

Preventing Avoidable Harm and Promoting Patient safety: the Doctors' Dilemma

Sukhmeet S. Panesar ¹ and Rajan Madhok ²

¹ NIHR Academic Clinical Fellow in Public Health, Imperial College London, UK

² Formerly Medical Director, NHS Manchester, UK; GMC Council Member, UK; and Adjunct Professor, INCLIN, India

rajan.madhok@btinternet.com

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In the last decade has seen considerable interest in patient safety globally, and specifically in the NHS in England.

The landmark report in 1999 – To Err is Human ¹ portrayed medical error as key public health challenge given that health care itself was the eighth leading cause of death; and this was followed soon after by two other seminal reports– Crossing the Quality Chasm ² and Organisation with a Memory ³ which provided roadmaps for addressing the problems and how to minimise avoidable harm. As a result of concerted efforts since then considerable progress has been made in understanding the frequency of patient safety incidents, how these vary by care settings, the reasons underpinning the failures of care and most importantly in the development of interventions aiming to enhance the safety of care.

Despite these developments over the last decade however, significant concerns remain about the effectiveness of the approaches to minimise avoidable harm and promote patient safety in the light of continuing high profile failures, the most notable being the Mid Staffordshire Hospital incident recently. This begs two questions: why are patients still suffering avoidable harm including deaths? And are we paying lip-service to the zeitgeist of patient-centeredness and safer care? The evidence provided by witnesses at the Francis Inquiry into failings at Mid- Staffordshire NHS Foundation Trust provide a chilling and compelling account of disinterest in high-quality patient care – “...one of the junior doctors told me that I needed to get my mum out of there as if she stayed in the Hospital much longer, we were going to lose her....he said that he was sorry about the way she had been treated...” ⁴

It will be interesting to see what the final report of the Inquiry, when it does get published, will have to say about not just Mid Staffs but also about the way in which the NHS has dealt with the issue of patient safety. Rather than indulge in speculation about the content of the final report, we would argue that the fundamental solution ultimately will lie with the clinicians; policymakers,

fundes, commissioners and providers can only help (or hinder, sadly) but unless the clinicians actively engage with the agenda by providing leadership and adopting best practice, we will remain in this quagmire. This is, however, easier said than done. The last few years have seen increasing erosion of 'power' and 'authority' away from the doctors and in any case the culture of the NHS, which still embodies the 'who did it' rather than 'why did it happen' spirit does not give confidence to the clinicians that when they raise concerns that they will be taken seriously. Those who muster the courage to whistle blow and alert others to situations of unsafe care are penalised; the 6th Report of the House of Commons Health Select Committee stated that 'The NHS remains largely unsupportive of whistle blowing, with many staff fearful about the consequences of going outside official channels to bring unsafe care to light.'⁵

How can we ensure that patient safety is in the DNA of the organisation when the mechanisms to promote this are fraught with danger; doctors who have cited poor unsafe care which has resulted in avoidable mortality have been prevented from returning to work.⁶ The NHS is not a learning organisation despite its rhetoric.

Doctors therefore face a dilemma: on the one hand, all good (which is the majority) doctors recognise the need to minimise avoidable harm and are taking appropriate actions, and on the other hand, there are considerable barriers in their way. However, doing nothing is not an option. Our patients deserve better and for the sake of our professional pride we must rise to the challenge. In any case, leadership is not about criticising or becoming disengaged, rather it is about making progress in the face of adversity. The recent NHS reforms do provide some opportunities. Commissioning will be a key driving force for the provision of high quality health services and one way of ensuring this will be to inter-twine hard measures of safety into the fabric of the commissioning process. Measures such as complication rates, complaints, compliments, readmission rates, outcomes, mortality and morbidity data along with procedure specific data and patient experience questionnaires should be up for scrutiny in the commissioning process⁷. Quality improvement measures such as clinical dashboards⁸, specialty scorecards⁹ and system ratings¹⁰ are all important tools that need to be disseminated wider in daily practice.

The introduction of revalidation for doctors offers another way to force the pace – proper revalidation cannot be delivered out with the overall clinical governance context. Of necessity organisations will have to ensure appropriate systems and procedures to enable doctors to revalidate.

The next few years will be testing times for all in the UK as the economic pressure continues and as the NHS changes start to embed. Indian doctors in the NHS can be a powerful resource for the good during these times, not just because of the large numbers but also because of their strong commitment to the NHS. We hope that BAPIO with its mission of promoting professional excellence will support them in their quest to minimise avoidable harm and promote patient safety everywhere.¹¹

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