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**HOUSE OF LORDS** SOCIAL POLICIES AND CONSUMER PROTECTION SUB-COMMITTEE

Safety First: Mobility of Healthcare Professionals in the EU

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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

National Association of LINks Members—Written evidence

168

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.

National Association of LINks Members—Written evidence

169

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.

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