Catastrophes in Anaesthetic Practice – dealing with the aftermath

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SECTION 1. SUMMARY

- The majority of anaesthetists are likely to be involved with an anaesthetic catastrophe at some point in their careers.

- The psychological impact on staff following death or serious injury to a patient should not be underestimated.

- It is vital that members of the anaesthetic department support the anaesthetist and a senior colleague or mentor should be assigned to this role.

- Contemporaneous records of the event must be kept.

- The clinical commitment of the anaesthetist concerned should be reviewed immediately by the clinical director.

- A team approach should be adopted to breaking bad news with relatives. This should not be done over the telephone.

- The task of breaking bad news should not be carried out by a trainee or staff grade or associate specialist (SAS) doctor without a consultant present.

- Each hospital must have a procedure for dealing with and investigating catastrophic events.

- Critical incident stress debriefing by trained facilitators with further psychological support may assist individuals to recover from the traumatic event.

- Anaesthetists are strongly advised to be a member of a medical defence organisation.

SECTION 2. INTRODUCTION

Although deaths due to anaesthesia are extremely uncommon with an estimated incidence of 0.5-0.8 per 100,000 anaesthetics[1,2,] we are all likely to experience a death on the operating table at some point in our careers. In the majority of cases, death is expected and the cause understood. However, when death or serious injury is unexpected, the experience can be extremely traumatic for all concerned including the theatre team, ward and ancillary staff. The 2000-2002 Confidential Enquiry into Maternal and Child Health report recommended that anaesthetists and staff who were involved in a maternal death should receive supportive counselling[3].

A survey of two hundred and fifty one anaesthetists from twelve NHS hospitals in England showed that 92% had experienced an intra-operative death; 60% of deaths were expected occurring mainly in emergency surgery (80%).[4]

Whether a death is 'expected' or 'unexpected' may be irrelevant, as the anaesthetist involved may be emotionally affected by any intra-operative death or serious injury to the patient. The training and ethos of anaesthesia to avoid harm and maintain patient safety at all times puts additional stress on the anaesthetist.[5-9] The psychological effects of an intra-operative death or serious injury on a background of continuing stress, may tip the balance towards acute personal, psychological or physical disaster.[10]

When a death or serious injury occurs in a private hospital, the anaesthetist may feel particularly vulnerable. Private hospitals may not have the support systems which are available in the NHS. However, it is the responsibility of the chief executive officer or the general manager of the private hospital to put in motion their governance and risk management systems to deal with a catastrophe.

It is incumbent on colleagues, hospital, Trust, family and society in general to provide practical help and support to the anaesthetist

involved according to individual needs. This is part of good clinical and corporate governance, and risk management.

Unfortunately, research into the effects and management of intra-operative deaths is minimal. The aim of this document is to suggest pragmatic ways of dealing with the aftermath of a death or serious injury during anaesthesia.

SECTION 3. ACTIONS TO TAKE AFTER THE EVENT

Consult departmental guidelines if available.[11]

a) Immediate Actions

Records

Keep an accurate and contemporaneous record of the anaesthetic and event. These should be legible, timed, dated and signed. Electronically stored monitoring records should be printed and filed in the notes. If stored monitoring records are unavailable, recordings should be made on the basis of recollection as accurately as possible and preferably corroborated by staff who were present at the time. Where practical, it is advisable during attempted resuscitation to allocate one member of the team to record times, the personnel involved, interventions including details of all drugs, fluids used and outcomes. Original notes and charts must not be altered in any way at a later date. Amendments and additions must be recorded separately, timed, dated and signed.

If the anaesthetist is unable to write notes immediately, a full retrospective account must be made as soon as possible. It is essential that this account concurs with the records in the notes and the recordings from the monitors or explains the discrepancy. The date and time of this retrospective record should be noted and signed (in black ink to allow photocopying). Any subsequent entries to the contemporaneous notes should be made in the same way. If it has not already been recorded, the anaesthetist should document details of the discussions with the patient pre-operatively regarding the risks of anaesthesia and surgery. It is important to keep copies of the records and make personal notes as these may be required later (see Section 8).

Dealing with the anaesthetist

For trainees or SAS grades, the responsible consultant should attend in person and deal with the situation. A consultant anaesthetist should inform a colleague who should attend the hospital and assist with the

aftermath. A decision will need to be made whether the anaesthetist should continue with his/her list or on-call. There is no standard advice in this situation although individual Trusts may have their own policies which should be followed (see Section 5). The decision is best made after assessing the situation between the anaesthetist involved, a senior colleague and the clinical director.

Dealing with the patient

In the event of a death, inform the Coroner (England and Wales) or Procurator Fiscal (Scotland) and the patient's general practitioner as soon as possible by telephone or other immediate means. The Coroner or Procurator Fiscal may decide to conduct their own investigation. The anaesthetist involved should contact his/her defence organisation. It is important to complete a Trust critical or adverse incident form.

In the event of death, all lines, tubes and other equipment connected to the patient must be left in place. If there is any cause for concern regarding the placement of the endotracheal tube, its position should be confirmed and recorded by an independent anaesthetist. The body should be transferred to an appropriate area for further investigation if necessary. In some circumstances, the Coroner may instruct a pathologist to investigate. At a later stage after the body has been prepared for viewing, the relatives may attend to pay their last respects.

Although it may be difficult to do, in the event of a medical catastrophe where the patient survived, it is important for the anaesthetist concerned to take an interest in the progress of the patient. This will involve regular visits to the ITU or rehabilitation unit. Failure to do so may paint a negative perception that the anaesthetist did not care. Regular communication with the family is also helpful.

Dealing with relatives

Breaking bad news should not be done over the telephone. It will be necessary to invite the relatives to come to hospital informing them that some complication had occurred but no details should be given. There may be pressure from the relatives to get information over the phone

but this should be politely and firmly resisted without antagonism. If there is no immediate family to accompany the relative, ask the relative to bring a friend. Some hospitals have established a bereavement service which can be helpful for grieving relatives.

The interview with the family

This will consist of an initial interview, possibly followed by more depending on the situation. Find a suitable quiet and comfortable room free from interruption for the interview. Do not speak to the family on your own or allow the surgical team to do this. *A team approach is essential.*

Before the interview, decide who should be the spokesperson. Speak to the family with your surgical colleague who may already have encountered members of the family prior to the operation. Other team members should include theatre or ward staff, chaplaincy staff and other support staff including an interpreter if appropriate. A senior colleague should accompany trainees and SAS doctors for support.

Explain the 'bad news' first in a straightforward and honest way, followed by answering any questions which may arise. If the cause of the disaster is known, then this should be explained in lay language. Giving an apology does not imply fault. However, if no cause has been identified, do not speculate or offer an opinion. Take time, listen and empathise. Use an interpreter in cases where understanding of English is limited. Give the family the time to take in the bad news and do not give them too much information initially.

Other members of the team interviewing the family can contribute during questioning led by the spokesperson. If appropriate, inform the relatives that a full investigation will take place and that this may take some time. If appropriate, reassure the relatives that all that could be done was done to keep their relative alive and that their relative was not in pain or aware during the resuscitation attempts. This knowledge may be comforting to them.

It may be necessary to conduct a second interview after a relatively short period of time to give further information, answer questions or to clarify certain issues. Further interviews may be necessary in the future.

b) 'Later' Actions

Equipment and drugs

The clinical director or a consultant not involved with the incident should take responsibility for checking the patient and equipment. If there is suspicion of equipment failure or a hazard affecting the theatre, a decision may be made to take the theatre or anaesthetic machine out of commission until further notice.

All anaesthetic equipment, drug syringes and ampoules should be kept, and moved to a secure store room for investigation. An accurate record should be made of all the checks undertaken including time and date of inspection. All disposable equipment including syringes and ampoules, airway devices etc. should be kept in a secure box. Further investigation may be required by medical equipment maintenance personnel, manufacturers or toxicologists.

Dealing with the theatre team

The team should be initially debriefed at a time to suit all staff and preferably within a few hours of the catastrophe. The aim is to provide and record information, and to gain feedback while details are still fresh. It is also useful to allay anxieties or misconceptions experienced by members of the theatre team. The presence of a trained counsellor may be useful to assist staff traumatised by the event (see Section 6).

Dealing with the media

The media may try to approach staff at the hospital or at home. A Trust manager trained with dealing with the media should be the only person communicating with them. All media enquiries should be directed to this manager.

SECTION 4. THE ROLE OF THE DEPARTMENT OF ANAESTHESIA

It is vital that members of the anaesthetic department support the anaesthetist who may be stressed and traumatised.[12] A stressed anaesthetist will be more prone to making errors. (see Sections 6 and 7)

It is important *to listen* to the individual and encourage him/her to talk and *refrain from being judgemental.* Informal, sympathetic peer review with a few colleagues is often useful. Keep all conversations confidential. At a later date, when the cause of the catastrophe is known, a departmental mortality and morbidity meeting may be useful to inform and learn lessons from the incident.

An experienced and sympathetic senior anaesthetic colleague should be assigned to act as mentor and provide support for as long as necessary. The mentor should be known and accepted by the anaesthetist concerned. Members of the department may have to take over the involved anaesthetist's duties including on call commitments, for a period of time.

The anaesthetist will feel particularly vulnerable when a catastrophe occurs in a private facility. It is the responsibility of the concerned anaesthetist to inform his/her colleagues of the catastrophe in order to obtain as much assistance as possible. The assistance from the department and colleagues should not be any less than if the catastrophe had occurred in an NHS facility.

SECTION 5. THE TRUST RESPONSE

Each Trust should have a policy detailing the response to serious incidents. Medical managers are responsible to the Chief Executive for managing the process.

Following a serious incident, the Trust should immediately review the safety of patients and staff, the clinical systems, drugs and equipment employed, and any implications for the NHS at large. Every Trust is different and specific roles will differ. Communication between all involved must be a high priority to ensure that timely, effective action is taken.

Out of hours, depending on the nature of the incident, the on-call consultant and duty manager must be informed.

The role of the Clinical Director (CD)
Working with their manager, the CD is responsible for Trust patient safety in anaesthesia. The CD should make an assessment of the nature of the incident to determine whether the catastrophe could recur or put other patients or staff at risk.

Urgent actions:
- Secure the area or equipment until investigated.
- Identify and support all staff involved. The anaesthetist should be interviewed as soon as possible and, after discussion, a decision made regarding continuation of work.
- Keep a record of all actions.
- Check that the relatives have been contacted, and cared for. Contact the patient's GP.
- Ascertain if there is any evidence of an equipment or drug problem.
- Ascertain if there is any evidence of poor staff performance or system failure.
- If there is suspicion of a criminal act, the police need to be contacted.
- Contact the GP.

- Check that the Coroner (England and Wales) or Procurator Fiscal (Scotland) has been informed.
- Ensure that an incident form has been completed and the Trust governance team is involved. They will liaise with Health & Safety Executive (HSE), Medicines and Healthcare Products Regulatory Agency (MHRA), National Patient Safety Agency (NPSA) and other NHS organisations as necessary.

Follow up actions:

- Report findings to the Medical Director as soon as possible (within 24 hours). Discuss the incident, and decide plans for an initial investigation.
- Initiate support for the anaesthetist involved. Meet the anaesthetist along with another colleague who will be asked to mentor the individual to provide support. Regular meetings should be scheduled with the mentor. Depending on the nature of the incident, explain the next steps which will usually involve contact with the Medical Director and possibly the legal department. Keep notes of this meeting.
- After discussion, consider taking the anaesthetist off call or duty and arrange for a few days leave while the incident is investigated. The anaesthetist may need support on return by working with a colleague for a short time. Involve Occupational Health if illness is a possibility.
- Together with the appropriate manager ensure that the relevant theatre staff are supported, and have been debriefed.
- Arrange for statements to be made by all who were present during the incident using the Trust proforma. Statements should be descriptions of what happened rather than interpretations of events. Statements may be legally disclosable in the future, so accuracy and care is essential.

The role of the Medical Director (MD)

The MD will work with the CD to ensure that all appropriate steps have been taken following the incident. In consultation with the Chief Executive Officer, the MD will decide the nature of the inquiry

required for the incident. This is a rapid decision based on the available evidence, and may be an internal or external inquiry. The NPSA Incident Decision Tree is useful at this stage. Serious incidents will require a root cause analysis. The inquiry should be started within two weeks and report its findings within six weeks.
Most deaths or serious injury have a clinical explanation, and the likely underlying cause can be determined. The Coroner or Procurator Fiscal will determine whether an Inquest/Inquiry will be required.

The MD will take responsibility for organising contact with the media.

Outcome from the inquiry may result in a number of possible actions:

- Personnel issues may require Occupational Health review, possible disciplinary action including the GMC or retraining issues. The National Clinical Assessment Authority (NCAA) may need to be involved.
- Deaneries and the Royal College of Anaesthetists may become involved for trainees.
- Equipment report to the MHRA and HSE.
- Prevention of future incidents utilising a systems approach for risk management.

SECTION 6. HOW A CATASTROPHE MAY AFFECT YOU PERSONALLY

The following symptoms are 'common' feelings to have after a traumatic incident. It is also important for colleagues and family to recognise these symptoms and offer help.

Reliving the event
The impressions left by the event may be so strong that it is re-lived long after it actually happened. Flashbacks and daydreams are common, as is re-experiencing of the feelings that surfaced during or after the event. Sometimes you may suddenly start to feel as if the original event is about to happen again. *This can be alarming, but be assured that it is not unusual.*

Shock
It could be that you don't feel anything for a while; instead you feel numb, exhausted and cold and it can become difficult to do everyday things.

Restless and Wound-up
You may find it difficult to rest and concentrate. You may also have problems sleeping. You may become irritable and tearful.

Doom and Gloom
You may feel the world is no longer a safe place and that the future is no longer bright. You may feel vulnerable and disappointed with life.

Anger
Strong feelings of rage or anger about what has happened can occur. You may feel strongly towards those you feel had some responsibility for what happened, or just that nothing is fair.

Fear

You may become afraid of new things, or of being left alone; leaving your loved ones; or of just going out. Other fears centre on breaking down, losing control, having unbearably intense feelings or worry that the original event might happen again.

Guilt

Often people feel guilty and wonder whether more could have been done.

Relationships

Stresses and strains previously taken as being part of life can appear unbearable to someone who had been through a traumatic incident. A tendency to withdraw from close contact with relatives, friends and colleagues is often observed. This can lead to additional problems. Longer term relationship problems can get worse and you can feel that *'absolutely nobody understands what I am going through'.*

Physical Effects

Your body also reacts to the trauma, sometimes straight away and sometimes much later on. You may feel the following:-

- Tiredness. All traumatic incidents are demanding on the body and use up a lot of energy. This may continue after the incident is over. You may stay hyper-aroused for a long time and eventually become exhausted.
- Muscle Tension. Being wound-up for too long can be unpleasant. Stiffness and tension can lead to localised pains, headaches, dizziness, breathing and swallowing problems.
- Other effects. As the body works overtime, you can become aware of palpitations, hands shaking, or that you are sweating excessively. You may also get nausea, diarrhoea or menstrual problems.

You may experience some or all of these reactions only occasionally, or all the time. *It is important to remember they are all recognised and a natural consequence of the event,* and are a sign that you are coping with something that is very difficult for a person to deal with.

Typically reactions start to lessen within a week or so before fading away altogether over a longer period of time. If they do not, then it is important that *you should take the initiative and talk* to someone about your reactions to extreme stress.

Longer Term Reactions

Some feelings may not occur until later and you may not notice them until someone else points them out. *Try not to become defensive.* You may lose confidence in pursuing everyday activities and things that you once did without a second thought can become difficult for a time. You may become emotionally detached, feeling cut off from people to whom you are usually close, or become irritable and annoyed with them.

What you can do to help yourself

The most important thing is to avoid bottling up feelings you have about what happened, however shocked or surprised you may be. *Be careful - accidents happen more frequently after severe stress, especially in the home or on the road.*

- Cooperate with all investigations.
- Get support from a senior colleague or mentor and arrange regular meetings.
- Talk about the event with your colleagues and your relatives. Talk to others who are not directly involved with the situation (see Section 9).
- Try not to isolate yourself.
- Get colleagues to help with difficult cases and take up some of your duties.
- Don't smoke or drink too much or self-medicate. Consult your general practitioner.
- Give yourself time to recover.

When to ask for help

Sometimes events are too severe (or too personal) for reactions to improve with time. If this happens to you, you might want more help, particularly if:

- Memories, dreams and images of the traumatic event continue to intrude on your consciousness, making you feel frightened and deprived of rest.
- Your bodily sensations remain overwhelming.
- Your feelings are not giving you any peace.
- You remain exhausted, wound-up and feel 'burnt out'.
- Your work performance is affected.
- You have to keep active to avoid feeling upset.
- You have nightmares or sleep problems.
- You have nobody to openly share your feelings.
- You find yourself getting uncontrollably angry.
- You feel lonely and isolated.
- You feel or become accident prone and cannot concentrate.
- Your relationships suffer, or other people comment that you've changed.
- You find yourself relying on medication or alcohol.

If you experience any of the above, talk to a close colleague or mentor and get some help.

SECTION 7. CRITICAL INCIDENT STRESS DEBRIEFING (CISD)

Psychological debriefing is a set of procedures which includes Critical Incident Stress Debriefing (CISD) and on-going psychological counselling. These activities involve the giving of information aimed at preventing psychological morbidity and aiding recovery after a traumatic event. CISD was developed to reduce immediate distress and identify individuals likely to develop longer term psychological problems.

There has been some controversy on the efficacy of CISD.[13] It was originally developed to be carried out by trained facilitators in order to mitigate stress responses amongst emergency responders. Some research has questioned its efficacy[14,15] but these may have been based on groups that have not been managed by appropriately trained counsellors or on participants who have not been followed up with further psychological support.

Appropriately trained and experienced counsellors can advise on the structure and process of debriefing sessions.[16] Although CISD was originally designed to be carried out in large groups made up of all those affected by the trauma, there is growing evidence that it may be more effective initially to group participants by professional role or make trained counsellors available both on-site and off-site to suit individual preferences.[17] If large group sessions are thought to be advisable, these can be arranged at a later date.

Whatever CISD process is decided upon, Trusts must ensure that any affected member of staff has the opportunity to see a trained counsellor within the first 72 hours after the event.

Doctors are notoriously reluctant to seek professional help and some anaesthetists will continue to feel traumatised long after the event. Although Trusts have a duty of care towards staff, *each individual also*

has a responsibility to ensure they are fit to work. It is important for colleagues and mentors to recognise signs of stress and remind individuals of the psychological resources available to them.

SECTION 8. MEDICO-LEGAL ISSUES AND THE GMC

Any professional involved in a medical catastrophe in their practice should want to encourage and assist in an investigation into what, if anything, went wrong and why. While the prospect of medico-legal consequences will weigh heavily on the mind of any anaesthetist involved in a catastrophic outcome, it should be remembered that very few such cases actually result in a formal disciplinary hearing or action for compensation. Adherence to the guidelines in this document should mean that the concerns of all parties will be adequately addressed, which will minimise the bad feeling that sometimes drives relatives to seek legal redress.

The wheels of medico-legal processes turn slowly and memory can become very inaccurate as time passes. The best explanation for one's actions is a *comprehensive, contemporaneous and accurate record of events* (see Section 3); these should be stored in an appropriate location and may need to be kept for many years. Your defence organisation, mentor and department will be able to help you prepare for any medico-legal or disciplinary investigations.

Legal Representation

If the incident happened in your employing NHS Trust, then you are covered by your employer for civil litigation, i.e. negligence claims through the NHSLA (National Health Service Litigation Authority).[18] However, it is always advisable to also have legal cover via one of the medical defence organisations, who should be informed of any unexpected death of a patient in your care. Personal representation of this sort is particularly important if there is any possibility of disagreement or dispute between you and your Trust, if the incident involves a private patient (in which case you are not covered by your NHS employer) or if there is any possibility of criminal charges being brought against you.

Suspension

It is not unusual for a clinician involved in a major untoward incident to be asked to stop clinical work pending the investigation of an incident. Sometimes this is by agreement to alter or change duties, and on occasion it takes the form of suspension by the employer. Suspension is, at least officially, a neutral measure aimed at protecting the individual, the Trust and its patients while inquiries are conducted. The suspended clinician will be kept on full pay, although admitting privileges to local private hospitals are nowadays usually curtailed for the duration. The anaesthetist may well be barred from visiting the Trust, and will be strongly advised not to discuss the matter in question with the media. Suspension should nowadays be a short-term measure, only employed to allow the facts to be clarified and appropriate disciplinary procedures to be considered.

Possible sequence of events

- Internal inquiry
- Coroner's inquest (England and Wales) or Procurator Fiscal's (Scotland) Investigation
- Criminal prosecution
- GMC investigation
- Civil litigation

Internal Inquiry

It is very likely that an unexpected peri-operative death or serious injury will lead to an internal inquiry. This is a fact-finding exercise, usually conducted by a senior clinician (often the medical or clinical director) who will interview and take statements from everyone involved. If asked to attend for interview, it is advisable to inform your medical defence organisation who may offer to send one of their representatives to accompany you; in any event, it is a good idea to take a trusted colleague or mentor along.

Inquests

In England and Wales, suspicious or unexpected deaths have to be reported to the Coroner, who will then decide whether to hold an Inquest. Coroners have wide powers of discretion as to which cases they wish to investigate. If in any doubt, clinicians are strongly recommended to inform the Coroner's Officer. The system is different in Scotland where sudden or unexpected deaths are investigated by the Procurator Fiscal who has the authority to ask for the assistance of the police in his/her investigation and may call a Fatal Accident Enquiry.

Inquests often happen many months after the death, so *good record-keeping is essential.* The Inquest is an enquiry into the identity of the deceased and, more importantly, the cause of death: it is not supposed to be about allocation of blame or determining negligence. However, there is an increasing tendency for interested parties - particularly the family of the deceased - to instruct legal representatives who are able, at the Coroner's discretion, to indulge in a degree of cross-examination of the witnesses. If the Coroner is persuaded that there is a genuine wider public interest in the outcome, then he/she may even choose to empanel a jury, at which point the Inquest starts to become more like a traditional adversarial Law Court. The Trust will provide legal cover for these situations but, again, the concerned anaesthetist is strongly advised to consult his/her own defence organisation in plenty of time before the Inquest.

Criminal Prosecution

Any clinician would be very concerned at the thought of a police investigation following a catastrophic outcome. Previously very unusual, police involvement has become more common following recent high-profile events such as the Shipman Inquiry and disasters involving blocked anaesthetic tubing and intrathecal administration of vincristine.[20-22] If they feel that there are suspicious circumstances or, perhaps more likely, that one or more of the clinicians have been grossly negligent, the police may recommend to the Crown Prosecution Service that criminal proceedings should be pursued; occasionally, the Coroner's verdict may encourage such action.

The potential implications of a criminal prosecution cannot be overstated. Gross negligence, i.e. "reckless disregard for the welfare of the patient" attracts a charge of manslaughter which, if proven, will inevitably lead to erasure from the medical register and, often, imprisonment. Even if cleared of such a charge, the accompanying media publicity and stigma will often profoundly impact upon the clinician's professional and private life.

General Medical Council (GMC)

The GMC requires doctors in practice to take appropriate action if they are aware of concerns about another individual's ability to practice safely. This requirement extends to medical directors who may feel it appropriate or necessary to report an incident which might indicate a problem with a doctor's competence or performance. The GMC will let the individual know that they have received a complaint or comment about them and invite a response; once again it is vital to inform one's medical defence organisation as early as possible.

Following initial investigation, the GMC case examiners may decide that no further action is warranted, issue a formal warning or refer the case to the Fitness to Practice Panel for final adjudication.[23] The case examiners can also ask the Interim Orders Committee to consider temporary suspension from, or restrictions to, the doctor's practice while investigation is underway. Once again, if this does eventually proceed to a formal hearing, the time delay can be very significant and *the importance of good contemporaneous notes* is vital.

The NHS does not provide doctors with legal representation for GMC hearings. Membership of a medical defence organisation is strongly recommended.

Civil Litigation

A possible outcome of an unexpected peri-operative death or serious injury is a civil case for negligence being brought against the Trust (if NHS) or the individual practitioner (if private). This is a slow process, with prolonged preliminary stages designed to minimise the number of cases coming to Court, and the anaesthetist will often have little idea of what is happening after his/her initial involvement in supplying a witness statement. It is not unusual for civil cases to drag on for five years or more after the precipitating event. If it is a child who has suffered injury, the claim may not be made for many years.

There are a number of reasons why the NHSLA may decide that a civil suit should be settled out of court. It is often a frustrating experience for anaesthetists who are confident that they could defend their own actions in a public arena, but there may be other aspects of the case which cannot be defended. It may be worth making vigorous representations to the NHSLA if it seems that such an action will be contemplated, although decisions are often made on pragmatic grounds and rarely reversed. At the time of writing, the Central Legal Office, the Scottish equivalent of the NHSLA, appears to be taking a more aggressive stance in defending doctors who they feel have not been negligent.

Should you be called to give evidence, *it is essential to have good quality records* and to spend as much time as necessary rehearsing the facts of the case; it is very difficult to jog one's memory from a large bundle of case notes in the stressful environment of the witness box. It is advisable to go over the events of the case with a colleague and, if unfamiliar with the workings of the law, visit the court beforehand to get an idea of layout, behaviour and protocol. Try not to get flustered by cross-examination, answer politely, slowly and truthfully, addressing the Judge at all times, and do not be tempted into giving an expert opinion.

SECTION 9. SOURCES OF HELP

Consult your medical defence organisation in the first instance.

Support services within the NHS

Occupational Health Department

Every NHS Trust has an Occupational Health Department that provides advice on the effects of work on health and the effects of health on work. Each NHS Trust provides a confidential counselling service for staff. Arrangements vary between Trusts but it is often linked with the Occupational Health Department.

General Practitioner

All doctors should be registered with a local GP. If you feel that the stress of your job, or of any particular incident at work, is affecting your health, you should make an appointment to see your GP. GP practices often have access to counselling services.

Phone based resources

Doctors' SupportLine

0870 765 0001 www.doctorssupport.org

Confidential, anonymous telephone helpline for doctors with any concerns whether work related or not. Staffed by trained volunteer doctors. Open 36 hours / week

BMA Counselling Line

08459 200 169

Confidential counselling service for discussing personal, emotional and work-related problems. Available 24 hours / day; 365 days / year. For BMA members and their families only.

Samaritans

08457 909090 www.samaritans.org

Confidential emotional support for people who are experiencing feelings of despair, including those contemplating suicide. Available 24 hours / day; 365 days / year.

AAGBI Sick Doctor's Scheme
020 7631 1650
This service is currently under review. Please contact the AAGBI for information.

Web based resources
Support4Doctors
www.support4doctors.org
A website run by the Royal Medical Benevolent Fund that aims to put doctors and their families in touch with a range of organisations who can help. Covers areas such as: Work & Career; Money & Finance; Health & Well-Being; Family & Home.

BMA Doctors for Doctors
www.bma.org.uk then click on ***doctors health and wellbeing***.
A web-based resource pack intended as a self-help tool to aid doctors in accessing appropriate help for any difficulties in which they may find themselves. For BMA members.

BMJ Careers Discrimination Matching Scheme
www.bmjcareers.com/discrimination/
It provides the opportunity for doctors who feel that they have been discriminated against in some way, to receive informal support from another doctor. Communication is purely electronic.

Support Groups and similar resources
Doctors' Support Network
0870 321 0 642 www.dsn.org.uk
Confidential self-help support group for doctors with mental health problems.
Meetings around the UK; Newsletter; email support groups.

Sick Doctors Trust
0870 444 5163 www.sick-doctors-trust.co.uk
Undertake to provide early intervention and treatment for doctors suffering from addiction to alcohol or other drugs, thus protecting patients while offering hope, recovery and rehabilitation to affected colleagues and their families.

Suspended Doctors Group of the Society of Clinical Psychiatrists
01725 513367 (Dr Peter Tomalin)
Confidential support for any hospital doctor who has been suspended, including advice based on the experience of others. Also has a network of psychiatrists around the country to whom doctors can be referred if they are becoming unwell.

Financial Support
Royal Medical Benevolent Fund
020 8540 9194 www.rmbf.org
Provides support ranging from specialist information and advice to financial assistance.

Royal Medical Foundation
01372 821011
www.royalmedicalfoundation.org
Provides support to medical practitioners and/or their dependants who find themselves in financial hardship.

BMA Charities
020 7383 6334
Established to help all doctors (not just BMA members) and their dependants in times of need.

SECTION 10. REFERENCES AND FURTHER READING

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