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In harm's way

Redefining professional accountability for everyday healthcare

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The tide of emotion, controversy, and judgment surrounding paediatrician Hadiza Bawa-Garba¹ has now retreated, leaving behind deep uncertainties about the future handling of such situations.

Avoidable harm is at its most contentious when the focus is on accountability. Demand for accountability is fiercest when a patient dies after care has fallen below acceptable clinical or compassionate standards. Individual providers are often in the frame, but these debates rarely threaten the health systems that manufacture risk and harm as a byproduct of their work. Nor do the public or the media seem too horrified by the lamentable failure of the NHS to learn from the past; despite the heartfelt wishes of grieving families, too many patients are still dying in vain. The victims of harm can be ignored and denied access to the truth.

Classic patient safety incidents (sometimes called “medical errors.”) are well defined, well documented, and circumscribed within familiar aspects of care.² They include wrong site surgery, medication errors, failure to recognise and act on deterioration of an acutely ill patient, diagnostic error, misuse of machines delivering drugs or fluids, misplacement of tubes, and loss of test results. They happen across the world.

Root cause analyses and other forms of investigation invariably show that these events are caused by a combination of individual failings, systemic weaknesses, and environmental factors.³ The thinking that led to patient safety programmes within the NHS and in other countries at the beginning of the 21st century^{4,5} emphasised the importance of a systems approach to safety. This was reinforced by extensive research beyond healthcare on error, causation, and the role of human factors in avoidable incidents.^{6,7} Important parallels were drawn with other high risk industries that had improved their safety record.⁸ As a result, a patient safety doctrine of learning rather than judgment, thinking systemically, and operating with no blame became policy,⁹ though not always practice.

Other manifestations of avoidable harm in healthcare have not been so well thought through. This is especially true when an individual healthcare professional contributes to patient harm not in a single error-prone moment but through decisions made within multiple, interlocking, dysfunctional processes of care; in many ways this can be everyday healthcare.

The responsible components of healthcare systems and processes are more complex and difficult to define in these circumstances. Insiders do not always recognise systemic weaknesses for what they are and can become habituated to clear risks to patients. Investigations into such adverse events need a more consistent, expert approach so that systemic problems are identified and fixed, lessons learnt, and individual acts or omissions are considered in the full context of the complexity and reality of frontline care.

We cannot rely on heroism

The responsibilities of individual healthcare professionals for patient protection are still poorly defined for those working in services that are unsafe or within local cultures that could put patients at risk. The inquiry into the failures of the Bristol Royal Infirmary Children's heart surgery service¹⁰ concluded that senior health professionals should have broken ranks from a prevailing “club culture” and come to the rescue of highly vulnerable young patients. The insular and self-serving environments that led to avoidable deaths in the Mid-Staffordshire NHS Foundation Trust and the Morecambe Bay Hospital maternity services were also condemned in subsequent inquiries.^{11,12} Here too, the implication was that staff working for these providers should have drawn and held on tightly to patient safety red lines, even when their organisations had seemingly abandoned theirs.

Statements of professional duties¹³ that do point clinicians to red lines for non-collusion in poor standards of care attempt to resolve some of these problems, and while they may work for the kind of outlier health organisations that hit the headlines, they have less to offer clinicians at the routine frontline of care.

Medical regulations, legal frameworks, and most statutory inquiries have so far failed to understand the difficulties for conscientious health professionals of keeping patients safe in a flawed and overloaded system. The situation for junior staff is even worse because many are enmeshed in the entrenched hierarchies that still dominate modern healthcare. Leading patient safety expert James Reason points to the importance in other fields of “heroic” individuals with the exceptional personal qualities who intervene and avert harm when a hole in the system has blown open.¹⁴ This framework may suit exceptional events, such as landing an ailing jumbo jet on the Hudson river in the US,¹⁵ but exceptionalism cannot be a sound basis for patient safety strategies in routine healthcare.

For the sake of all patients, and the many healthcare professionals whose daily heroism is unsung, it is time to move towards collective accountability for patient harm and build robust safety systems that work for everyone. Each healthcare organisation in the country should be required to commission an annual expert risk assessment of the safety of their clinical services (including weekend and night time care), incorporating patient and staff insights, and publish the results.

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