

mind. Doctors may be making inappropriate decisions for the sake of maintaining relationships with patients without checking whether their assumptions about patients' preferences are correct. To do something clinically unnecessary that the patient wants, for the sake of the relationship, is one thing, but if the patient does not want it it is truly unnecessary. One can only suppose that a better relationship would be based on a more accurate understanding, gained by finding out directly what patients are expecting. The objection is often made that this would take up too much time. But Little et al make the point that carrying out unnecessary investigations is itself time consuming.¹ The evidence shows that, although longer consultations on the whole lead to better patient outcomes, some skilled doctors are able to achieve these outcomes without spending more time.⁹

If we really want to know what is going on in the consultation we need to study the interaction. Without this, interpretation is conjecture. Interventions aimed at changing the dynamics of the consultation cannot be evaluated fully if these interactions are not analysed. Although the leaflets in Little et al's interventional study encouraged patients to list the issues they wanted to raise, the consultations themselves were not analysed.² Thus it is not clear if increased satisfaction arose from patients' greater articulation of their expectations, or from feeling reassured that the doctor was willing to listen, or something else altogether. If the purpose of interventions such as leaflets or decision aids is to alter the dynamics of the consultation then any evaluation should investigate those same dynamics. The growing number of studies of the consultation carried out by specialists in sociolinguistics and conversation analysis promise to provide a better

understanding of exactly how expectations are or are not articulated and if articulated how they are responded to.¹⁰ This type of investigation could also help us to understand exactly what skilled doctors, who can achieve good communication within normal time constraints, are doing.

Nicky Britten *professor of applied health care research*

Institute of Clinical Education, Peninsula Medical School, Universities of Exeter and Plymouth, St Luke's Campus, Exeter EX1 2LU
(nicky.britten@pms.ac.uk)

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- 1 Little P, Dorward M, Warner G, Stephens K, Senior J, Moore M. Importance of patient pressure and perceived pressure and perceived medical need for investigations, referral, and prescribing in primary care: nested observational study. *BMJ* 2004;328:444-6.
- 2 Little P, Dorward M, Warner G, Moore M, Stephens K, Senior J, et al. Randomised controlled trial of effect of leaflets to empower patients in consultations in primary care. *BMJ* 2004;328:441-4.
- 3 Cockburn J, Pit S. Prescribing behaviour in clinical practice: patients' expectations and doctors' perceptions of patients' expectations – a questionnaire study. *BMJ* 1997;315:520-3.
- 4 Britten N, Jenkins L, Barber N, Bradley C, Stevenson F. Developing a measure for the appropriateness of prescribing in general practice. *Qual Saf Health Care* 2003;12:246-50.
- 5 Butler CC, Rollnick S, Pill R, Maggs-Rapport F, Stott N. Understanding the culture of prescribing: qualitative study of general practitioners' and patients' perceptions of antibiotics for sore throats. *BMJ* 1998;317:637-42.
- 6 Barry CA, Bradley CP, Britten N, Stevenson FA, Barber N. Patients' unvoiced agendas in general practice consultations: qualitative study. *BMJ* 2000;320:1246-50.
- 7 Stivers T. Participating in decisions about treatment: overt patient pressure for antibiotic medication in pediatric encounters. *Soc Sci Med* 2002;54:1111-30.
- 8 Jenkins L, Britten N, Stevenson F, Barber N, Bradley C. Developing and using quantitative instruments for measuring doctor-patient communication about drugs. *Patient Educ Couns* 2003;50:273-8.
- 9 Belle Brown J. Time and the consultation. In: Jones R, Britten N, Culpepper L, Gass D, Grol R, Mant D, Silagy C, eds. *Oxford textbook of primary medical care*. Oxford: Oxford University Press, 2003.
- 10 Heritage J, Stivers T. Online commentary in acute medical visits: a method of shaping patient expectations. *Soc Sci Med* 1999;49:1501-17.

Making amends for negligence

Current system operates well, but reforms are still needed

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That doctors are more likely to be sued for negligence now than they have been in the past is undeniable. In particular, in the 1980s and 1990s the number of claims steadily increased, relative to the number of treatment episodes. The reasons for this are by no means clear but probably include elements of a cultural shift in attitudes to the medical profession and the growth of the legal services "industry." More contentious, however, is whether this change represents a good or a bad thing, and what if anything needs to be done about it. The chief medical officer's consultation paper, "Making Amends," starts from a premise that something does need to be done, and it puts forward suggestions for reform, including fast track arrangements for smaller cases, but stopping short of a full no fault scheme for all patients.¹ Two contributors to this issue have reacted to the chief medical officer's document somewhat critically. Brian Capstick maintains that the proposals for reform run the risk of increasing the burden on clinicians and hospital managers because the number of claims will increase and that therefore costs may be prohibitive.²

Bertie Leigh in his commentary argues that there is no real crisis in the current system—costs are under control, and claims are dealt with proficiently on the whole.²

The chief medical officer's proposals clearly have some anomalies, and the current, much reformed tort system operates more efficiently than most people think.³ However, this does not take away the case for reform, and there is a risk that the debate over "Making Amends" is being limited by a too narrow perspective on the financial and administrative burden of settling claims against the NHS. Some fundamentals must be kept in view: the chief medical officer estimates that there are 850 000 adverse events related to NHS care annually. Only a tiny percentage involve litigation or compensation payments, yet a sizeable proportion cause harm to patients, resulting in costs borne by patients themselves, families, employers, insurers, social security, and, ironically, the NHS itself. These costs are central when accounting for the full consequences of medical error, and the cost of any compensation system must be set alongside the impact of that system on the total number and cost of adverse events.

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A system that generates more claims, and therefore an increased burden on clinicians and managers, is not necessarily a bad system. If the financial responsibility for claims changes the behaviour of providers and makes hospitals safer places for patients, then the overall impact may be a reduction of costs, in the wider sense that includes social harm. Of course, not all adverse events can or should be prevented: medical care has inherent risks, resources are limited, and principles of cost effectiveness should apply here as elsewhere in the NHS. Unfortunately, most NHS hospitals are some distance from having in place comprehensive cost effective mechanisms to increase patients' safety.

"Making Amends" implies two ways in which claims may be encouraged. Firstly, the proposed basic redress scheme will make claiming cheaper and quicker, and more adverse events may consequently result in a claim. Secondly, eligibility for the proposed redress scheme for birth related injuries will be based on a test of causation, not fault, and this should result in more claims being met than at present. Providing that healthcare providers see these claims as generating valuable information and use this as a basis for action to improve patient safety, increased claims will have benefits as well as costs. But two conditions must be met for this to be plausible: the administrative costs of processing claims must be well controlled and some financial responsibility for claims should remain with the healthcare provider. Concerning the first condition, the chief medical officer envisages a streamlined process for dealing with claims under the redress schemes. Concerning the second condition, however, financing the redress schemes has been left open. The NHS litigation authority has been given the central

responsibility for collecting contributions from NHS trusts. Whether and how these contributions will be related to the trusts' experience in reducing patient claims remains unclear. This raises complex issues about the relative complexity of trusts' case mix, and the range of variation in contributions that is desirable, but these issues should be part of the debate about principles, not just about implementation. Surely a fair principle is that hospitals with a poor record in patients' safety (relative to what might be expected) should bear a greater share of the compensation costs, by comparison with hospitals that have a good safety record. The challenge for the future is to find ways of harnessing data from the proposed redress schemes to achieve this end.

Paul Fenn *professor of insurance studies*

Nottingham University Business School, Nottingham NG8 1BB
(paul.fenn@nottingham.ac.uk)

Alastair Gray *professor of health economics and director*

Health Economics Research Centre, Department of Public Health,
University of Oxford, Oxford OX3 7LF

Neil Rickman *reader in economics*

Department of Economics, University of Surrey, Guildford, Surrey
GU2 7XH

Adrian Towse *director*

Office of Health Economics, London SW1 2DY

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- 1 Department of Health, UK. Making Amends: a consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS. DoH: London, 2003.
- 2 Capstick JB. Making amends—the future for clinical negligence litigation [commentary by Leigh B]. *BMJ* 2004;328:457-60.
- 3 Towse A, Fenn P, Gray A, Rickman N, Salinas R. *Reducing harm to patients in the National Health Service. Will the government's compensation proposals help?* London: Office of Health Economics, 2003.

No time to train the surgeons

More and more reforms result in less and less time for training

Surgical training in the United Kingdom is beset by fundamental problems raising what has been described as "considerable disquiet amongst trainees and trainers."¹ Basic and higher surgical trainees progress through a system comprehensively reformed five years ago to emphasise structured training, supervision, and regular assessment. So why are senior house officers' skill levels regarded by trainees and trainers as "very shallow"?² Why is there insufficient capacity in the system to train surgeons in the way that their trainers want?³ And why is it that, in a recent poll of consultant surgeons, two thirds would not wish to be operated on by a Calman trained consultant colleague?⁴

In 1993 Sir Kenneth Calman proposed reforms of the registrar grades to bring the United Kingdom into line with a European Union directive on medical training. It was hoped that encouraging structured learning and supervision would compensate for reducing training time. The European Working Time Directive became part of British law in 1998, and it means that

soon no doctor may work more than 48 hours a week. The combined impact of these two reforms on surgical training is profound.

Before Calmanisation and the European Working Time Directive a trainee could expect to work over 30 000 hours between becoming a senior house officer and getting a consultant post. The Royal College of Surgeons calculates that this will now fall to 8000 hours.⁵ The chief medical officer proposes reforms that would further reduce this to 6000 hours.⁶ To become a competent surgeon in one fifth of the time once needed either requires genius, intensive practice, or lower standards. We are not geniuses. So has there been an increase in the intensity of teaching to compensate for the fivefold decrease in the length of surgical training?

Well no, not really. The largest ever survey of senior house officers in orthopaedic surgery showed that a third of these trainees were not taught in theatre or clinic.⁷ That many senior house officers arrive at posts halfway through their rotations without any real com-

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