pathology, pharmacology and in the acronyms of their trade and then they have to communicate with patients. This communication is the key.

2. No patient presents with clearly identified, articulated and prioritised symptomatology. The patient is often unaware of the significance of what information he has about his condition. He may be embarrassed, resentful, confused, anxious. Often his offerings of his concerns are at best opaque. If he is elderly, or from a rural area, or from the inner city, his communication may be predominantly in the idiom of the area, dialect that is the currency of the locality. In Yorkshire he may say that he is 'dowly', 'mardy' etc and this will mean nothing to those not attuned to the idiosyncrasy of the 'native speaker'. Then there are the inevitable euphemisms, 'waterworks', 'down there' and so on. The picture has to be teased out, from what he says, does not say, from his demeanour and so forth. All this can be aided by knowledge of the context, family, social group etc etc. But the days when a doctor's knowledge of the patient was lifelong have ended. Few GPs deliver the baby, see the child grow, watch him become an adult, marry, retire and grow old. Patient and doctor are more often strangers.

3. Healthcare is a service of intimacy at a time of vulnerability. There may be moments of discomfort, pain and indignity. This can rob even the most articulate and composed of individuals of the ability to respond cogently. The doctor or nurse's capacity to empathise is absolutely pivotal as the opportunity for establishing the essential confidence, trust, encouragement, co-operation may be very fleeting and equally difficult to define. Patients are not merely the disease or the condition but nuanced and dimensioned human beings, and finding that 'window for meeting of minds' works at a level of subtlety that can be impossible to those who do not have English as their first language.

4. Patient choice means that a woman needing hip replacement may leave the care of her GP and the consultant to whom she is referred and go to have the procedure in Leicester or Newcastle because she has a daughter there to care for her in her convalescence. She will be under a health care team she has never met before and which has never met her. Again, the protagonists are strangers. The abolition of GP practice boundaries similarly generates more patient mobility in the primary sector and further fractures any doctor-patient familiarity.

5. The practice of healthcare exacerbates this. Patients have 'choice' and provision now extends to GP surgery, walk in centre, Independent Treatment Centre, Darzi centre, minor injuries centre, A and E and all the other names for places the patient may access. The Central Care Record is still a dream. The out-of-hours doctor will make a judgement without access to the patient's notes. The Telehealth system makes the patient remote from the individual caring for him. Practice boundaries are to be abolished so the patient may attend where he works, many miles from home territory. Locums appear at all levels of the system and as quickly move on. Continuity of care does not exist and 'ownership' of patients can be flimsy.

6. Healthcare systems overseas differ in many key respects. For example, where there is no national health-service and the patient pays at the moment of contact, the doctor, knowing

the financial strain on the patient, may well prescribe more generously in dosage terms, on the basis that one good slug should deal with the problem. But the therapeutic index of drugs is tight, the window between efficacy and toxicity small and because a little helps, it does not follow a lot helps more. Polypharmacy, especially amongst the elderly and chronic sick, compounds the problem. The margin of error is small, the distress enduring, redress protracted or impossible. A foreign doctor may not understand the yellow card system, for contraindications' recording, he may not be familiar with our formulary nor with the fact that the formulary of a PCT may differ from the formulary of an acute trust or that the definition of a 'child' may be 14 in one institution and 18 in another. The new 100 hour pharmacies opening all over the country already show some evidence of the more 'aggressive marketing' employed by medical professionals/pharmacists. Prescriptions taken in after normal chemists' hours, because there is an emergency in the household, are followed up with automatic repeat prescriptions to that patient, and even with home delivery of these, wholly without the patient's consent. This is a 'gaming' mechanism, whereby the 100 hour pharmacy tries to poach the patients from other chemists. It confuses and frustrates the patient and costs the patient's GP a considerable amount in duplicated and wasted medicines. Whether driven by motives of commercial advantage or through reasons of system ignorance, the result is undesirable to all.

7. CDP can be of limited value. For example, CPD certificates, carrying 'points' for accreditation, are awarded to delegates at conferences simply on the basis of attendance. Some CPD modules are very simplistic and of limited clinical value. There is no standardised benchmarking of any competency these sessions may profess to assure.

8. Heard language is as critical as spoken language. Many medical terms are extremely similar. Many drugs have very similar sounding names but do very different things, even opposite things, such as stimulate or anaesthetise. The 'shorthand' of acronyms can be similarly scrambled – DNA and DOA sound very similar but denote did not attend and dead on arrival respectively. There are many more examples. The nuances and rhythms of unfamiliar speech may render many terms ambiguous or indecipherable, especially when work load is high. Other countries' language training to equip medical staff in English may be provided by non-English speakers, or at less than appropriate locations which do not represent the generic of the English language. Such testing as is undertaken, wherever undertaken, is often weighted towards the written, in which form any problems of accent and fluency will be less apparent.

9. The investment in medical training in the UK is already under threat in that the Deaneries are pressing for ring fencing for their budgets that have suffered financial rape. The government's resistance to the term 'ring fencing' has led to pleas by the Deaneries for their budgets to be 'protected'. Any shortfall in the capacity of UK medical training will invite further importing of skills from outside the UK. The lead time for medical training is long – the tap cannot be switched on and off.

10. Medicine is a very demanding profession. The stresses are great and the margins for error extremely small. Medicine, despite miraculous advances in diagnostic equipment, is not an exact science. It relies on the experience, assiduity, focus and skill of the doctor and nurse. A health worker who feels isolated from the team, unable readily to contribute to and benefit from the indefinable but crucial support that the flex of the team can provide, will be more stressed. Pressures exist at every levels, some common, some different, but all very real. The isolated doctor is trouble. Mistakes can be impossible to rectify.

11. Non-English doctors can present very differently and seem alien and remote. This can be very off-putting to some patients. In addition to their own anxieties over being unwell, the patients are straining to understand and be understood and many are the instances where the patient feels so conscious of saying 'Pardon', 'Excuse me' 'Could you repeat that' that he leaves still not knowing what has been said to him.

12. The current context of medical provision is much harassed by budget limitations. This will not improve. More is expected for less, the demands for productivity, pace, and patient through-put are relentless. Yet errors are financially as well as socially costly. The CNST (Clinical Negligence Scheme for Trusts) premiums are large. Payouts can be huge, especially for maternity and neonates, to the extent that some trusts will cease to offer this sort of service. Additionally, the statistics for SUIs (Serious Untoward Incidents) and 'never events' are not encouraging. That any further uncertainty and grounds for error should be allowed is wholly undesirable both for the survival of the healthcare system and for patient confidence. How safeguards are to be introduced to be fair to European nationals wishing to practice here yet ensuring the safety of patients is hard to say but it is easier to see sound control and monitoring and accreditation being applied in the UK to provide assurance than to look to the wider European community for this.

13. It is accepted that there will be many doctors from the European Union who are dedicated, skilled and competent. But competence is more than language. It is knowing the people, both the clinical cohort and the patient constituency. It is knowing the healthcare system. It is knowing the cultural context. That is a big 'ask' for someone who may never have lived in the UK.

14. The UK model of a regulatory system does not exist in Europe. Where 'regulation' is to be found, it exists at different levels and means different things and is frequently regional rather than national and very problematic to access. What there is is hard to align and where the gaps are, there seems little to incentivise to fill them. It is difficult to see how the current situation can provide any assurance.

13 July 2011