DOCTORS’ THINKING ABOUT ‘THE SYSTEM’ AS A THREAT TO

PATIENT SAFETY

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Abstract

‘Systems thinking’ is an important feature of the emerging ‘patient safety’ agenda. As a key component of a ‘safety culture’, it encourages clinicians to look past individual error to recognise the latent factors that threaten safety. This paper investigates whether current medical thinking is commensurate with the idea of ‘systems thinking’ together with its implications for policy. The findings are based on qualitative semi-structured interviews with specialist physicians working within one NHS District General Hospital in the English Midlands. It is shown that, rather then favouring a ‘person-centred’ perspective, doctors readily identify ‘the system’ as a threat to patient safety. This is not necessarily a reflection of the prevailing safety discourse or knowledge of policy, but reflects a tacit understanding of how services are (dis)organised. This line of thinking serves to mitigate individual wrong-doing and protect professional credibility by encouraging doctors to accept and accommodate the shortcomings of the system, rather than participate in new forms of organisational learning.

Keywords:
Patient safety, medical culture, discursive regimes, systems thinking

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Introduction

‘Patient safety’ has emerged as a global health policy priority (World Health Organization, 2004). In the US it has been shown that as many as 98000 people die every year as a result of clinical error and mistake (Brennan and Leape, 1991). Like other health care systems, the National Health Service (NHS) of England and Wales is not immune to the risks and errors that threaten the safety of patient care. It has been estimated that one in ten hospital patients experience some form of clinical error and on an annual basis there could be as many as 850000 of these events, costing the health service over £2billion in additional care and claiming up to 40000 lives (Department of Health, 2000; Moore, 2000). The policy agenda currently being implemented across the NHS aims to enhance the safety of patient care through establishing a new logic and approach to organisational learning. Led by the newly created National Patient Safety Agency (NPSA), this involves the introduction of a service-wide National Reporting and Learning System (NRLS), which is designed to gather information about the threats to safety thereby enabling both local and national service leaders to identify the ‘root causes’ of danger and the opportunities for service improvement (NPSA, 2003).

What marks out the emerging ‘patient safety’ agenda from previous models of clinical risk management and quality improvement is a fundamental re-conceptualisation of what constitutes a threat to safety. Drawing from the theories of ergonomics and
social psychology, the Human Factors approach suggests that whilst human error is inevitable it is also conditioned, enabled and exacerbated by the wider environmental, socio-organisational and technical systems within which behaviour is located (Reason, 1997; Vincent et al, 1998). A distinction is made between ‘active errors’ at the sharp-end of clinical work, and the ‘latent factors’ that can negatively influence performance, such as, broken communications, poor team working, mismanagement of resources, technological complexity, or a lack of warning systems (Department of Health, 2000; Vincent and Reason, 1999). Through gathering information about the threats to safety and identifying the relevant ‘upstream’ latent factors the NRLS offers to deliver enhanced patient safety (NPSA, 2003)

Despite policies emphasising the role of latent or systemic factors, it has been suggested that the professionals, staff and culture of the NHS remain characterised by a ‘person-centred’ approach to safety that too readily focuses on individual responsibility and wrong-doing (Reason, 2000). This restricts organisational learning, not only because it neglects the latent factors that produce error, but more insidiously because it fosters a culture of blame where individuals are held responsible and often reprimanded for instances of patient harm. The blame culture has major implications for organisational learning because it discourages staff from being open about their mistakes and reporting information to organisational leaders because of the belief that they will be punished by colleagues or other disciplinary procedures. Although there are many known barriers to incident reporting, such as the lack of resources, time constraints, cultural taboos and collegiality, these cultural issues remaining some of the most illusive and difficult to change, especially for medical professionals (Lawton and Parker, 2002; Vincent et al., 1999; Waring, 2005a).
It has been argued therefore that a ‘systems approach’, which appreciates the latent factors that threaten safety, should be fostered within the NHS to counter the culture of blame and encourage incident reporting (Reason, 2000). This is couched within the wider objective of cultural change, where the creation of a ‘safety culture’ has been designated the first of ‘seven steps to patient safety’ (NPSA, 2003). Within the prevailing thinking of ‘safety science’ it has been shown how High Reliability Organisations (those organisations with good records of safety) are characterised by a strong ‘safety culture’ that underpins organisational learning and error management through shaping how employees make sense of safety, encouraging ‘mindfulness’ to dangerous situations, determining the relative importance of safety amongst other priorities and translating sense-making into communication and learning (Helmreich and Merritt, 1998; Weick, 1987, 2002; Reason, 1997). Accordingly the promotion of a ‘safety culture’ within health care, specifically ‘systems thinking’ is fundamental to the implementation of the ‘patient safety’ agenda in that it shapes how staff give meaning to safety in such a way to overcome the blame culture, and in doing so support organisational learning through encouraging staff participation in the NRLS (NPSA, 2003; Reason, 2000; Weick, 2002).

It is far from clear, however, how far the ideas and practices of the patient safety reforms, especially ‘system thinking’, have actually penetrated the work and culture of frontline clinical staff. There is little contemporary evidence about how health care professionals, specifically medical doctors, think about the threats to patient safety, what informs their thinking, and whether indeed doctors favour a ‘person-centred’ approach as opposed to a ‘systems approach’. A number of sociological studies have
revealed much about ‘what’ doctors see as the errors in their work, ‘how’ they come to hold these views, and what ‘consequences’ they have for professional regulation (Rosenthal, 1999). Significantly these show that perception, interpretation and understanding is formed within the lived experience and social fabric of clinical practice, shaped by the shared cultural norms, attitudes and beliefs into which members are socialised (Paget, 2004). The way in which doctors give meaning to error has been linked to the inherent uncertainty of medical knowledge (Fox, 1975; Rosenthal, 1995), the rituals of professional training and socialisation (Bosk, 1979), the collective strategies for normalising and rationalising wrong-doing (Mizrahi, 1984) and for reinforcing the exclusivity and credibility of medical knowledge and professionalisms (Freidson, 1975; Rosenthal, 1995).

The constructionist approach typically adopted by these studies highlights how shared culture(s) and knowledge(s) inform thinking about safety but also how these shared and patterned ways of thinking and communicating represent distinct, and sometimes competing discourses, which have significant implications for social order and control. For example, how one social group gives meaning to issues of safety has obvious ramifications for how safety is managed and this may be different from another social group. This constructionist perspective fundamentally questions the salience of proffered objective or universal taxonomies and definitions that are themselves the product of particular bodies of knowledge and cultural assumptions, including those ideas advanced by the Human Factors approach.

Importantly, much of the existing socio-cultural research pre-dates the current patient safety agenda by many years and potentially lacks contemporary relevance given the
broader changes witnessed in health care management, quality improvement and now patient safety. Following the major scandals and inquiries into health care safety, for example the Bristol Inquiry (Kennedy, 2001) and the Shipman Inquiry (Smith, 2005) and the subsequent emergence of the ‘patient safety’ agenda there is now much greater exposure to the type of ‘systems thinking’ advocated in policy. An additional issue with the existing studies is that they typically focus on how the socialisation processes and collegial norms of medicine serve to deal with the uncertainties of medical knowledge and protect professional status. There is therefore little contemporary evidence of whether medical thinking about the threats to patient safety actually portrays a ‘person-centred’ approach (Reason, 2000) or whether it resembles the type of ‘systems thinking’ promoted by the patient safety movement. As suggested by Rosenthal (1999) in her review of the existing sociological literature shortly before the emergence of the UK ‘patient safety’ agenda, if the medical profession is to find new ways of improving its safety then it may “have to reach outside its own ranks, to other experts, who have studied human error in other fields” (p152).

It is exactly this process of reaching out, or the extent to which other ideas have reached into medicine, that I want to consider in this paper. Specifically, the aim of the paper is to understand whether the idea of ‘systems thinking’, as promoted by the patient safety movement, is penetrating the culture and epistemology of frontline medical doctors. I elaborate this aim along three lines of enquiry, first, to what extent do doctors think about ‘the system’ as a threat to patient safety; second, where does this type of ‘systems thinking’ originate or on what is it based, with specific consideration for the influence of ‘systems thinking’ as promoted by the patient safety
movement; and third, to consider the implications of doctors’ thinking about ‘the system’ as a threat to patient safety for medical professionalism and the ongoing implementation of the ‘patient safety’ reforms, especially medical participation in incident reporting and the extent of cultural change. These questions have significant implications for the success of the NRLS, culture change and securing medical participation in incident reporting.

Methods

The findings were gathered from an ethnographic study of one hospital’s experiences of implementing the ‘patient safety’ reforms, undertaken between 2000 and 2003. The setting of the research was a single medium-sized NHS District General Hospital in the English Midlands, which was selected on the basis of its generality in regard to other acute NHS hospitals. This paper is primarily based on the findings of in-depth, face-to-face interviews carried out with 30 specialist (consultant grade) physicians. The participants were selected from two samples. Initially, five doctors were selected from the management level of the hospital based upon their leadership roles and responsibilities within the areas of clinical risk, regulation and safety; this included the Medical Director, the Director of Clinical Audit, the Clinical Manager of Infection Control, the Clinical Manager for Medical Devices and a clinical representative for Education and Research. A further 25 specialist doctors were sampled from five medical departments: acute medicine, anaesthesia, obstetrics, rehabilitation and surgery, including the Clinical Director for each department. The interviews lasted
between 40 minutes and two hours in length with an average of one hour and ten minutes.

Given the sensitive nature of the subject, i.e. medical error, and also the prevailing policy significance for the subject, ethical approval was sought from the organisation’s Research Governance Committee and Management Committee. Ethical issues were also addressed in writing with the hospital and the Medical Director to protect the anonymity and confidentiality of participants. Individual participants were informed of these ethical considerations and the confidential handling of data before acquiring their consent and participation.

The conversational-style, semi-structured interviews (Burgess, 1991) were guided by a thematic guide that addressed a number of topics in accordance with the wider objectives of the ethnographic study, including questions related to how doctors made sense and responded to the threats to patient safety experienced in their work, and to investigate whether this thinking was informed by and commensurate with the kind of ‘systems thinking’ promoted by the patient safety movement. The interview guide and approach was sufficiently flexible and open to enable participants to talk freely in their own language and terms, giving the doctors the opportunity to put forward and develop narrative accounts of their work, descriptions of what they saw as unsafe patient care and to elaborate explanatory models of how these events were brought about. All interviews were electronically recorded and transcribed verbatim before being imported into the computer package *Atlas ti* for the purposes of analysis. Analysis took place concurrently with data collection broadly following the principles of grounded theory (Charmaz, 2000) whereby emergent themes and concepts were
elaborated and clarified through subsequent research activities, and through the processes of coding and thematic categorisation the findings were comparatively analysed for their internal consistency and conceptual relationships to address the research objectives and aims of the paper.

It is important to consider the limitations of the study’s ambitions and design. Firstly, I do not intend this research to substantially develop or refute existing research in this area. The likes of Bosk (1979) and Rosenthal (1995) have thoroughly explored the professional socialisation processes that surround medical performance and error, although long before the current policy context. It is my intention therefore to empirically develop these findings within the current period of NHS reform. Secondly, I recognise that the sample size and also the selection of only one hospital may risk showing only the views of those working within one organisational setting and as such may not reflect the medical profession more generally. Whilst it is important to acknowledge this fact, it is also worthwhile recognising that the pre-existing works in this area provide a reference point on which to support analysis, whilst the case study methodology succeeds in providing depth and validity to the data. Moreover, additional work reported by the author has substantiated the wider themes identified within this paper.

The findings

Initially, it is worth briefly considering the general manner in which doctors talked about the threats to patient safety. A common finding related to the apparent difficulty and complexity with which doctors articulated those aspects of their work associated
with notions of error, risk and patient harm. This may be indicative of the sensitivity of the subject matter, especially the associations with error and wrong-doing, and also the difficulty for frontline staff to explain factors beyond their immediate work setting. Moreover, the data often revealed multiple, divergent and sometimes contradictory lines of reasoning for why patient safety could be compromised, whilst relatively small sections of dialogue would raise a number of significant themes associated with how doctors make sense of the threats to patient safety in their work, including assumptions about causality, attitudes towards responsibility and blame, the meaning of professionalism, the role of management, the bureaucratized nature of health service, and the preferred models of quality improvement. For example, the assertion by one participant that “well, that’s not my fault it’s a system error” (Participant 23) reveals important findings about causality and the distinction between individual and system responsibility, it also highlights some appreciation for systems thinking, whilst indicating a particular perspective about the wider culture of blame and fault-finding within the NHS. These narratives and themes revealed much about how doctors gave meaning to the threats to patient safety, but in line with the aims of this paper, I asked three interrelated questions of the data: first, to what extent do doctors think about ‘the system’ as a threat to patient safety; second, where does this type of ‘systems thinking’ originate or on what is it based, with specific consideration for the influence of ‘systems thinking’ as promoted by the patient safety movement; and finally what are the implications of systems thinking for the profession and the implementation of policy.

Do doctors think about the ‘system’ as a threat to patient safety?
A major finding from the interviews related to the way in which doctors would attempt to explain and account for the threats to patient safety experienced in their work. In the early exchanges of each interview the participants would typically talk about the threats located within the distinct stages of medical involvement in patient care, often using terms related to diagnosis or decision-making before moving on to consider treatment or intervention, such as, prescribing drugs or surgical technique. This would often involve a description of the uncertainty and difficulties of making a diagnosis or providing a treatment, highlighting the inherent uncertainty of medical practice (Paget, 2004; Rosenthal, 1995). Here the detailed language, jargon and explanations offered by doctors appeared highly individualistic and ‘technical’, resembling classifications and taxonomies proposed by other researchers (Tamuz, et al. 2004). My first impression of the data was that doctors did indeed follow, to some extent, a ‘person centred’ approach. However, what often followed was the attempt by participants to further explore the reasons why patient safety could be compromised and threatened by looking both inwards, towards the limits of medical knowledge and ability, and also outwards, to the wider context within which care is delivered. Through following this line of reasoning it appeared that this line of medical thinking was characterised by a ‘search for causality’, which eventually led participants to move beyond narrow technical descriptions to seek out wider systemic factors. This illustrated a significant shift in medical thinking about the threats to patient safety and it was at this stage that the ‘system’ began to feature as a prominent cause of individual error and, more generally, as a threat to patient safety.

“I think that you can work it from the bottom upward and almost all adverse incidents are related to failures at multiple levels.” (Participant 19)
“[There] are people not thinking what they do and making a mistake. There are machine and equipment failures and things do go wrong. And then I suppose there are ones where it’s a sort of system failure and maybe several things have happened all at the same time.” (Participant 5)

When talking about the ‘system’ doctors seemed to describe its character in two ways. The first was as an impersonal structural force that framed or structured care provision, such as staff shortages, resource limitations or winter pressures. The second related to the activities of individuals or groups, often face-less and name-less, working elsewhere within the hospital who somehow undermined the desired or expected level of clinical care, for example, patient notes had been lost, test results were not delivered on time, resources were not made available by managers. In the first instances doctors seem to unable to locate the exact causal factors, often referring instead to the ubiquitous, endemic and structural “pressures” of the NHS, whilst in the second instance doctors would identify a specific organisational role, function or duty with the wider organisation of care that had not been appropriately fulfilled or completed. Bringing these two themes together, the way in which doctors made sense and used terms such as ‘the system’ typically relate to the wider organisation and management of services at locations and levels removed from front-line clinical practice.

“You must know the NHS [laughter]… there are so many things that go wrong, patient notes going missing, test results delayed, beds not available, my God it rarely work like I think maybe it should.” (Participant 16)
“There are many things that make it difficult for us to provide the service that we want to and a lot of the time it comes down to the management of the system.” (Participant 24)

What participants understood as ‘the system’, together with its influence on patient care, was typically expressed with reference to the specialist areas of medical practice; where, for example, surgeons and anaesthetists highlighted the organisational problems of the operating department, and physicians working in acute medicine talked about the pressures of ward staff or bed availability.

“Of course quite often these aren’t technical type errors, they are system, organisational errors…patient brought in too late, not properly assessed, brought down to theatre without being fully prepared.” (Participant 19: Anaesthetist)

“In the middle of winter and a flu epidemic, we are still going to get patients admitted with respiratory disorders sent to wards that are completely unsuitable… every time there is a ward move there is a communication problem or could be, everybody does their best but it can lead to all sorts of delays and it can lead to mistakes eventually.” (Participant 20: Gerontologists)

The impact of ‘the system’ on patient care was also articulated in two ways. The first was as a contextual and indirect influence that made the delivery and management of care sub-optimal in general, for example a lack of available beds or equipment, which
did not directly impinge upon medical performance and technical competence, but framed the wider environment for care provision experienced by many groups of staff. The second, and perhaps a more profound influence, was what doctors saw as the direct impact upon medical practice, where ‘the system’ compromised the quality and efficacy of medical decision-making or treatment, typically by requiring doctors to deviate from their normal routines, work sub-optimal conditions or through providing distractions or pressure. In this case ‘the system’ primarily threatened the safety of medical work but in doing so threatened the patient’s well-being.

“There are many pressures on what we do because of the way the service is organised and financed…these make it difficult for us to work to our best and sometimes it leads to patient harm.” (Participant 8)

“Human error is always going to occur and it depends on how much pressure people are under, whether they have got time to make considered judgements or whether they are having to work so fast that they are having to make snap decisions which inevitably some of them go wrong. So again I would look at the system.” (Participant 15)

Thinking about ‘the system’ was clearly something that doctors did readily stemming from a shared desire to identify ‘why’ safety could be compromised through explaining, in a backwards ‘step-wise’ fashion, the underlying causal relationship. This represents an ‘attributional process’ that seeks to locate or re-locate the sources of danger away from individual practice. I later develop this interpretation to suggest that this process helps to mitigate individual responsibility, providing a discursive
resource to legitimise professional competence. This ‘cause and effect’ understanding is not dissimilar from the practice of ‘root cause analysis’ promoted in policy (NPSA, 2003) and on face value resembles the type of ‘system thinking’ promoted by the patient safety movement (Department of Health, 2000; Reason, 2000). Questions still remain, however, about the source of this type of thinking and whether it is shaped by current policies and reforms.

Where does this ‘system thinking’ come from?

Four common and shared discursively influences appeared to shape medical thinking about ‘the system’ as a threat to patient safety. First, the prevailing principles of ‘patient safety’, as articulated in national policy; second, other media sources, such as professional journals, research reports and television programmes; thirdly, formal audits and reviews carried out within the hospital; and finally, knowledge and insight acquired through working in the NHS over a number of years.

Only a small group of participants appeared to have a detailed understanding of the national ‘patient safety’ agenda and, significantly these all held medical-managerial responsibilities within the organisation, as either Clinical Directors in the medical departments or as medical representatives within hospital management, such as the Medical Director. In occupying these leadership and representational positions these individuals appeared to have greater exposure to policy, as policy guidelines and edicts were disseminated across the health service. Exposure to this information certainly seemed to be informing and shaping how these medical-managers talked about ‘the system’, with a many making direct reference to An Organisation with a
Memory (Department of Health 2000), referring to it by the acronym “OWAM”, and using the language of policy, such as the ‘Swiss Cheese model’ and ‘root cause analysis’. In general, these participants regarded the patient safety agenda positively and were encouraged by new attempts at organisational learning.

“Root cause analysis is standard stuff in industry and other places, you know we shouldn’t be reinventing the wheel just for the NHS” (Participant 11: Medical Director)

“Maybe several things have happened, each one pretty small but they just happen to happen all at the same time and contributed to something more important, which is the Swiss Cheese theory and that sort of thing.”

(Participant 5: Director of Clinical Audit)

This is not to say that those participants without medical-managerial responsibilities were oblivious to the ‘patient safety’ agenda but for these other doctors their understanding of policy and ‘systems thinking’ was typically informed by other sources, such as professional publications, television documentaries or high-profile media ‘scandals’. In many cases these other influences corresponded with, endorsed or provided commentaries to the new policy agenda, for example the Channel Four documentary Why Doctors make Mistakes (Moore, 2000) and the special themed edition of the British Medical Journal titled “Reducing error: improving safety” (March 2000). These did much to reinforce and legitimise the type of reasoning followed by doctors, especially the ‘search for causality’,

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“Yes individual errors do occur there is no doubt about that and research has shown and popular television programmes about medical errors have shown that it is usually a systems error.” (Participant 7)

“I have that issue of the BMJ with the aeroplane on the front, and I have been telling my colleagues about it and lending it out.” (Participant 14)

Another influence on medical thinking about the threats to patient safety was information produced by internal reviews and investigations, such as Confidential Enquiries, Clinical Audit and the Morbidity and Mortality Committees. It was suggested by most participants that through participating in these collegial activities they had come to appreciate how the wider context of care can have a negative influence patient safety and medical practice. As such participation in these processes seemed to crystallise and substantiate a shared understanding of those factors that threaten both the quality of medical practice and patient safety. There was, however, little indication that these procedures were informed by or promoted current policies, but rather reflected the collegial and regulatory customs of medicine (Freidson, 1975; Rosenthal, 1995).

“We audit our service and this has picked up some consistent problems that, when we have analysed them, we have found to be problems with how the service is managed not really clinical practice” (Participant 5)
“When we note that something is not right, somebody is asked to audit that straight away…[it] is a very well oiled system and a very tight system when things go wrong we just go and do things very quickly.” (Participant 24)

Perhaps the most powerful, embedded and deeply felt influence on medical thinking, however, came from years of working within the NHS. This represented a tacit or ‘taken for granted’ (Polanyi, 1966) understanding of how the organisation of services can undermine the quality of medical care. It was often difficult for participants to explicitly articulate how they knew about ‘the system’ and to explain what evidence they had of its causal powers, yet it was apparent in the way doctors talked about their work, their hospital and the NHS in general that they shared an understanding of how services could be dis-organised. This implicit and tacit knowledge can be seen in many of the quotations presented above where participants talked, almost as a matter of fact and with some humour, about the organisational pressures on their work.

“I don’t know…I guess you just know…after spending 15 years working here I’ve got to know how the place works and sometimes doesn’t.” (Participant 16)

It can be speculated that this knowledge is acquired and tacitly held through first hand clinical experience. Through the processes of medical training, specialisation and daily practice doctors not only learn and develop invaluable technical knowledge and expertise, but also implicit and ‘taken for granted’ knowledge of the many influences and pressures found in clinical practice, from the demands of teamwork to resource limitations. Furthermore, it can be argued that the more experienced and socialised a
doctor becomes within the organisation of health care, the more these pressures are perhaps accepted, taken for granted and implicit understood as ‘par for the course’ as they learn to work within ‘the system’. Later I develop this interpretation to suggest that this tacit understanding and learning to work with the system has wider implications for medical professionalism.

Although a number of participants were clearly aware of the national policy agenda and were appreciative of the Human Factors approach, ‘root cause analysis’ and ‘systems thinking’, for the majority of doctors it was the tacit or taken for granted understanding of service organisation, resource limitations, (mis-) management or the competing priorities of national policy that seemed to have the most pervasive influence on medical thinking about ‘the system’ as a threat to patient safety. Although difficult to articulate and express, this further illustrates its deep cultural and discursive significance to medical practice and thinking. Importantly, this knowledge is acquired through years of first hand experience (Paget, 2004) and was embedded within medical thinking long before the current policy context and promotion of ‘root cause analysis’. As such it can be surmised that whilst doctors’ thinking about the threats to patient safety is indeed indicative of ‘system thinking’ it is not informed by the prevailing ideas promoted by the patient safety movement.

*The implications of ‘systems thinking’*

My next concern was to understand the implications of the doctors’ type of ‘systems thinking’, as opposed to the policy approach, for both medical professionalism and the ongoing implementation of the patient safety reforms. Like those sociological works discussed above I conceive medical thinking as a shared and communicated way of
perceiving, interpreting and responding to safety concerns that is forged from within medical culture and knowledge, having important consequences for maintaining professional status whilst also impinging upon the success of reform.

The professional implications build on Mizrahi’s (1984) concept of ‘discounting’ where he shows how trainee doctors blame other factors for error, including the system, in an effort to mitigate or ‘discount’ responsibility. Elaborating this idea, I found that doctors identify ‘the system’ as a threat to safety through making an interpretative causal link between ‘the system’, ‘individual practice’ and ‘patient safety’. This can be seen in my earlier discussion of the doctors’ ‘search for causality’ where, for example, one participant suggested that “you can work it from the bottom upward and almost all adverse incidents are related to failures at multiple levels” (Participant 19) or similarly where another talked about the impact of ‘winter pressures’. It can be argued that this way of thinking serves to relocate the source of danger or “failure” to other “pressures” thereby deflecting questions of professional competence and protecting against criticism, self-doubt and a loss of credibility. As one surgeon stated when describing an example of unsafe care, “well, that’s not my fault, it’s a system error” (Participant 23). Systems thinking can therefore be invoked to protect against professional blame and responsibility when patient care is threatened or substandard.

“We all make mistakes, there but for the Grace of God…but a lot the problems are not down to what we do, they are the result of other things going on with the organisation” (Participant 27)
However, this type of ‘systems thinking’ could be seen as too easily removing professional accountability. The safety management literature highlights the problem of ‘learned helplessness’, whereby an excessive focus on latent factors leads to the individual being seen as a passive victim with little responsibility, even when there may be an issue of individual responsibility or complicity. As such the prevailing logic of policy demands analysis of the interaction between the active and latent factors, and could inadvertently question the ethos of a ‘no blame culture’ endorsing instead a ‘low blame’ or a ‘just blame’ culture (NPSA 2003). However, the doctors’ thinking about the threats to patient safety seemed to reflect more than just a desire to shift blame, revealing something more significant about the nature of medical socialisation. As indicated above, through the experiences of care provision doctors seem to acquire a tacit understanding of, what were often termed, the “pressures” of ‘the system’. An anticipated implication for medical professionalism is that it is expected that newcomers to the service must rapidly learn to appreciate and work with these factors in order to provide patient care, in other words learning to cope with the systems and still provide clinical care.

“These problems arise day-in, day-out, I suppose what is important is learning how to cope with them.” (Participant 8)

“…members of the firm need to realise how we work and how the service is organised…the house officers are on a steep learning curve and a part [of that] being gaining through clinical experience but also getting to grips with the service” (Participant 16)
Rather than ‘learned helplessness’ it could be argued, therefore, that a feature of medical socialisation and culture could be termed ‘learned tolerance’. This sense of coping and tolerance was further illustrated in the way doctors would respond to the threats to patient safety. The interviews revealed that the doctors placed primary importance on dealing with the immediate clinical danger, for example, blood loss or a miscalculation of dose, which would normally involve some instant technical intervention. Despite recognising that in many cases such dangers were brought about by other factors, such as poor communication or time pressures, there was little indication that the participants would at some later time seek to make broader or more systemic changes.

“We never seem to have enough laryngeal masks of the right size… obviously you do the best you can…get one from another theatre, try and make do with some thing that is slightly out, otherwise the patient can’t be intubated and anaesthetised” (Participant 20)

“Obviously the important issue is to treat the patient as best you can, I can’t make changes to the way the hospital runs…I might have a word with our Clinical Director and raise it in a meeting. I once wrote a letter to the Medical Director, but that did nothing” (Participant 15)

The emphasis therefore appeared to be on accommodating, coping and tolerating with the threats presented by ‘the system’ in order to deliver effective and safe patient care. This has further implication for the implementation and success of the patient safety reforms, especially incident reporting. Given that doctors appeared to tolerate
the systemic threats, whilst focussing their efforts on the immediate remedial intervention, there appeared to be little recognition of the role played by incident reporting. Specifically, it was argued that there was little relevance in incident reporting because the threats presented by the system were almost inevitable, and emphasis was placed on learning to cope, rather than changing the system.

“What good does [reporting] do? It’s not like it could ever make us error-free”

(Participant 5)

“These problems are so ingrained in how the service is organised…there have been a number of attempts to sort them out, and incident reporting is the new one, but it will never really be able to deal with the underlying problems”

It could be argued therefore that whilst doctors’ thinking about the threats to patient safety certainly illustrates a form of ‘systems thinking’, when responding to these threats the doctors maintained a narrow, technical or ‘person-centred’ perspective. These may be a consequence of medical training whereby learning to work with or cope with the system is a feature of medical socialisation; it may also indicate the over-riding importance of treating the presenting (current) patient effectively and safely rather than seeking to modify the wider management of services, which perhaps reveals a division of responsibility between service managers and service providers; or alternatively it may suggest that past efforts to improve the organisation of service have been unsuccessful thereby discouraging participation in the NRLS.
When considered alongside accounts of the closed, collegial and exclusive domains of professional regulation (Kennedy, 2001; Rosenthal, 1995), the capacity to ‘discount’ individual error by invoking ‘the system’, together with the doctors’ tendency to work with and tolerate ‘the system’ and the apparent lack of support for incident reporting (see also Vincent et al, 1999; Waring 2005a) leads to the possibility that some threats to safety, whether individual or systemic in nature, may consistently escape scrutiny. This also raises serious questions about the extent to which cultural change and the creation of a ‘safety culture’ is being made (NPSA, 2003), given that despite openly acknowledging the causal role played by ‘the system’, doctors maintain an individualised and ‘person-centred’ approach for responding to these threats.

Although medical thinking about ‘the system’ clearly resembles the ideas promoted by the patient safety movement, it is important to consider that they represent divergent discourses, which have different preferences for the control or management of safety. Nevertheless, the clear willingness of doctors to think in terms of ‘the system’ is promising for policy and suggests that the need to instil a completely new way of thinking may be unnecessary. The future of ‘patient safety’ may be enhanced through better articulating the similarities between medical thinking and the principles of policy, showing that it is not necessarily something radical, managerial or non-medical; bringing to the two discourse of safety together around common themes and objectives. This may involve persuading doctors to be ‘mindful’ (Reason, 1997) of the threats to patient safety. This may require a language that is less managerial in style and more grounded in the real experiences of patient care. This is not to say, however, that advances made in this area will necessarily overcome the barriers to incident reporting that exist in other areas of medical practice and culture.
Conclusions

It has been said that the health service is too often characterised by a ‘person-centred’ approach to safety that fosters a ‘blame culture’ amongst professionals and inhibits organisational learning (Department of Health, 2000; Reason, 2000). The creation of a ‘safety culture’ is therefore central to the success of the patient safety movement, with ‘systems thinking’ being promoted to encourage ‘mind fullness’, counter the fear of blame, further the virtues of openness and learning, and encourage staff participation in the NRLS. In this paper I have been concerned to appreciate whether the idea of ‘systems thinking’ as promoted by policy has penetrated medical culture and doctors’ thinking about the threats to patient safety. Referring back to Rosenthal’s (1999) suggestion, this paper has sought to appreciate if medicine is reaching out or being reached by experts in other fields to change its way of thinking.

Although much has been written about how doctors make sense of mistakes, this work pre-dates the current patient safety agenda. Building on these studies, my findings indicate that contemporary medical thinking is characterised by a ‘search for causality’ that commonly identifies ‘the system’ as an underlying threat to patient safety. This questions the alleged prevalence of a ‘person-centred’ approach, and suggests that medical thinking outwardly resembles the type of ‘systems thinking’ advocated in policy. Doctors’ thinking about ‘the system’ as a threat to patient safety is not, however, strongly informed by policy, being instead acquired through the first-hand experience of working within the health service, whereby doctors come to
implicitly appreciate the pressures and limitations inherent with the organisation of the NHS. Ultimately, medical thinking is not commensurate with the discourse of safety advocated in health policy, representing instead a distinct social discourse that competes to define and control the threats to patient safety. Significantly, it can be seen as constituting a resource for rationalising or mitigating issues of individual wrongdoing (Mizrahi, 1984), whilst the main implication for policy relates to the doctors’ engagement with the NRLS, with doctors appearing to accommodate and work-with the threats presented by the system, rather than participating in incident reporting. This questions the extent to which cultural change within the NHS is being made as medical thinking and behaviour remains distinct from the ambitions of policy, with doctors’ thinking remaining strongly influenced by the socialisation processes and longstanding culture of medicine (Bosk, 1979; Rosenthal, 1995). In conclusions, it seems therefore that doctors are neither reaching out to nor being reached by the experts from other fields and the idea of systems thinking as promoted by the patient safety movement is not significantly penetrating frontline medical staff.

References


