To Blame or Not To Blame

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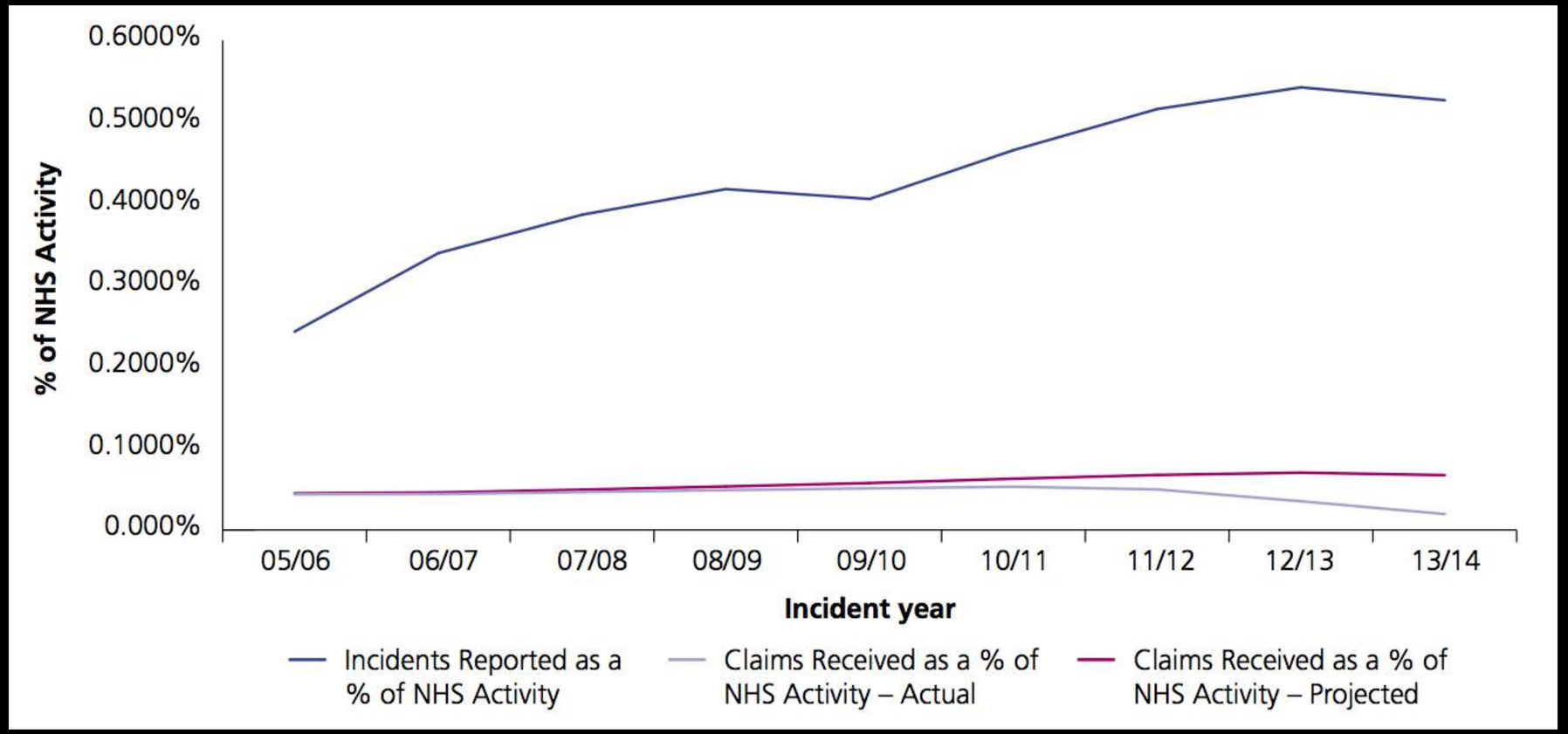
adverse event **serious incident (SI)** critical incident



serious incidents reported in ≈ **0.5% of NHS activity**

negligence claims made in ≈ **0.05% of NHS activity**

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Does our current system of medical litigation:

- adequately compensate victims of medical error
- help or hinder improvements in safety
- or are there better ways?

Is the NHS

- capable of learning from adverse events
- spreading that learning for prevention
- able to sustain safe practice?

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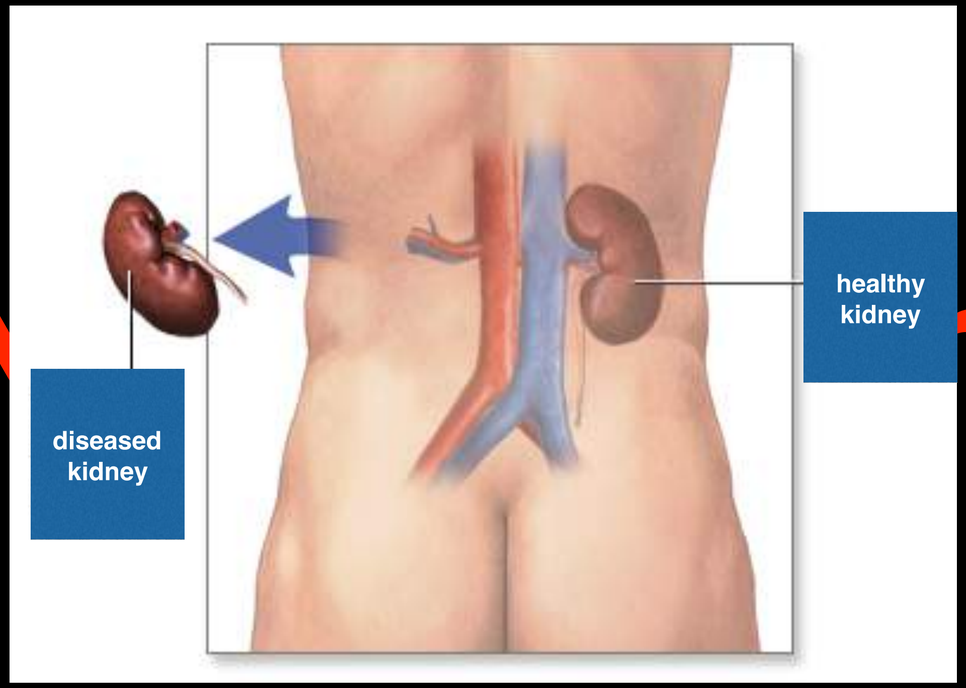

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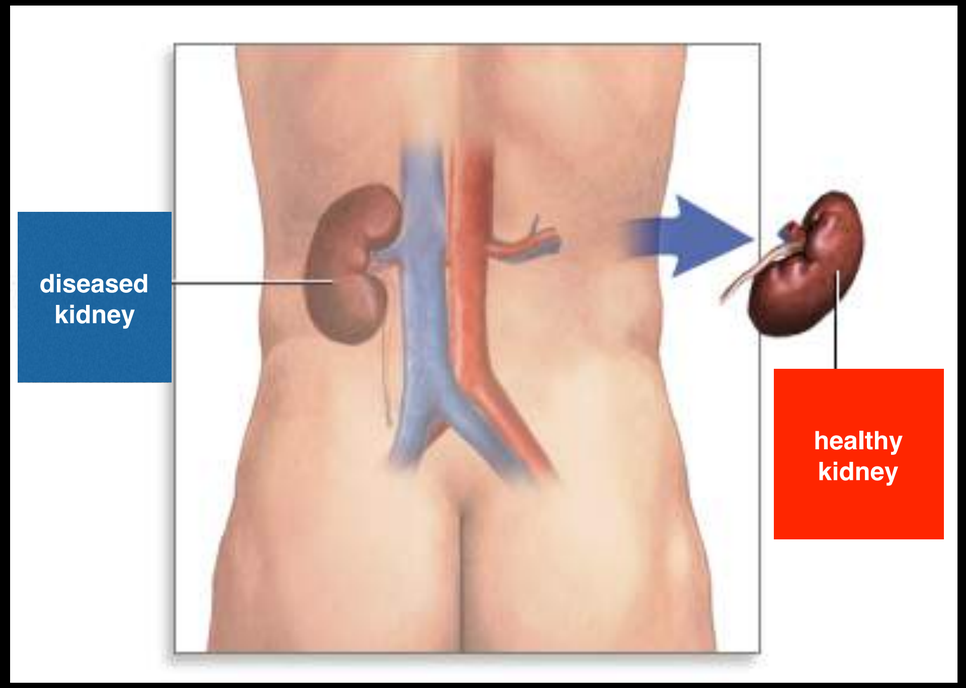

Oops

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compensation.... it wasn't your fault

investigation..... what really happened

learning..... it mustn't happen again, anywhere

support..... for everyone involved

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Duties

The duty of CARE

The duty of CANDOUR

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The Duty of Candour

long-standing ***ethical duty*** of doctors

after the Francis Report (2013)
a ***legal obligation*** for doctors AND organisations

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Why?

what was wrong at mid-Staffordshire

- a repressive, opaque leadership culture and a lack of transparency throughout the organisation
- a failure to respond to outside pressure
- marginalisation of clinical staff and those who raised issues or complained
- dominance of finance over quality and safety
- poor safety monitoring and failure to deal with early warning signs
- tendency to blame the ‘shop-floor’ workers, despite them raising issues

Sadler BL, Stewart K. Leading in a Crisis: the power of transparency. London, 2015

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“Whilst there had been a perception that the hospital’s staff had been silent, it transpired that the organisation had been deaf”

Vincent C, Burnett S, Carthey J. The measuring and monitoring of safety. London, 2013.

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empathy, explanation and an apology may not be enough

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Serious Incidents

- **Acts or Omissions occurring under NHS care that result in:**
  - unexpected or avoidable **death** (including suicide and homicide)
  - unexpected or avoidable **injury causing severe harm**
  - actual or alleged **abuse** (sexual, physical or psychological)
- **A Never Event**
- **An incident that threatens continuity of service provision**

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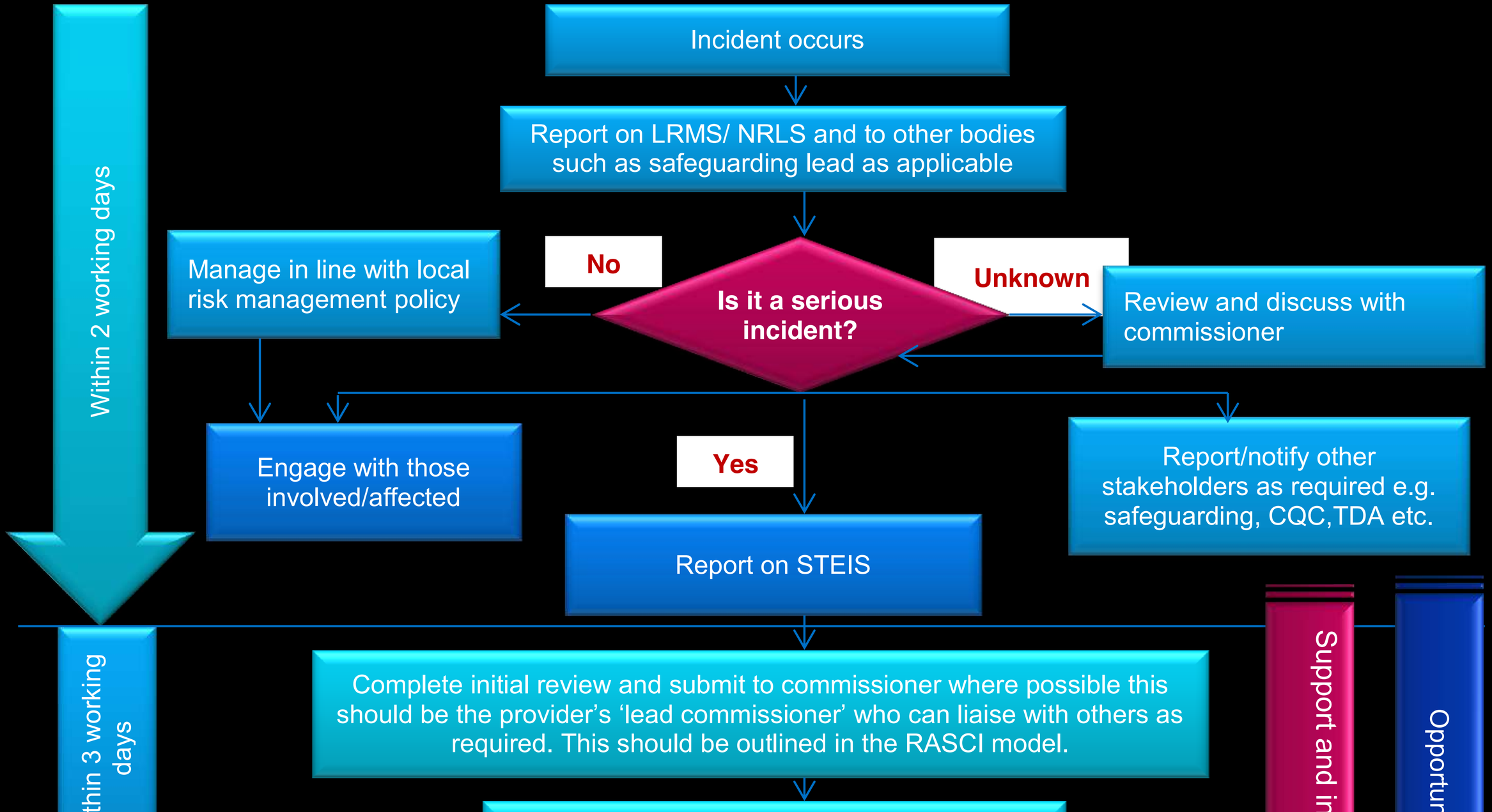
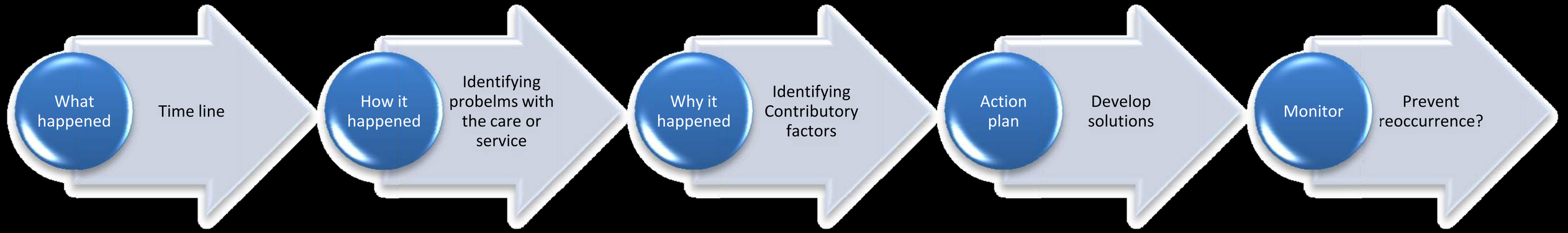
1. Overview of the Serious Incident Management Process



Basic Steps of Root Cause Analysis



The 5 Why's

Fishbone Analyses

http://www.nrls.npsa.nhs.uk/resources/collections/root- cause-analysis/ .

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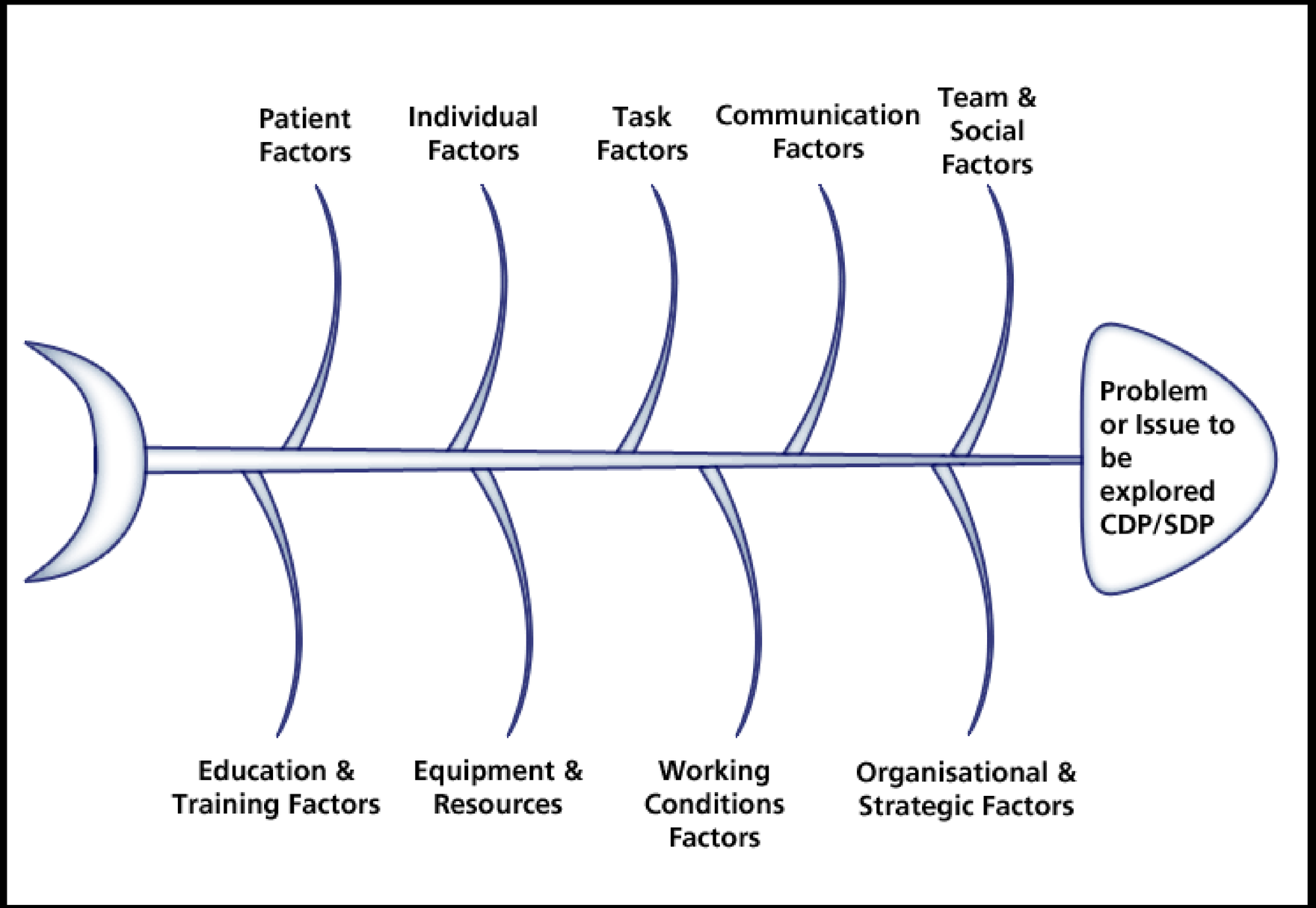

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60 Days

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anxiety

fear

blame

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blame culture

a culture that
names, shames and blames
those who make errors

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The Media Seek to Blame

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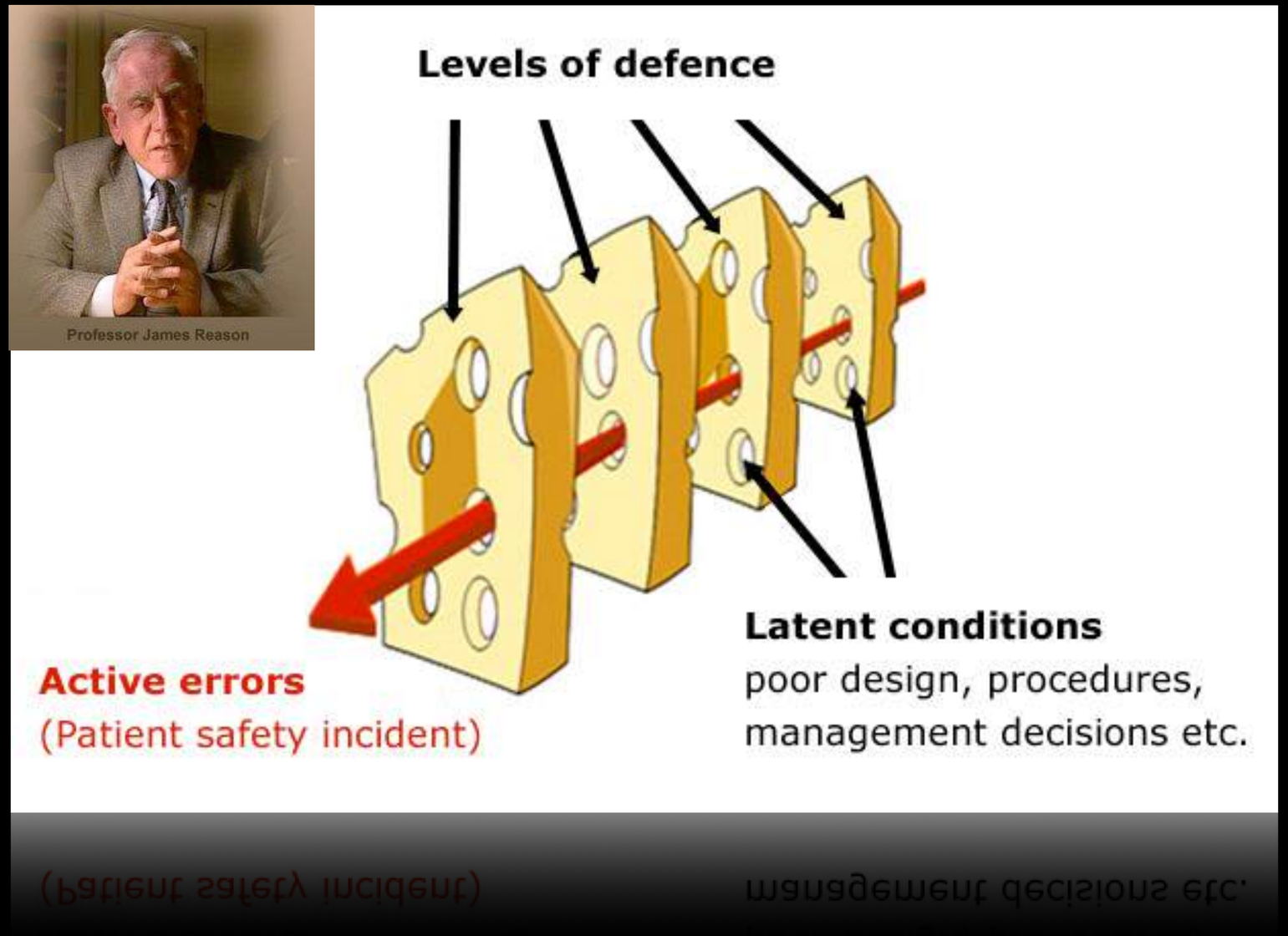
Daily Mail

BBC RADIO 4 TODAY

Who's to blame for this?

Reason's Swiss Cheese Theory



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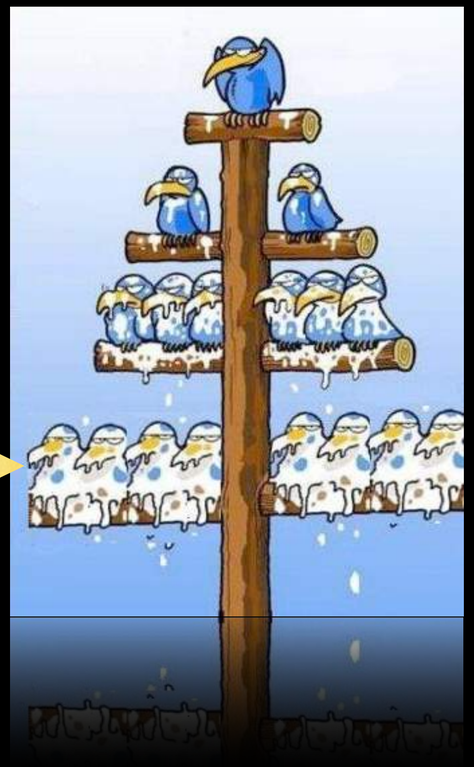
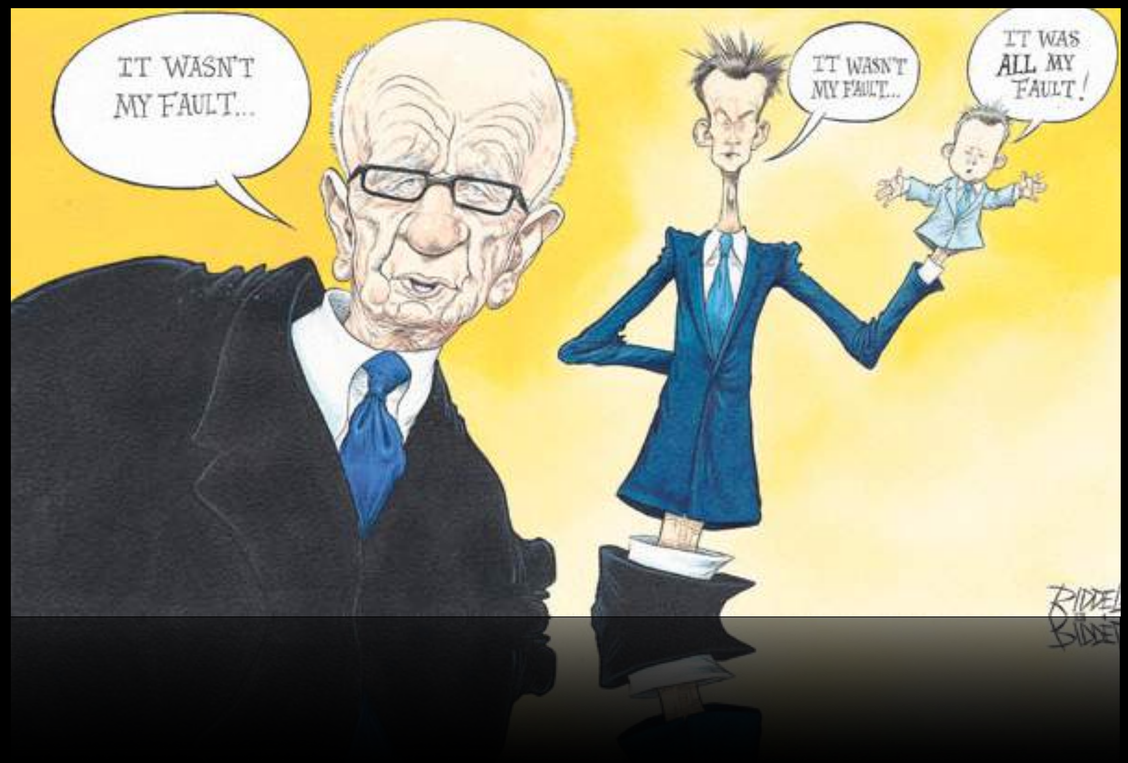
BMA

Blame **M**ust be **A**llocated

the surgical trainee





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Feel free to celebrate Boss's Day by blaming me for one of your many mistakes today

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MDT

Blame makes people in meetings

insecure
nervous of contributing
over-cautious

Blame can lead to

fear
defensive medicine
resistance to reporting errors
harm to patients

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“The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes”

Professor Lucian Leape

Testimony to US Congress 2009

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Victims

1st

2nd

3rd

the patient

the error maker

the institution

initial numbness
detachment
de-personalisation
confusion
anxiety
grief
depression
withdrawal
agitation
flashbacks
shame
guilt
anger
self-doubt
PTSD

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Table 3. Personal and professional outcomes of an adverse event or a near miss (n=1,463).

Outcome	%	n
Lower confidence in ability as a doctor	63.2	886
Difficulty sleeping	59.9	840
Reduced job satisfaction	48.5	681
Affected relationships with colleagues	25.5	358
Damaged professional reputation	20.1	282
Other personal or professional outcomes	15.8	221
Anxious about potential for future errors	81.5	1,192
Generally distressed (eg depressed, upset or angry)	73.6	1,077
Generally anxious (eg nervous, panicky or tense)	68.0	995
Negative towards yourself (eg shame, guilt or feeling incompetent)	27.3	399
More confident in your abilities (eg feeling effective, efficient or competent)	7.5	110
Determined to improve (eg feeling determined, resourceful or strong)	80.6	1,179

Doctors' experiences of adverse events in secondary care: the professional and personal impact

Clinical Medicine 2014 Vol 14, No 6: 585–90

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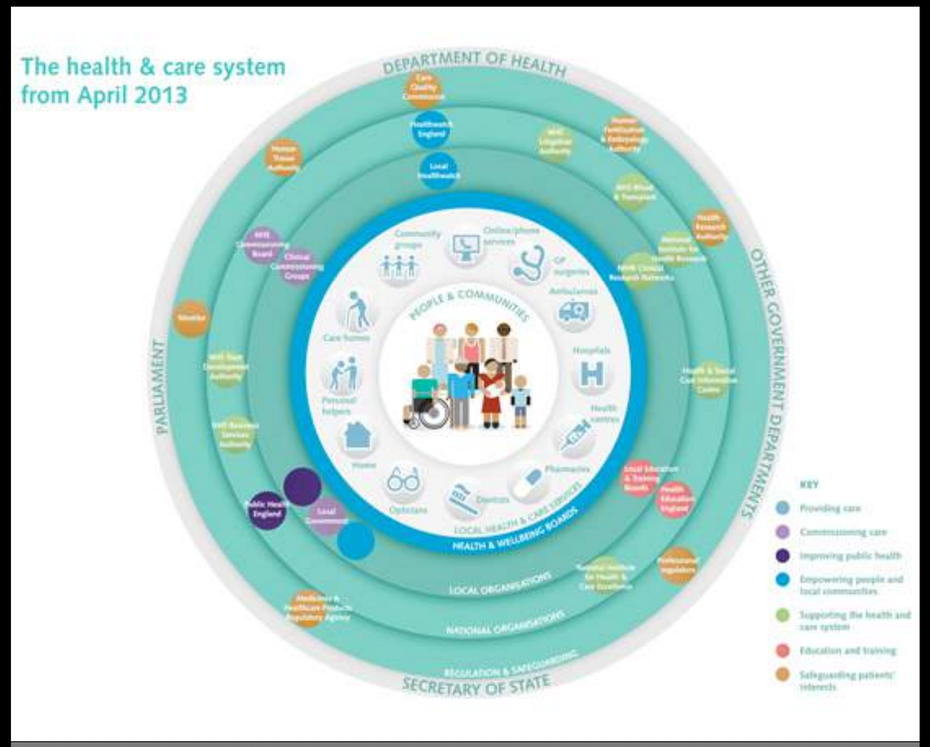
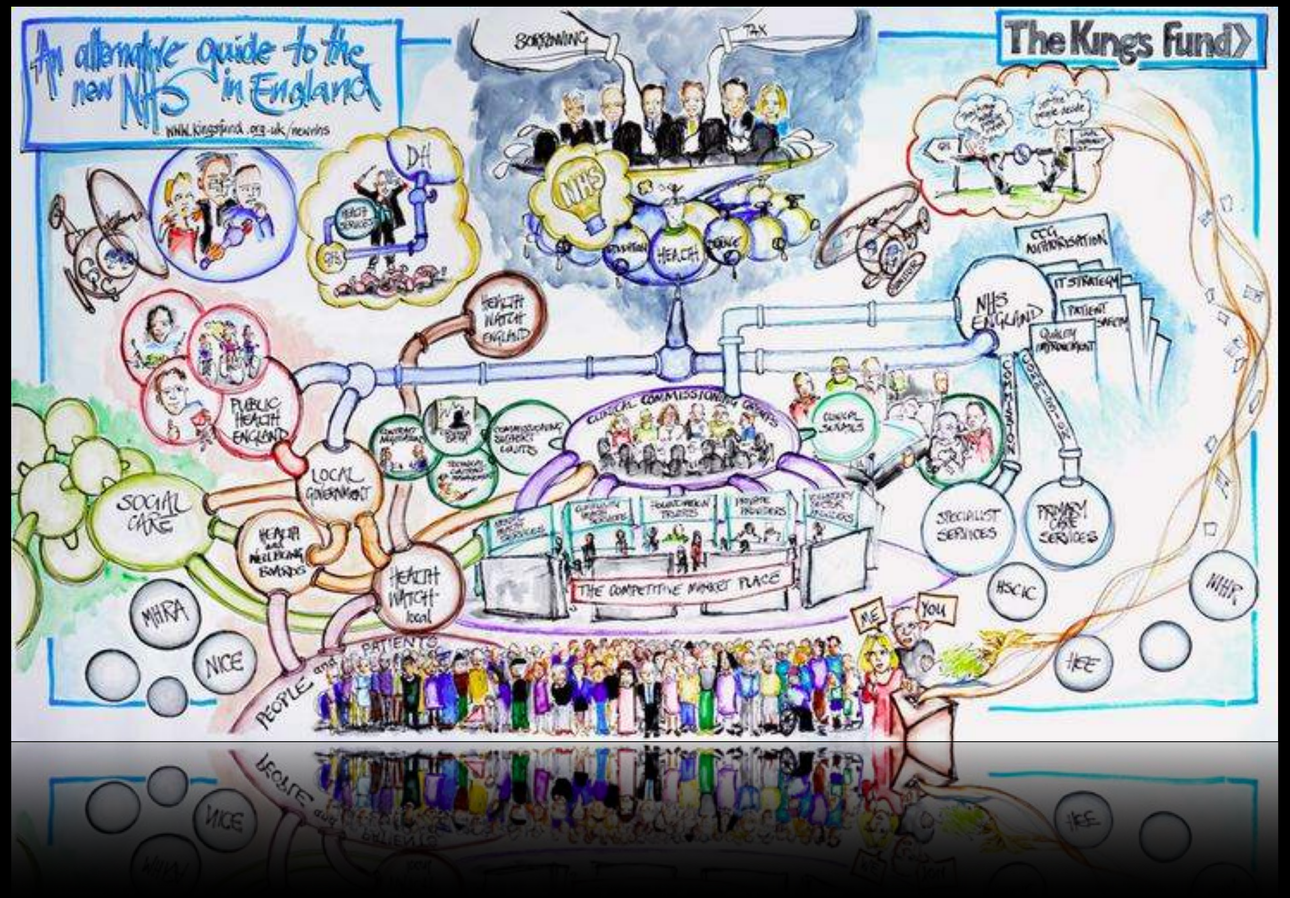
The **NHS** is extremely **Complex**





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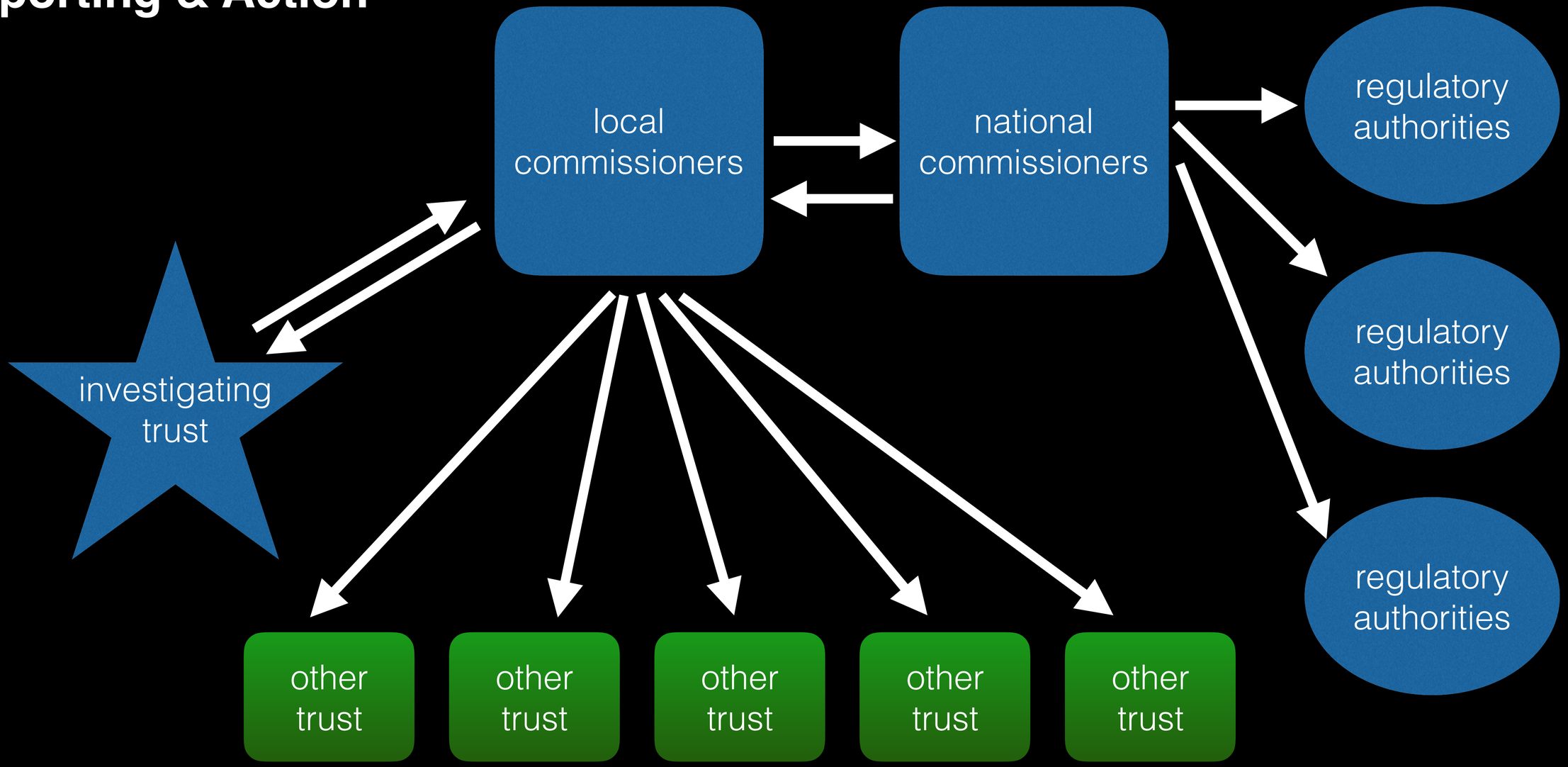
Reporting & Action



will they change anything? how will we know?

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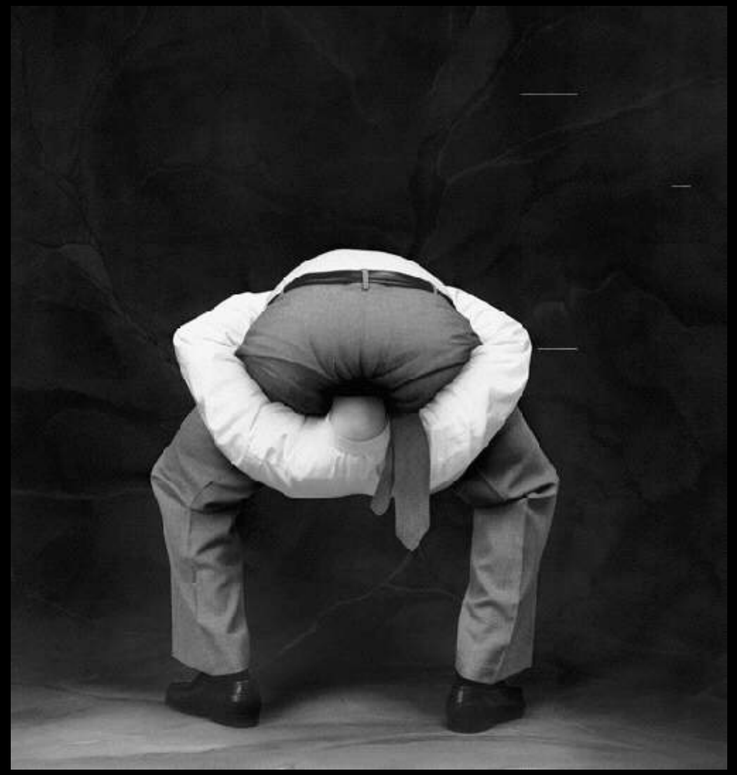

“That could never happen here!”

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Investigate ✔

Report ✔

Recommend ✔

Act ?

Compensate?

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Moind's Fourth Postulate

The degree of certainty
in one's level of competence
is
inversely proportional
to the actual level.

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In the NHS in England the only way you can get compensation is to take legal action by making a claim of medical negligence

Kennedy I, Grubb A. Medical Negligence. In: Kennedy I, Grubb A, eds. Medical Law. London: Butterworths, 2000:273-574.

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Tort

- a wrong must be done by someone to someone else
- civil rather than criminal proceedings
- not enforced by police
- one party must sue another
- trials held before a judge, not a jury

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Motivations for Medico-Legal Action

- **RESTORATION,** including financial compensation or other intervention's make the patient whole again'
- **CORRECTION,** such as system change or competence review to protect future patients
- **COMMUNICATION,** which may include an explanation, expression of responsibility or apology
- **SANCTION,** including professional discipline or some other form of punitive action

Bismark M, Dauer E. Motivations for Medico-Legal Action - Lessons from New Zealand. J Legal Med 2006;**27**:55.

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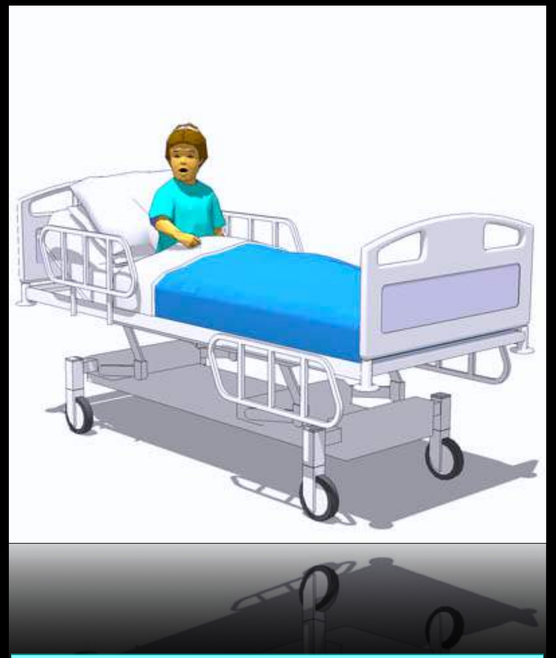
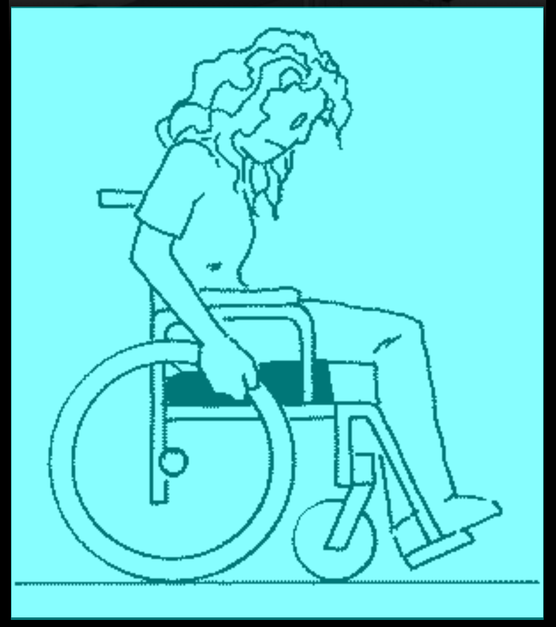
unfairness



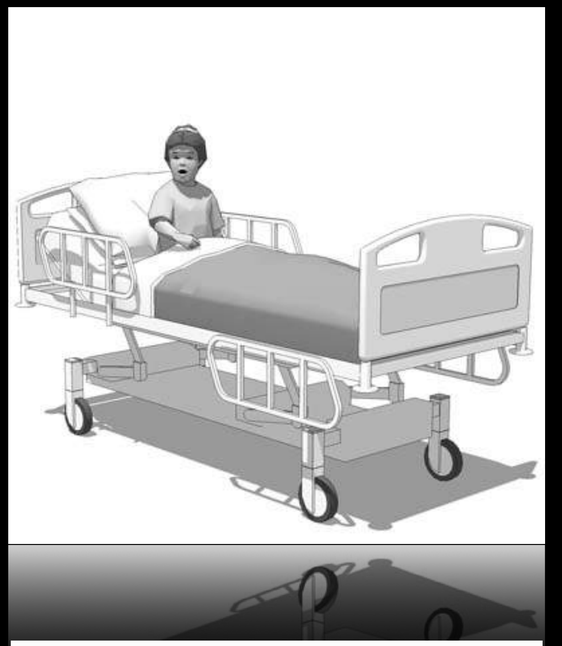


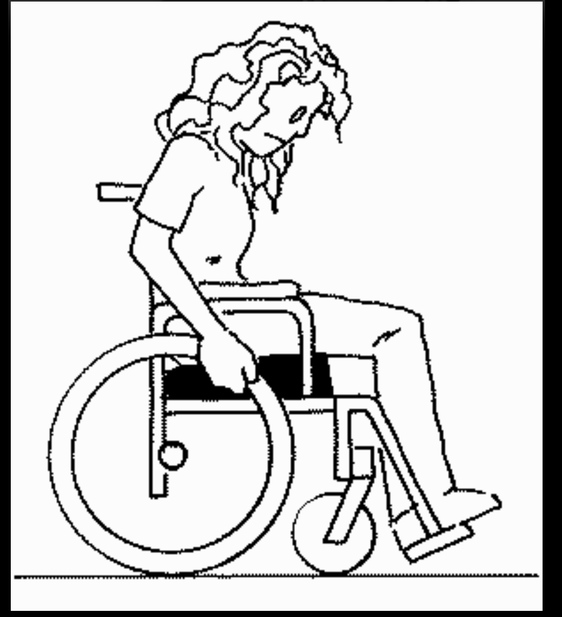
negligent act

disease state

£££

000





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NHS Litigation Authority (NHSLA)

since 1990 has taken over responsibility for negligence attributable to its medical and dental staff in hospital and community services

NOT GPs, or those in private practice
it does not cover referrals to GMC etc or criminal proceedings

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Negligence

for negligence to be proven, the following must exist:

- a **duty** of care
- a **breach** of that duty
- that breach causing material **harm**
- the harm must **not be remote** (in time) from the breach of duty

Kennedy I, Grubb A. Medical Negligence. In: Kennedy I, Grubb A, eds. Medical Law. London: Butterworths, 2000:273-574.

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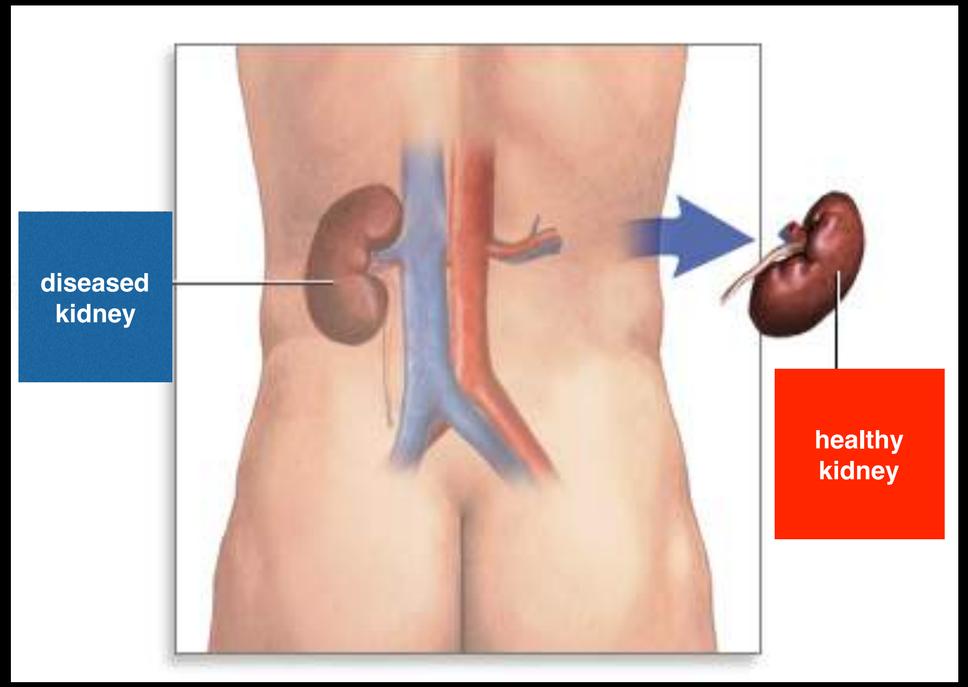
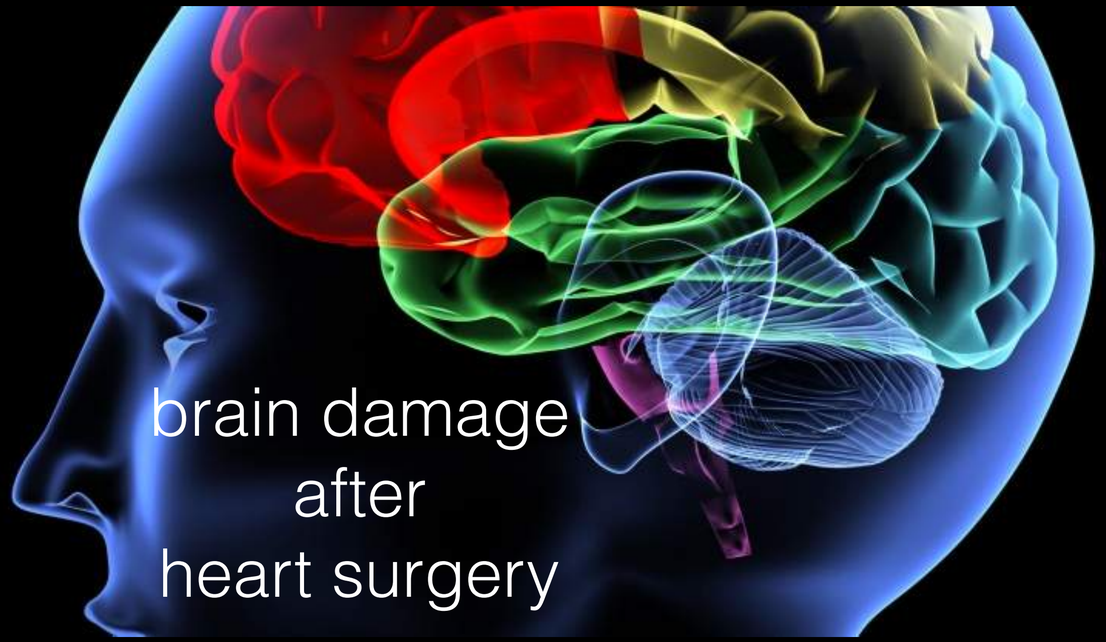
Breach of Duty





the judge's ability to determine if a breach has occurred will depend on the views of expert witnesses

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The **Bolam** Test

Bolam v Friern Hospital Management Committee: 1957, 1 WLR 582, 587

If a doctor reaches the standard of a responsible body of medical opinion, he is not negligent

The **Bolitho** Case

Bolitho v City and Hackney Health Authority: 1997, 4 All ER 771

The judge should be able to choose between two bodies of expert opinion, and to reject an opinion which was 'logically indefensible"

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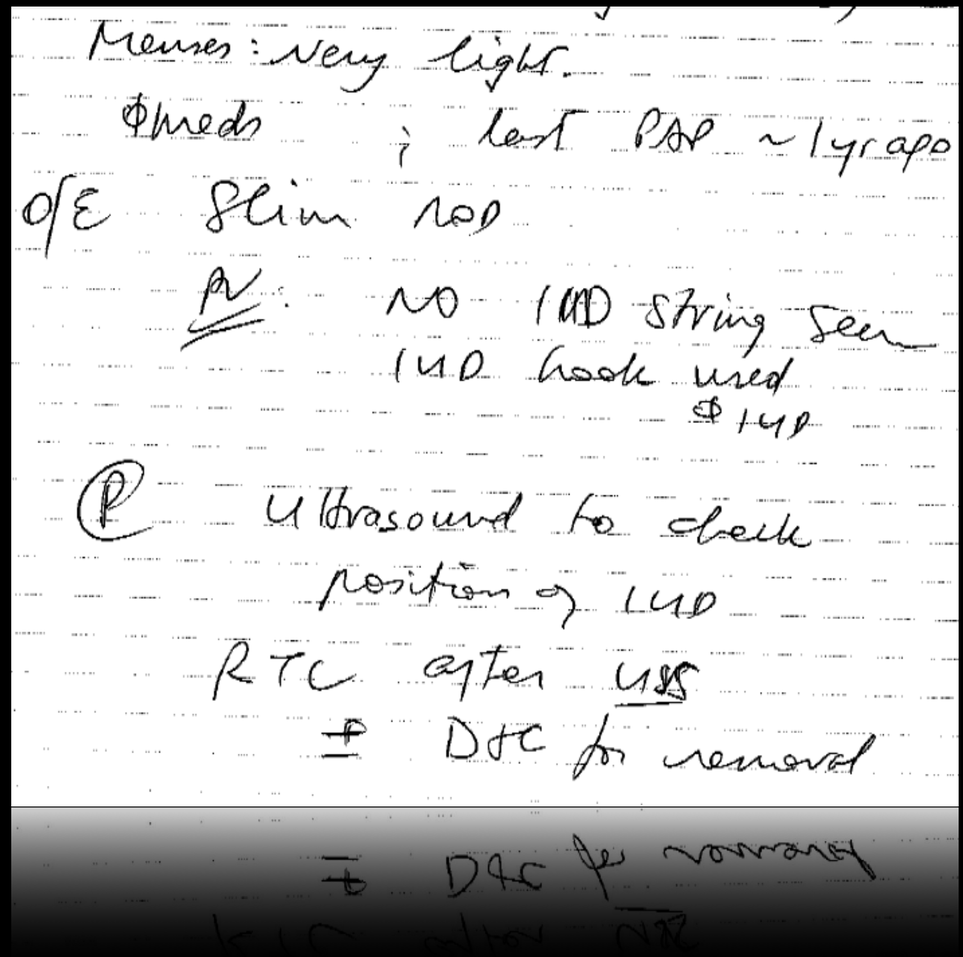
the evidence



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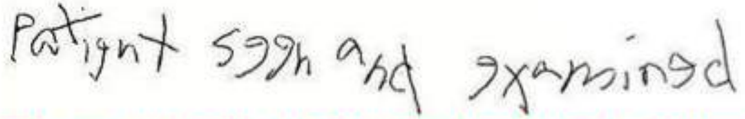
{THE 6 TYPES OF PHYSICIAN HANDWRITING}

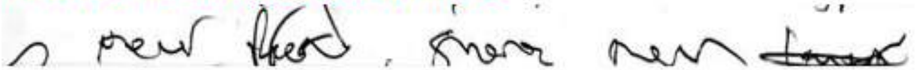
TYPE 1 THE CHICKEN SCRATCH – WHY THEY MADE THE MCAT A CBT



TYPE 2 THE PERFECTLY ILLEGIBLE – "75 OR 95%?" THE CHOICE IS YOURS, PHARMACIST

TYPE 3 THE "EVERY – OTHER – WORD – MAKES – SENSE"

TYPE 4 THE INTOXICATED – OR PROBABLY JUST ON PERCOCET



TYPE 5 THE DEBONAIR SANSKRIT – OR IS HOPING THE PHARMACIST IS JAPANESE

TYPE 6 THE DR. HOUSE – HOW CAN I PISS OFF THAT WALGREENS PHARMACIST EVEN MORE?

–MEDSCHOOLGUNNER.COM
–MEDICALHUMOR.WORDPRESS.COM

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intuitive - pattern recognition

Aoccdrnig to a rseearch at Cmabrigde Uinervtisy, it deosn't mttaer in waht oredr the ltteers in a wrod are, the olny iprmoatnt tihng is taht the frist and lsat ltteer be at the rghit pclae. The rset can be a toatl mses and you can sitll raed it wouthit porbelm. Tihs is bcuseae the huamn mnid deos not raed ervey lteter by istlef, but the wrod as a wlohe.

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intuitive - pattern recognition

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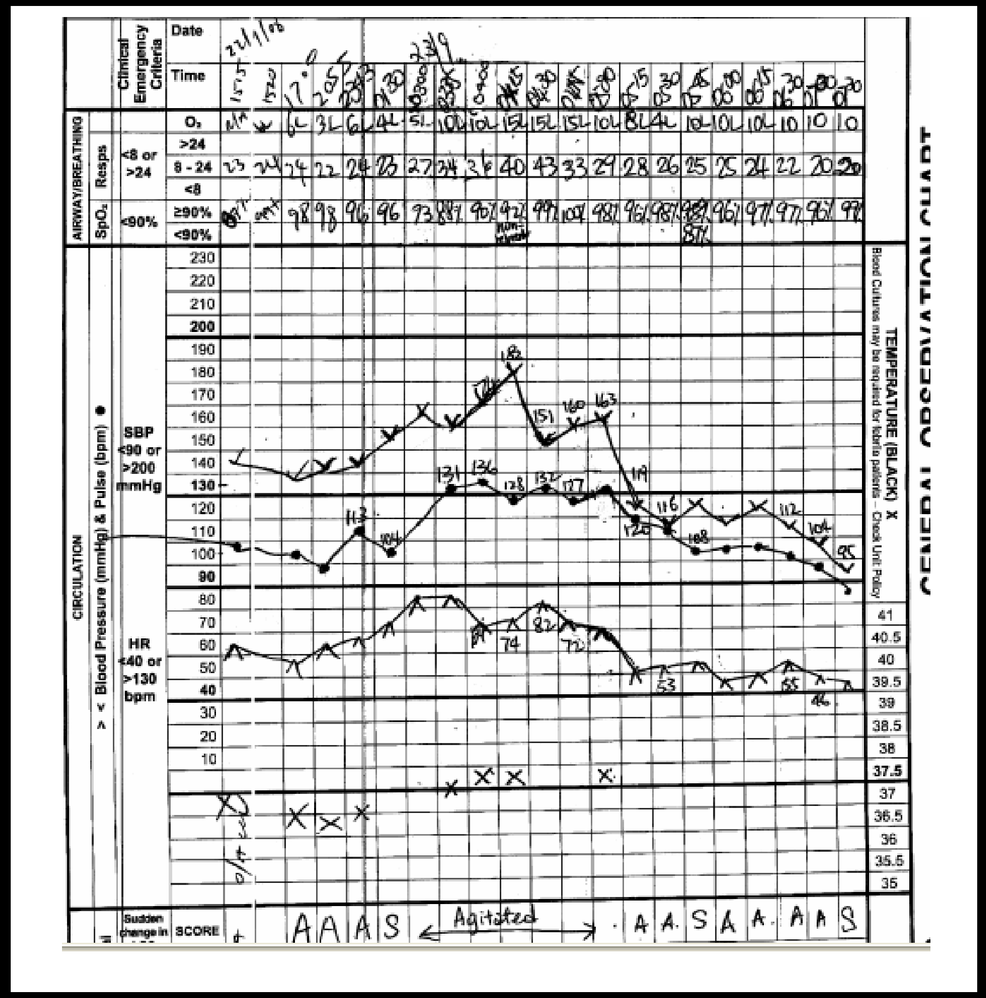

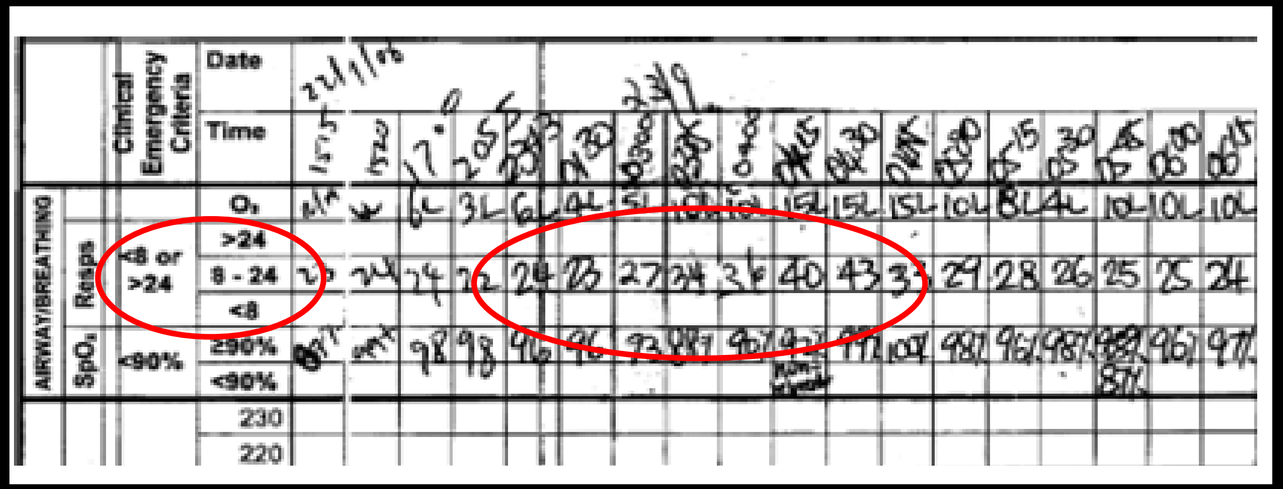

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Copying, on an industrial scale

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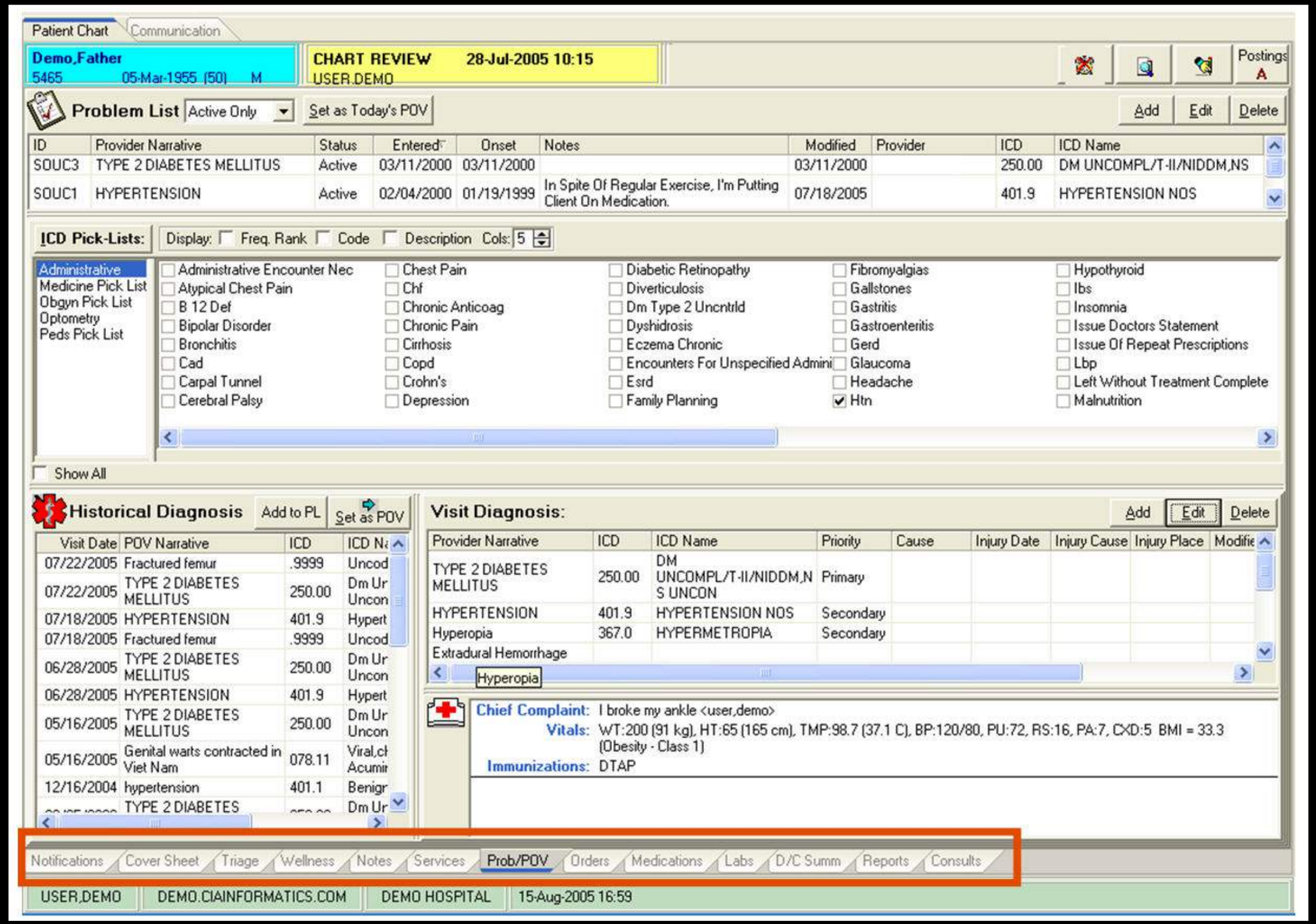
Electronic Medical Record

the
lost
narrative



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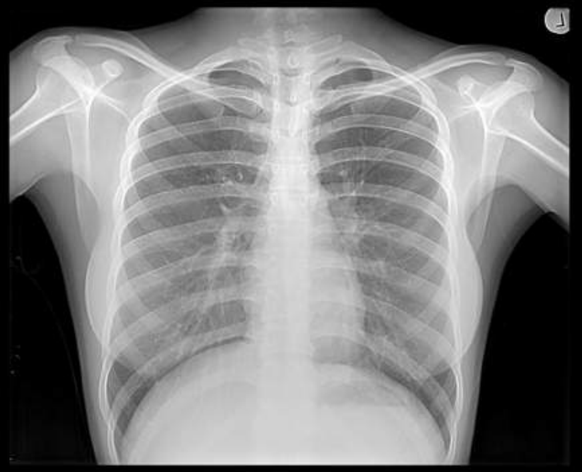

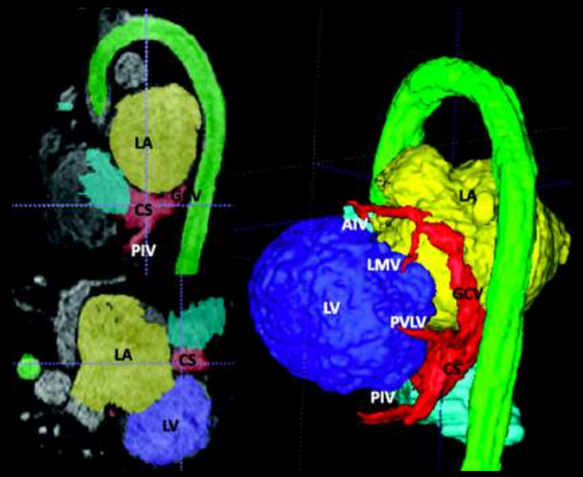

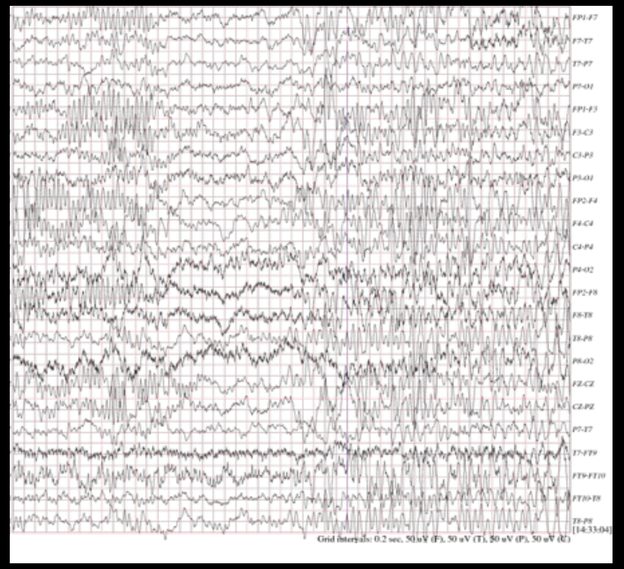

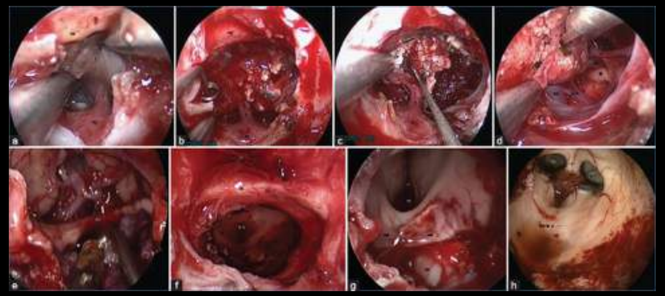

Analyte name	8/31/2009	9/8/2009	9/14/2009	9/21/2009	9/28/2009	10/5/2009	10/19/2009	10/27/2009	11/3/2009	12/16/2009	Range
White blood cell count	8.30	6.70	10.30	**11.10**	8.70	8.30	8.40	**11.70**	9.10	8.20	3.8-10.8
Red blood cell count	4.56	4.26	4.39	4.45	4.39	4.62	4.49	4.70	4.40	5.07	4.2-5.8
Hemoglobin	16.20	15.00	15.60	15.60	15.60	16.40	16.00	15.90	15.00	15.50	13.2-17.1
Hematocrit	48.90	45.00	46.60	46.00	45.90	48.70	46.30	47.00	42.30	46.40	38.5-50.0
MCV	**107.30**	**105.60**	**106.10**	**103.40**	**104.50**	**105.40**	**103.20**	**100.00**	96.10	91.50	80-100
MCH	**35.60**	**35.30**	**35.40**	**35.10**	**35.50**	**35.60**	**35.80**	33.80	**34.10**	30.50	27-33
MCHC	33.20	33.40	33.40	34.00	33.90	33.80	34.60	33.80	35.50	33.30	32-36
RDW	**24.00**	**22.50**	**21.90**	**20.80**	**19.40**	**18.30**	**16.50**	14.10	**15.50**	**15.30**	11.0-15.0
Platelet count	281.00	182.00	302.00	302.00	239.00	242.00	284.00	323.00	386.00	304.00	140-400
Glucose	**144.00**	**103.00**	**100.00**	79.00	93.00	78.00	80.00		94.00	87.00	65-99
Absolute Neutrophils	6242.00	4945.00	**8106.00**	**8381.00**	5672.00	5212.00	5552.00				1500-7800
Absolute Lymphocytes	1552.00	1253.00	1751.00	1943.00	2445.00	2415.00	2184.00				850-3900
Absolute Monocytes	465.00	482.00	402.00	677.00	479.00	564.00	554.00				200-950
Absolute Eosinophils	25.00	**7.00**	21.00	78.00	87.00	83.00	76.00				15-500
Absolute Basophils	17.00	13.00	21.00	22.00	17.00	25.00	34.00				0-200
Neutrophils %	75.20	73.80	78.70	75.50	65.20	62.80	66.10		64.00	67.00	
Lymphocytes %	18.70	18.70	17.00	17.50	28.10	29.10	26.00	26.00	25.00	22.00	
Monocytes	5.60	7.20	3.90	6.10	5.50	6.80	6.60	11.00	9.00	8.00	
Eosinophils %	0.30	0.10	0.20	0.70	1.00	1.00	0.90	1.00	1.00	2.00	
Basophils %	0.20	0.20	0.20	0.20	0.20	0.30	0.40	0.00	1.00	1.00	
Creatinine	0.78	**0.66**	**0.66**	**0.70**	0.88	0.80	**0.73**		0.80	0.80	0.76-1.46
Sodium	135.00	137.00	137.00	137.00	138.00	140.00	142.00		137.00	140.00	135-146
Potassium	4.10	4.00	4.20	3.90	3.80	3.70	4.30		4.00	3.80	3.5-5.3
Chloride	**96.00**	100.00	100.00	100.00	100.00	98.00	101.00		105.00	101.00	98-110
Carbon Dioxide	24.00	24.00	26.00	24.00	26.00	28.00	26.00		29.00	21.00	21-33
Calcium	8.60	8.90	9.00	8.90	9.00	9.20	9.00	9.50	9.20	9.50	8.6-10.2
Protein	6.80	7.00	7.00	6.70	6.60	6.80	7.10		6.90	7.20	6.2-8.3
Albumin	3.90	3.70	4.10	4.10	4.10	4.10	4.00		3.10	3.40	3.6-5.1
Globulin	2.90	3.30	2.90	2.60	2.50	2.70	3.10		3.80	3.80	2.1-3.7
AST	22.00	35.00	18.00	27.00	28.00	27.00	34.00		27.00	**49.00**	10.0-35.00
ALT	42.00	46.00	32.00	25.00	24.00	23.00	23.00		18.00	21.00	9.00-60.00
BUN									**5.00**	**6.00**	7.00-25.00

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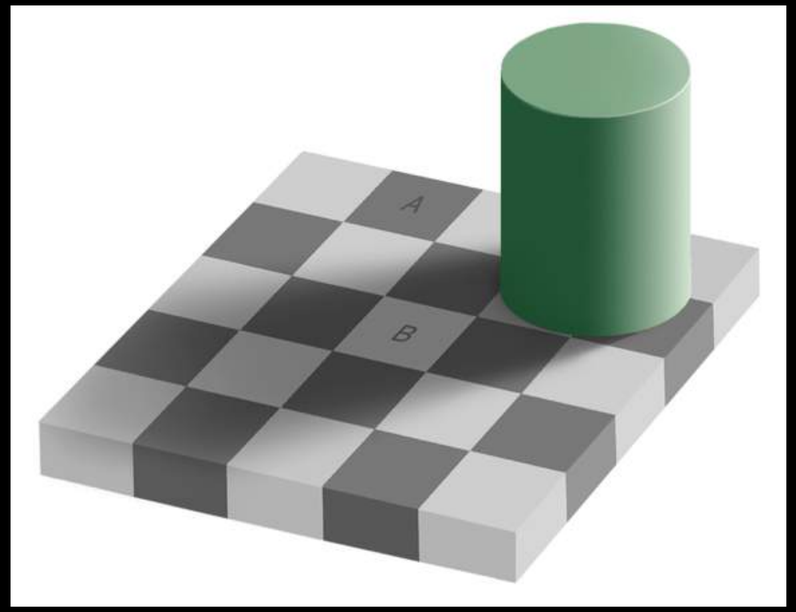

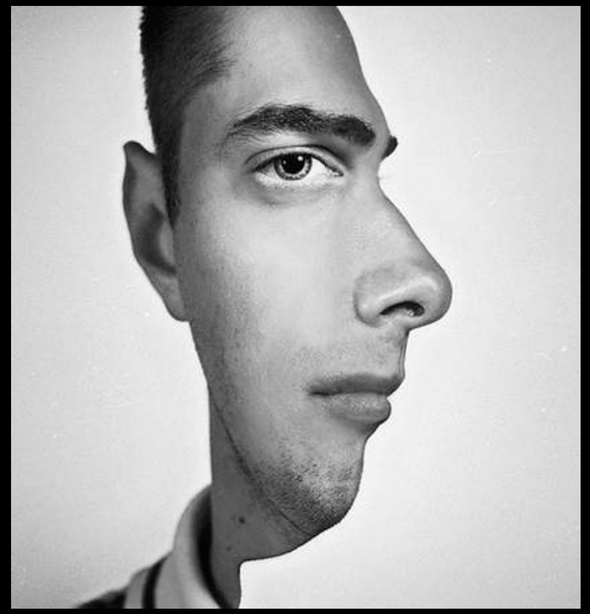

is what we see correct?

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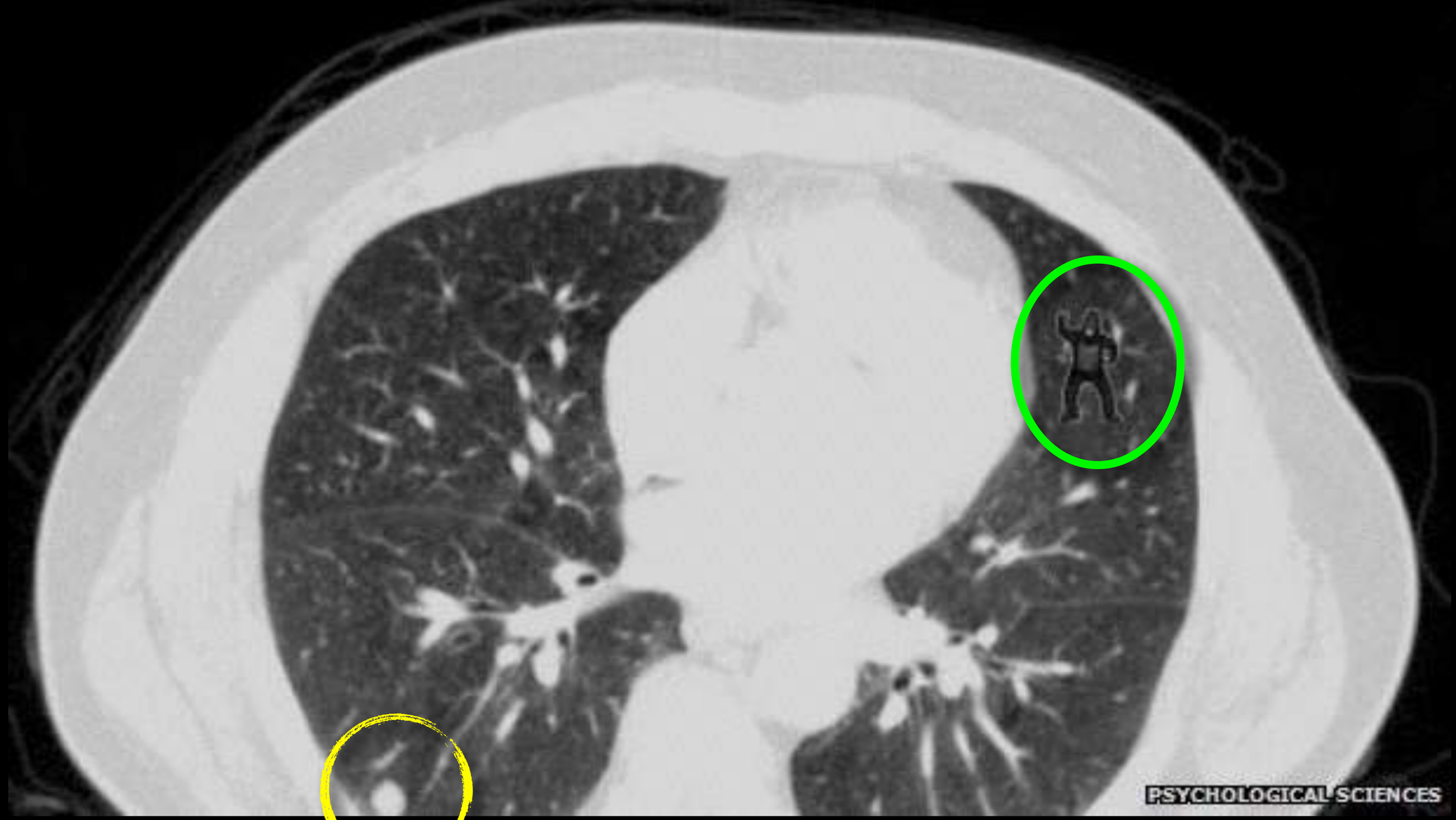

TUMOUR

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a clinician

takes risk & makes decisions (many)

under pressure

a lawyer

analyses risk & decisions

at leisure

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Deciding without Data

Jeffrey R. Darst, MD[1,*], **Jane W. Newburger, MD, MPH**[1], **Stephen Resch, PhD**[2], **Rahul H. Rathod, MD**[1], and **James E. Lock, MD**[1]

[1] Department of Cardiology, Children's Hospital Boston and Department of Pediatrics, Harvard Medical School, Boston, Mass, USA

[2] Department of Health Policy and Management, Harvard School of Public Health, Boston, Mass, USA

Congenit Heart Dis. 2010 ; 5(4): 339–342.

The basis of doctors' decisions

Table 1

Decision Definitions

1. **Arbitrary/instinct**: Multiple options are present, but one is chosen without a clear cut reason in mind; decision not attributable to the 9 categories below.
2. **Avoid a lawsuit**: Done without definable value to the patient; for documentation only.
3. **Experience/anecdote**: Based on a memory of one or more cases; if specific cases cannot be recalled, the decision may be arbitrary.
4. **Trained to do it**: Taught by a more senior or experienced colleague.
5. **First principles**: Things we know to be true, physiology-based.
6. **Limited study**: Case reports, small series.
7. **General studies**: *Can be related* to the question at hand.
8. **Specific studies**: *Expressly addresses* the question at hand.
9. **For research**: Anything done primarily out of curiosity or to learn something about the patient or the disease.
10. **Parental preference**: An otherwise arbitrary decision that is swayed by parent input.

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Table 2

Basis of Decisions

	n = 1188	
	Number of Decisions*	**% of Total**
Experience/anecdote	441	37.1%
Arbitrary/Instinct	175	14.7%
Trained to do it	173	14.6%
General study	146	12.3%
First principles	146	12.3%
Limited study	61	5.1%
Specific study	34	2.9%
Parental preference	6	0.5%
For research	4	0.3%
Avoid a lawsuit	2	0.2%

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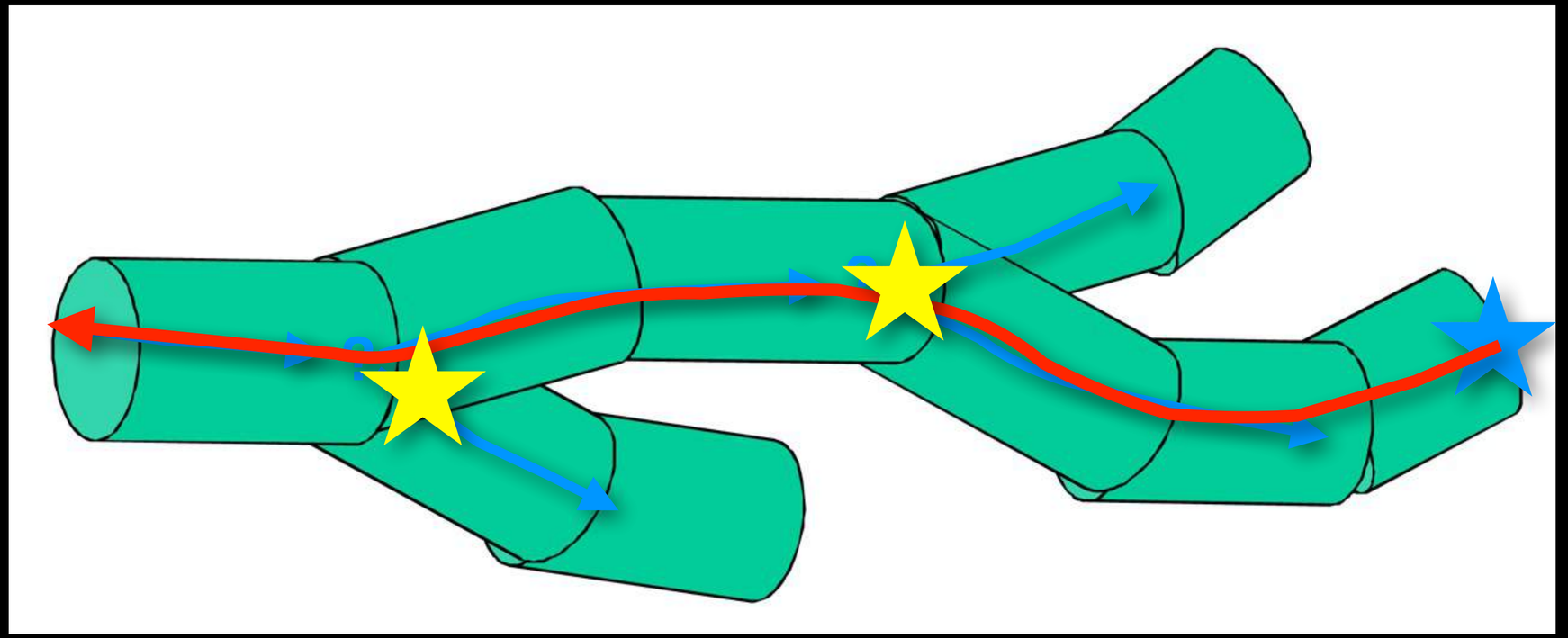
Decision Making

The Retrospectoscope



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The Wisdom of the Law

“Judges are the most pragmatic of ethicists, combining law and ethics to arrive at a concrete answer. They cannot sit on the fence.

There is much about practical decision making that doctors and ethicists can learn from them.”

“What evidence do I have for this?”

Sokol DK *BMJ* 2013;347

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COSTS

The NHSLA is supposed

"to minimise the overall costs of clinical negligence…to the NHS, and thus maximise the resources available for patient care, by defending unjustified actions robustly and settling actions efficiently"

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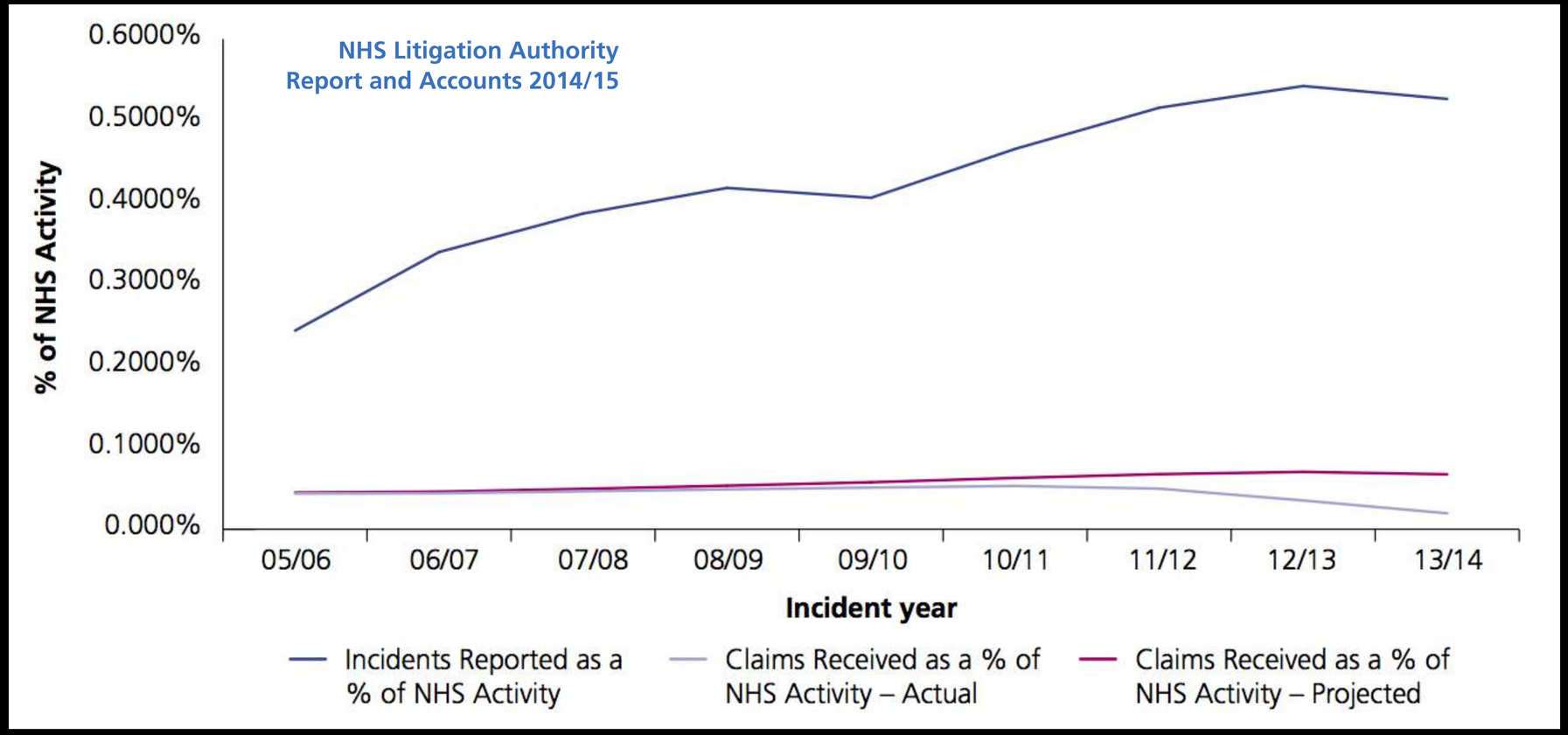

negligence claims made in ≈ **0.05% of NHS activity**

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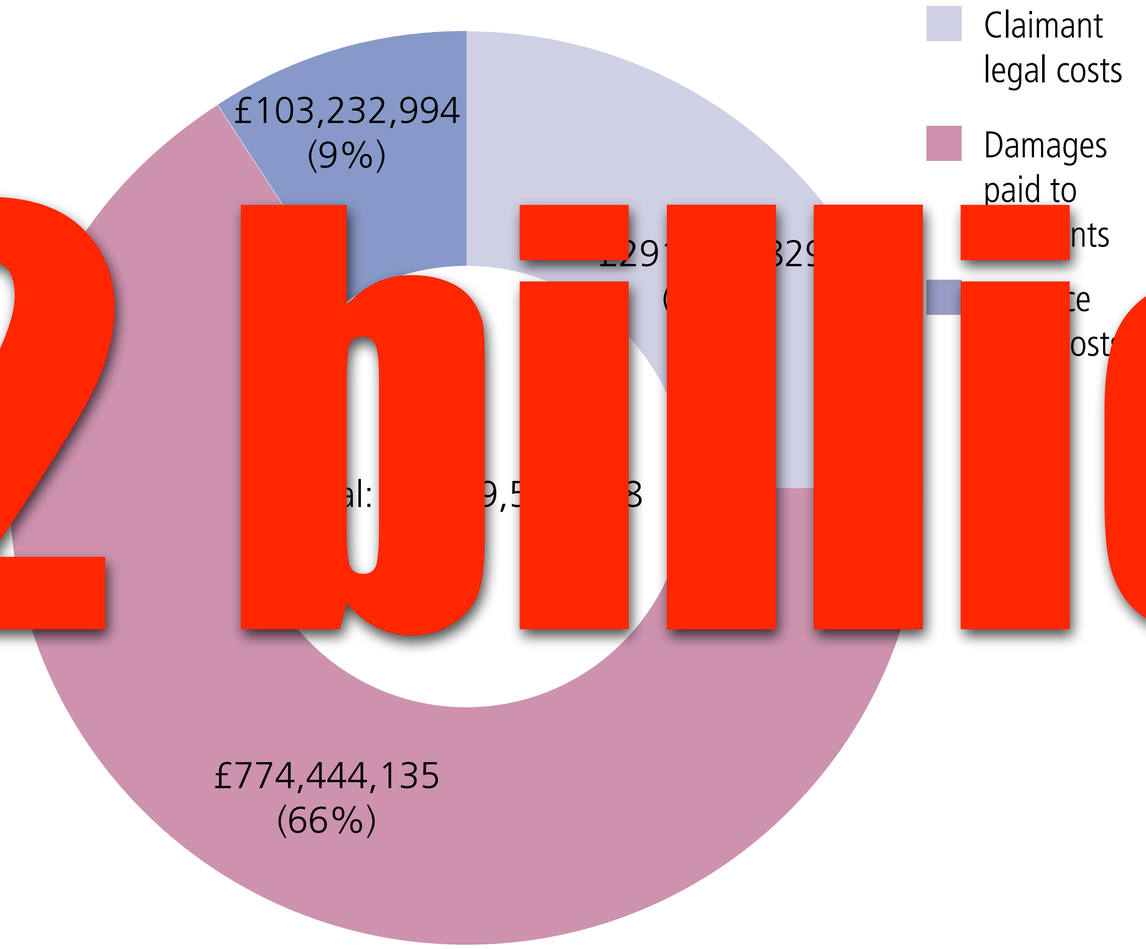
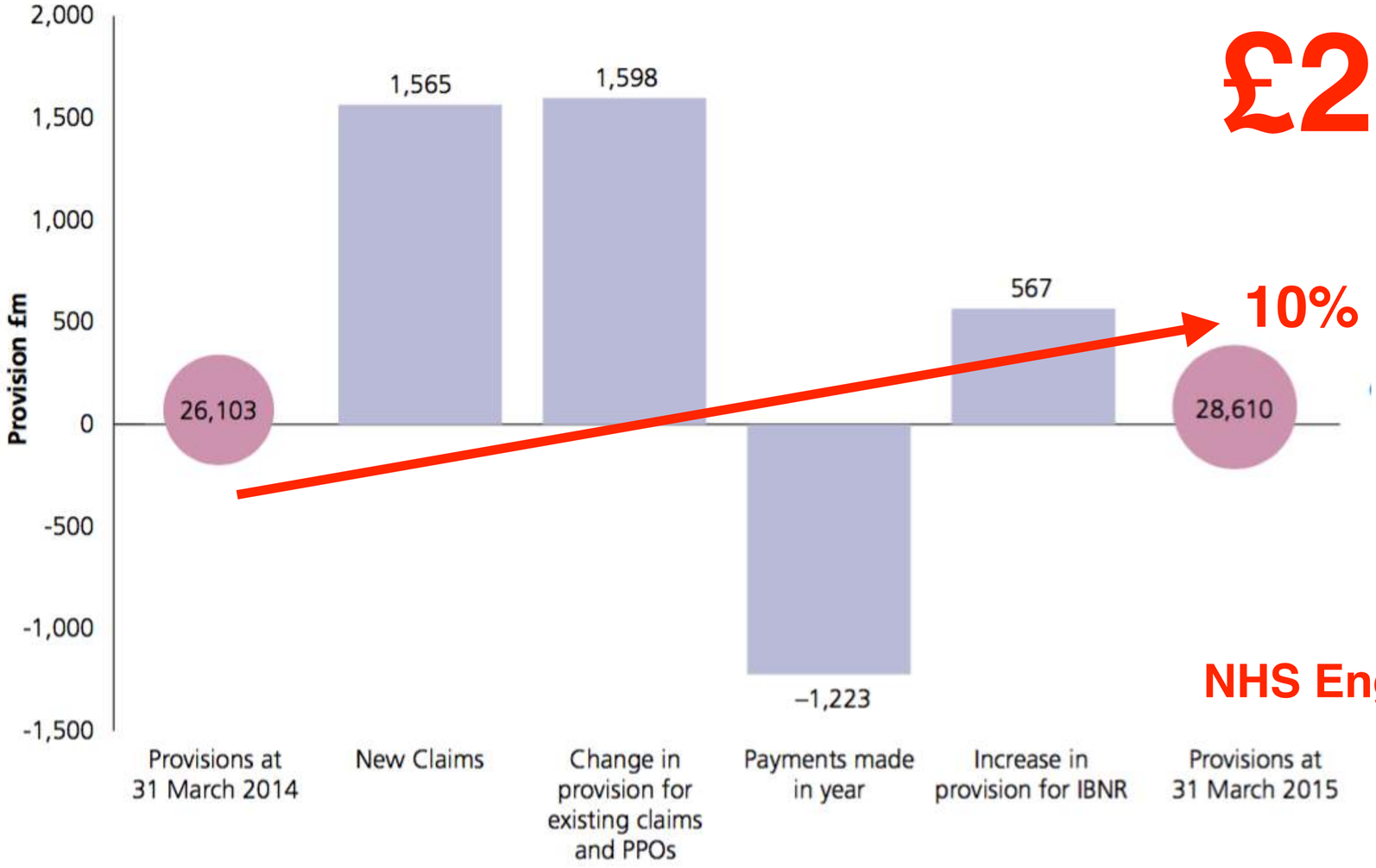
Figure 11: Clinical negligence expenditure including interim payments 2014/15



£1.2 billion

Amount Set Aside for Claims by NHSLA 2014/15



£28.6 billion

25%

NHS England Commissioning Budget

NHSLA Annual Report 2014-15
NHS England Annual Report 2014-15

Legal Costs in 2014/15 were £300m

excluding costs met by claimants themselves or the Legal Services Commission

NHS Litigation Authority
Report and Accounts 2014/15

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Trusts pay ‘contributions’ to the Clinical Negligence Scheme for Trusts (CNST), part of the NHSLA

Total to be Collected in CNST scheme for 16/17 is £1,659m a 17% increase on 15/16

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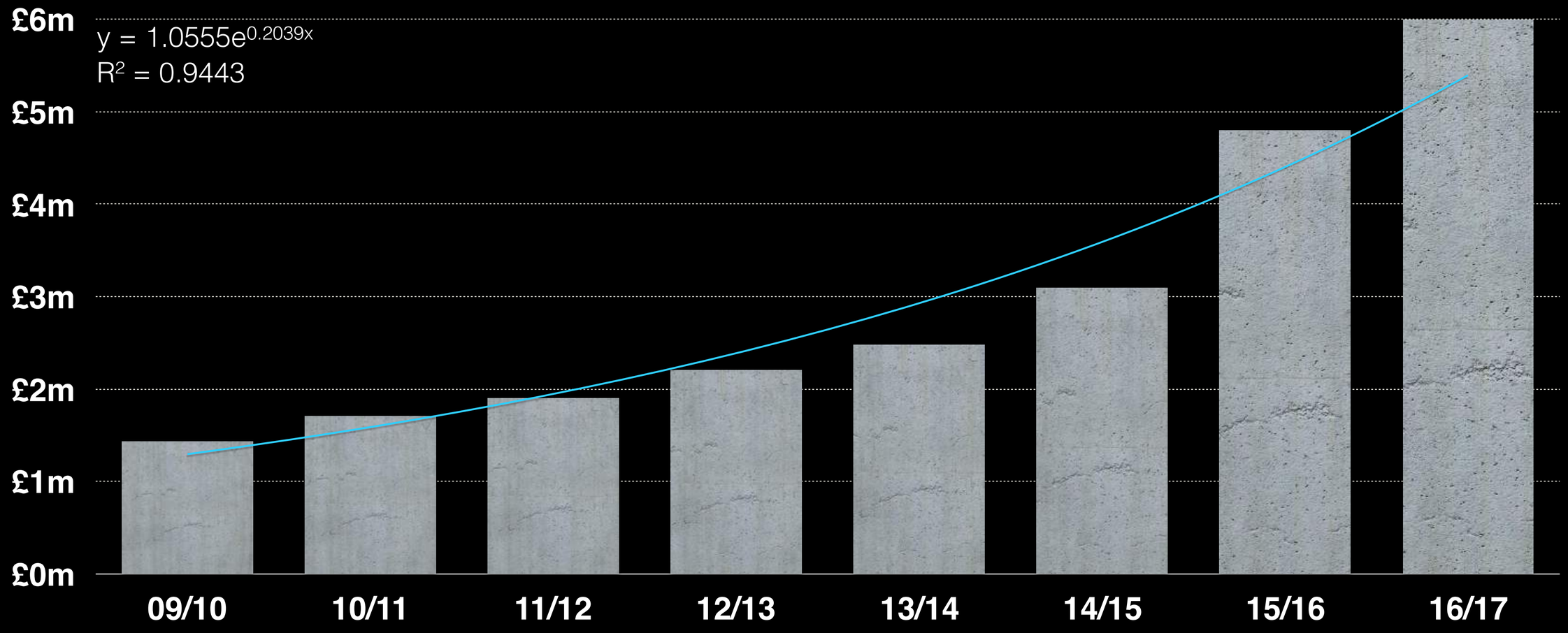
Annual Clinical Negligence Cover Premiums at GOSH



CNST contribution calculated as weighted avg of 3 elements: risk based related to staffing and activity levels; previous 5y claims experience; known outstanding claims

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Professional Indemnity Schemes

THE MDU

MPS

The NHSLA does not cover GPs, or those in private practice.
Nor does it cover referrals to GMC etc or criminal proceedings.

Professional Indemnity is Expensive

£10s of thousands per year out of take home pay

in 30 years as a paediatric cardiac surgeon I have paid >£500,000

I have yet to need it

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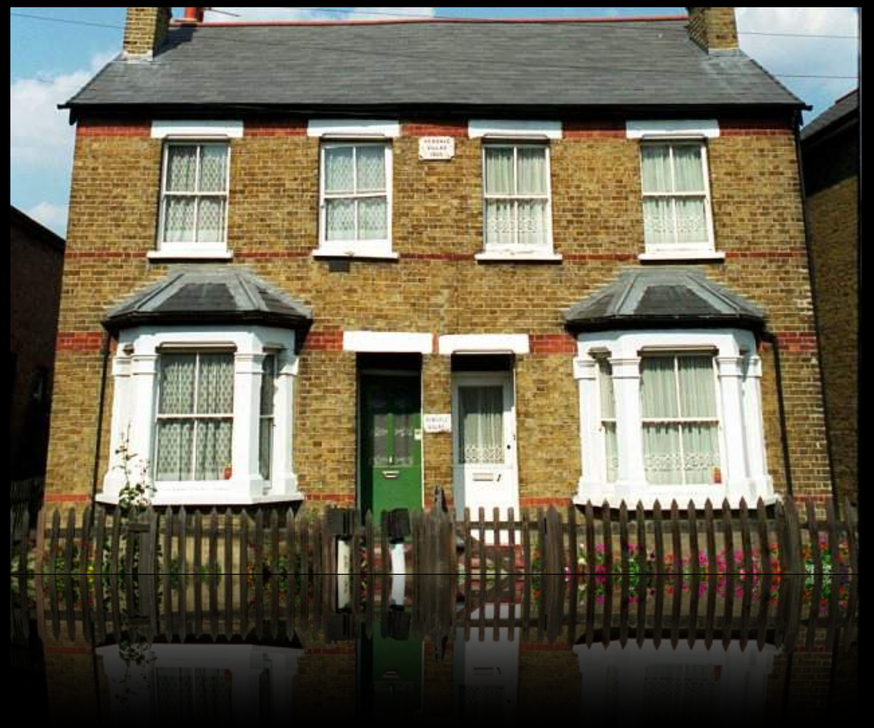
14% of doctors appearing before the GMC do not have indemnity cover



personal communication, Prof Terence Stephenson

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Legal Costs for the Claimant are High

50% of claim value for claims <£100,000

legal aid is no longer available for medical negligence cases

‘no-win, no-fee’

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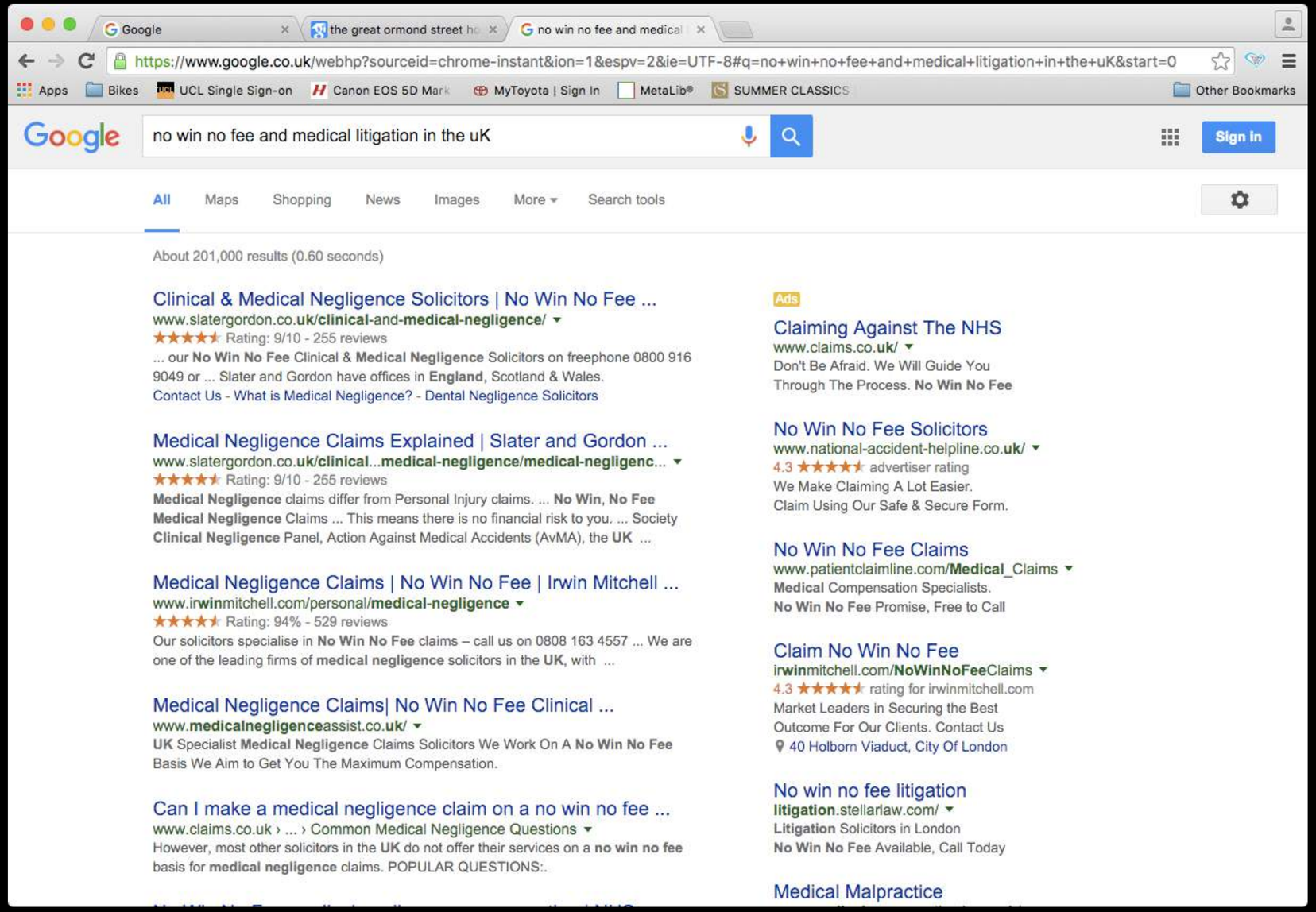

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The life-long costs of harm can be enormous

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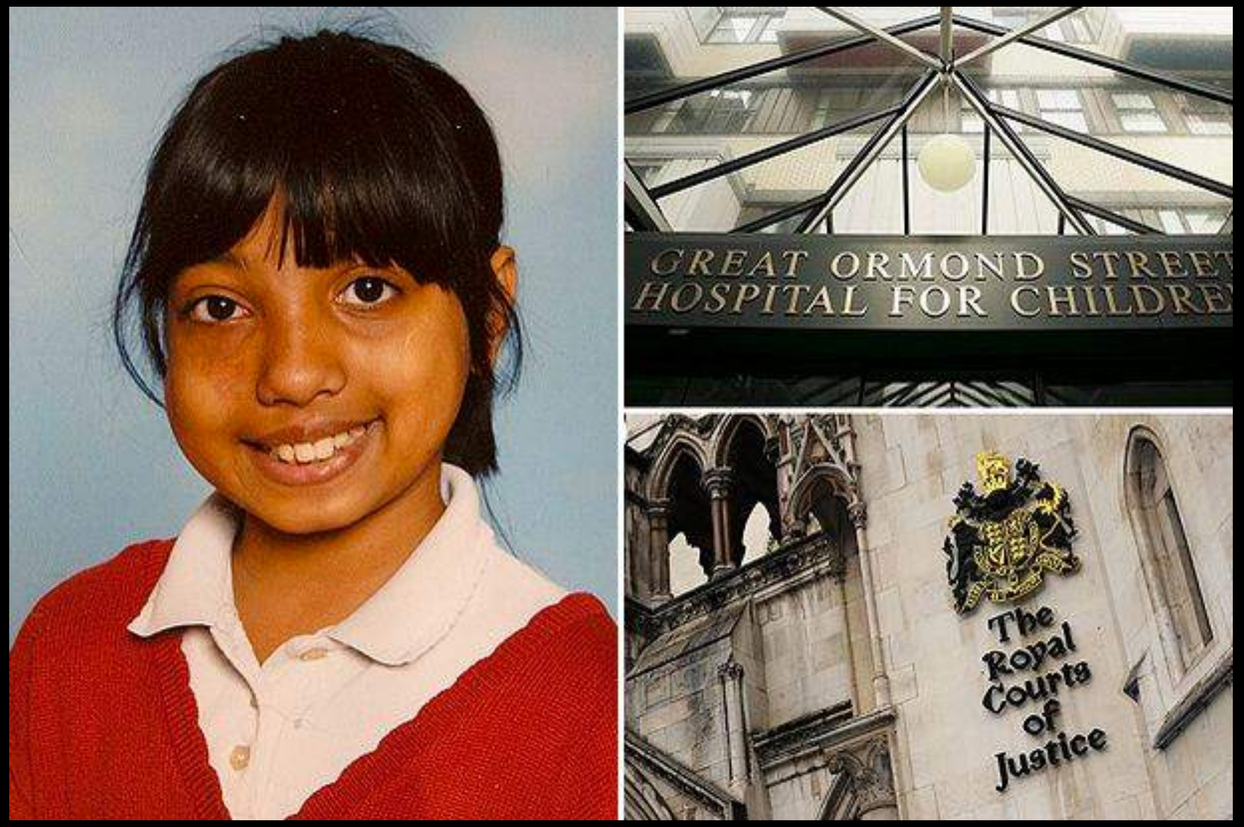

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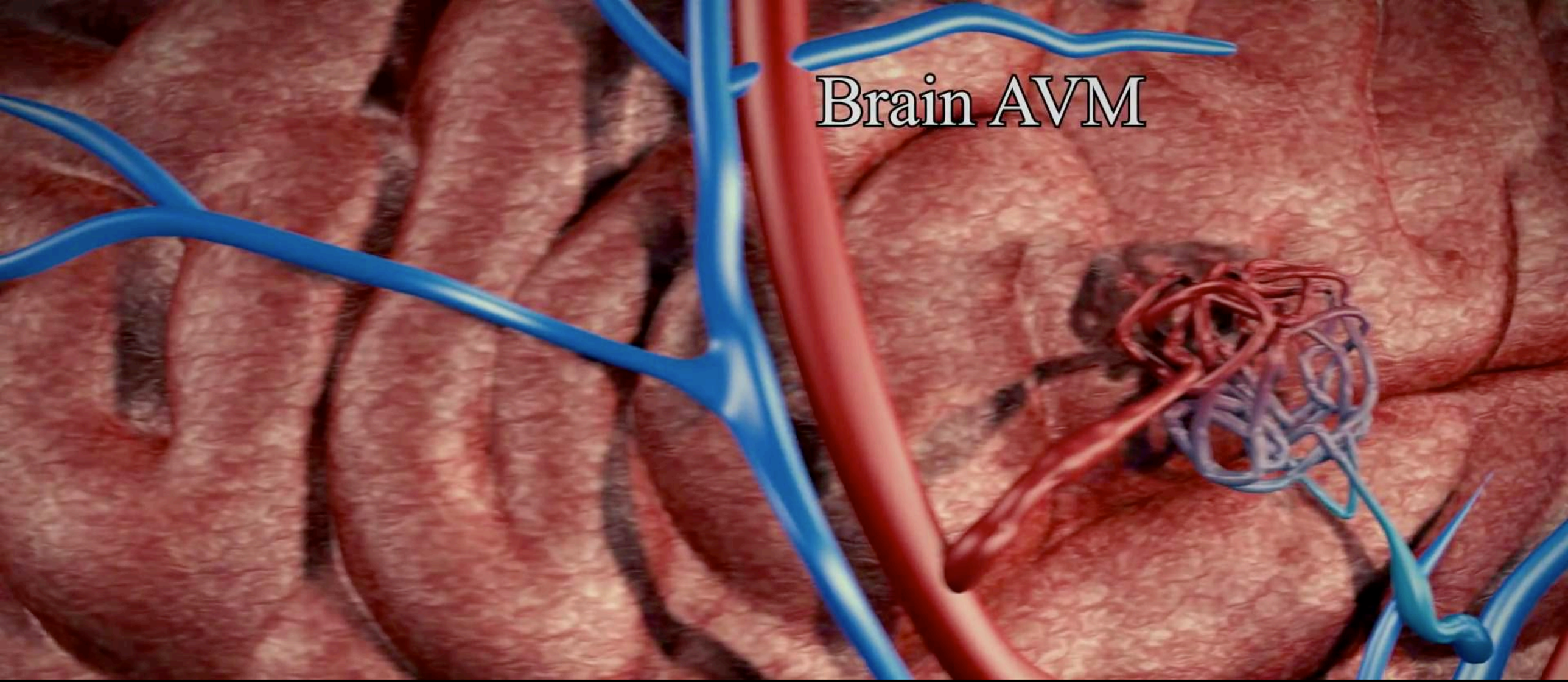

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Dye

Glue

Glue

Dye

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severe brain damage
life-long, 24/7 care

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Cost to NHSLA will be £24,000,000

the case took **four** years

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the operator

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2003, Liam Donaldson, CMO

Making Amends, proposals to reform clinical negligence in the NHS

complex
unfair
slow
costly
unsatisfactory for families
encouraging defensiveness and secrecy

"an asymmetric system damaging the doctors and hospitals with out significantly benefitting the patient/victim"

Keren-Paz, Medical Law Review;2010;18(3);363

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Making Amends

- Donaldson proposed a **fast-track** negligence system
- dealing with compensation, but also correction and communication
- developed into the **NHS Redress Act of 2006**
    - compensation, explanation, apology & report of action
    - but, **waiver of the right to sue**
    - consensual, not judicial, process during which legal rights suspended

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Making Amends

- secondary legislation not passed
- no political will to introduce it
- left with the ‘asymmetric system’
- and a system of litigation which encourages physicians and institutions *“to cloak themselves in confidentiality, forgoing opportunities to learn from problems that lawsuits can sometimes help to illuminate”*

Studdert DM, Brennan TA. No-Fault Compensation for Medical Injuries: The prospect for error prevention. JAMA 2001;**286**:217-23.

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No-Fault Compensation

no need to prove negligence to be eligible for compensation

- all schemes have eligibility & threshold criteria
- limitations on extent of cover, & caps on compensation
- lower compensation levels than tort-based systems
- access to courts usually restricted
- comprehensive social welfare/insurance system in place

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New Zealand

Trust in the System

for levy payers	60%
for clients	76%

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Why not here in England?

the size of the population, and its growth rate

the cost of establishment, and size of, the necessary fund

current political drive to reduce size of welfare state

lack of belief that ‘no-fault’ will influence behaviour

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If the current system too costly and disliked, & no-fault schemes are unaffordable, what else can we do?

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Cap Fees and Compensation

- has worked in California (Medical Injury Compensation Reform Act (MICRA)
    - reduced lawyers ‘billable hours’
    - reduced length of trials
    - reduced defensive medicine (5-9% reduction in healthcare costs)
- proved impossible to spread across USA because of right to jury trial
- not included in recent Obama-care reforms

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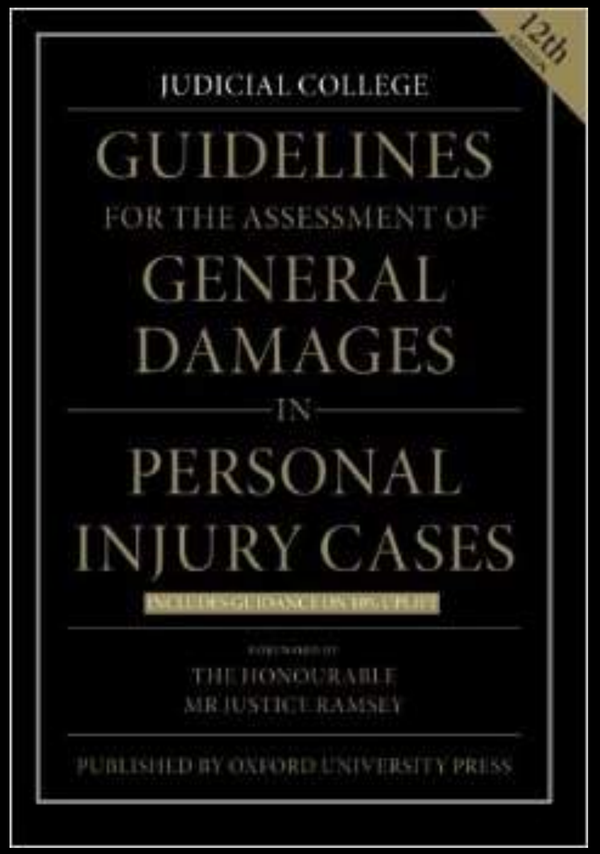
Caps in England



- no punitive damages
- defined categories of payment for specific ‘injuries’
- reviewed and published regularly by the **Judicial College**, as **The Guidelines for The Assessment of General Damages** ‘for pain, suffering and ‘loss of amenity’
- money recoverable from NHSLA or the plaintiff

Tetraplegia ≈ £230,000 to £285,000, *in addition* to life-time costs

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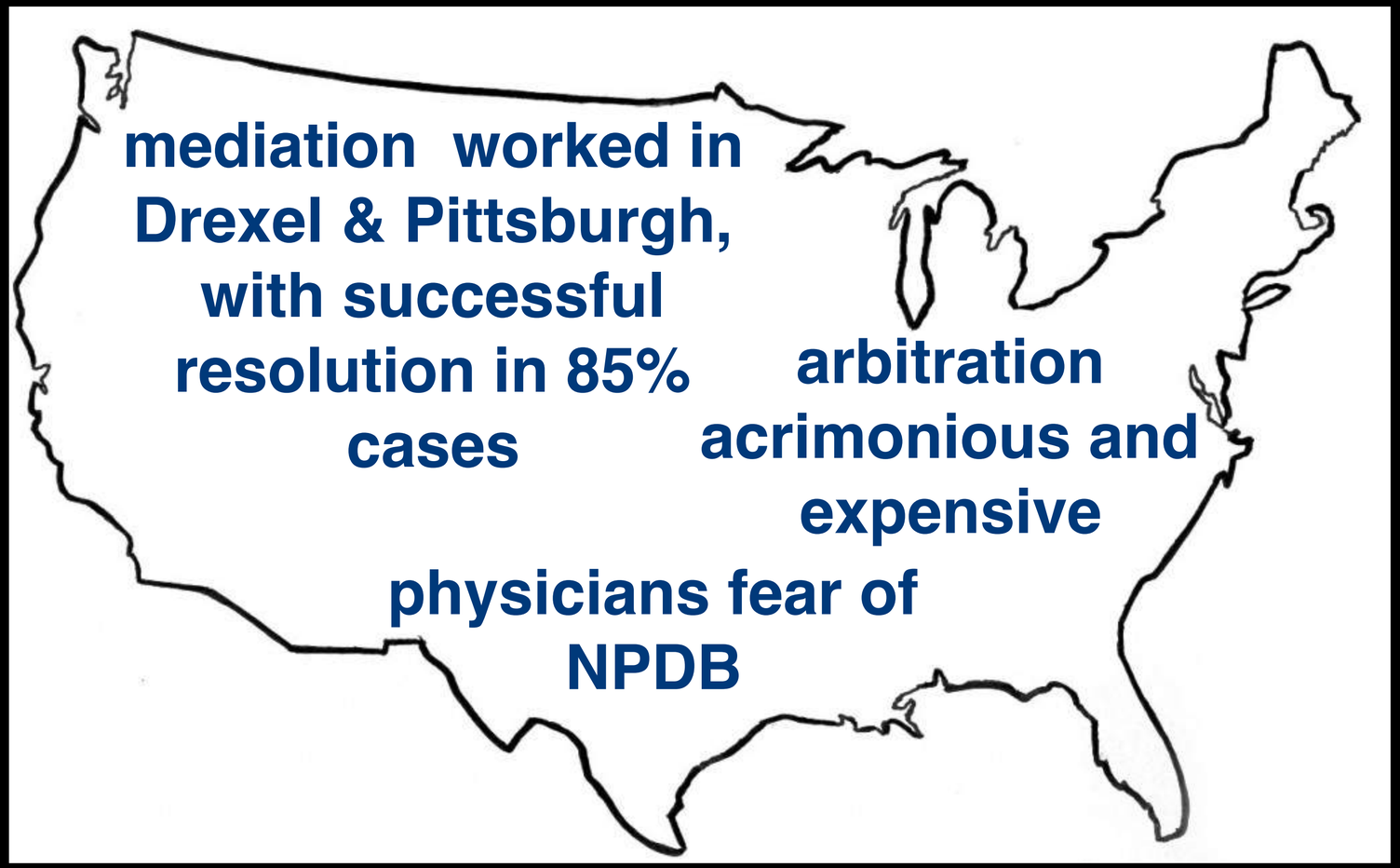
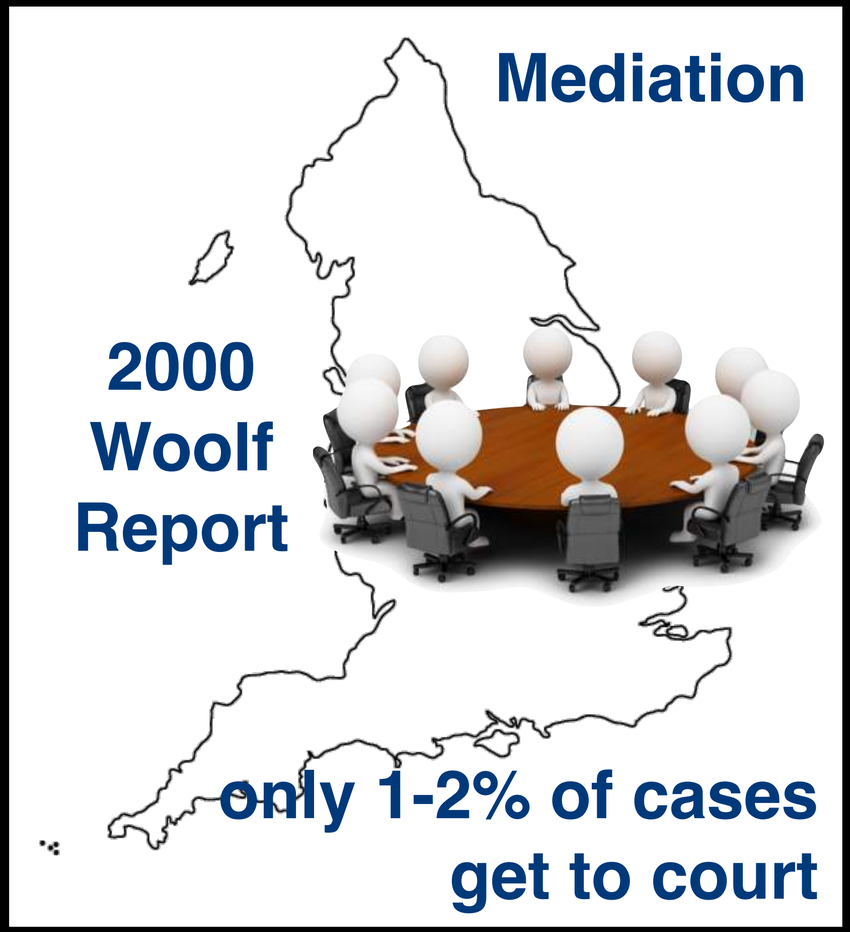
Alternative Dispute Resolution

early apology **mediation** **arbitration**





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Health Courts

An attempt in the USA to use tribunals before medically ‘savvy’ judges or tribunals , rather than juries.

Constitutional objections related to right to jury trial

Supreme Court still to adjudicate

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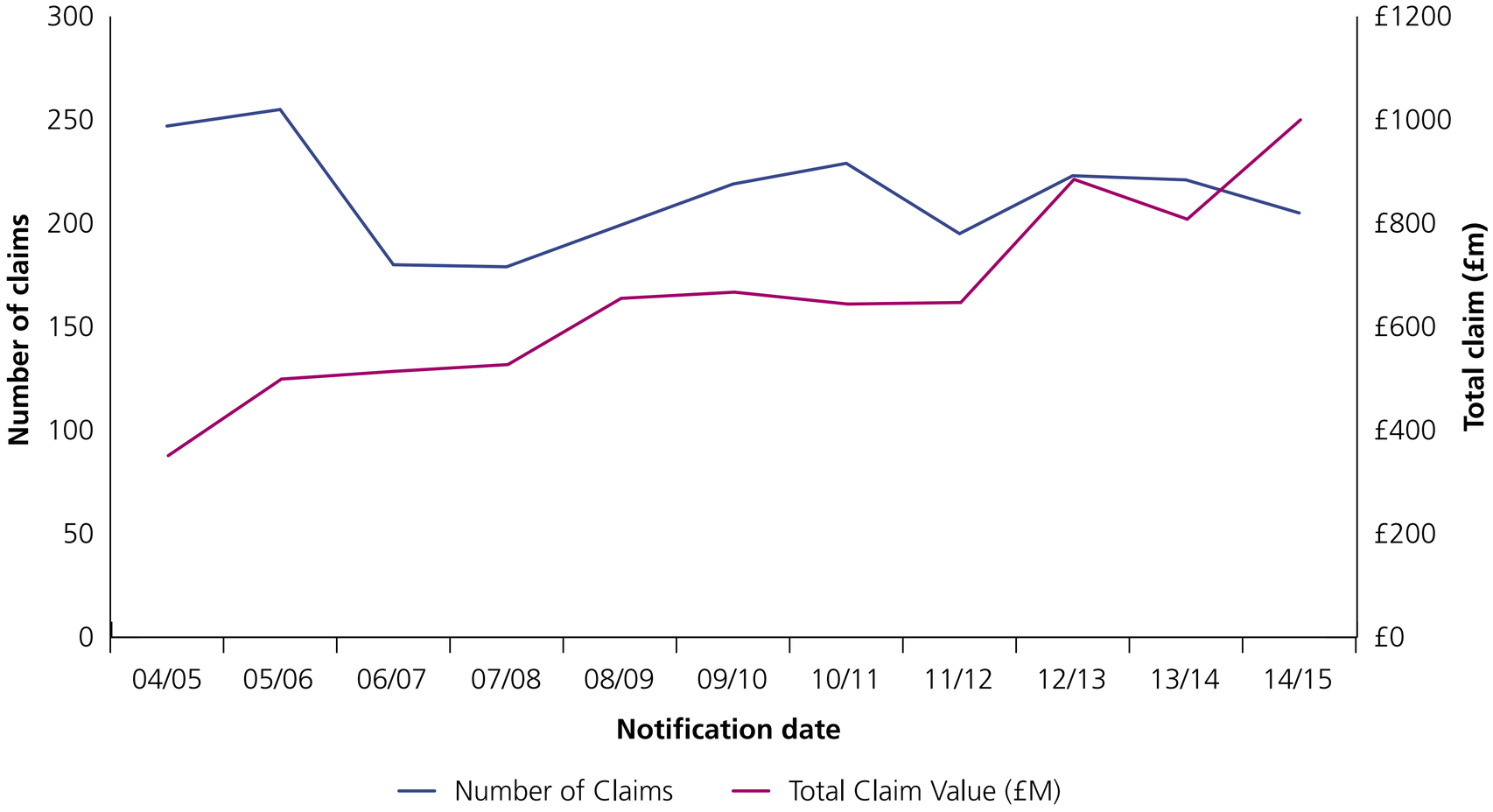
Is Litigation Changing Behaviour?

Figure 9: Number & value of maternity cerebral palsy/ brain damage claims received



Maidstone and Tunbridge Wells NHS Trust Caesarean death 'avoidable'

13 January 2016 | Kent

The death of a woman just hours after a Caesarean birth was wholly avoidable, a court has heard.

Frances Cappuccini, 30, suffered heavy bleeding at Tunbridge Wells Hospital on 9 October 2012 and was operated on but never woke from the anaesthetic.

Inner London Crown Court heard she died after going into cardiac arrest.

Dr Errol Cornish denies manslaughter by gross negligence, while the Maidstone and Tunbridge Wells NHS Trust denies corporate manslaughter.

It is the first time an NHS trust has been charged with corporate manslaughter since the offence was introduced in 2008.

Local Prevention

Reduce Errors at Source

Most errors are committed by good, hardworking people trying to do the right thing at the right time

Everyone makes errors

Repeating an error, or allowing errors to escalate is not good

some things ARE worthy of blame

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Safety Culture

JUST Culture
people encouraged (rewarded) for reporting error, but **clear accountability**

Informed Culture
those who manage know all the factors (inc.human) which determine safety

Learning Culture
willingness and competence to use safety data to reform

Reporting Culture
people are prepared to report their errors and near misses

Flexible Culture
ability to reconfigure in face of high tempo events or dangers

Based on ***Reason (1997)***

The Components of Safety Culture: Definitions of Informed, Reporting, Just, Flexible and Learning Cultures

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doctors don’t like being told what to do

AT FOR

they don’t feel ‘employed’

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Performance Management of Doctors

- traditionally been ‘weak’ and peer enforced
- 2012 GMC Revalidation appraisal, 360 deg feedback and limited performance data
- signed of by Responsible Officer at each Trust
- “one of the most comprehensive, and ambitious schemes in the world”
- BUT

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Performance Management of Doctors *within* Units

- remains weak and lacks detail
- hard to discipline life-long colleague in a small team
- identification of repeat errors poor
- repeat errors lead to big errors, low grade poor performance leads to big problems

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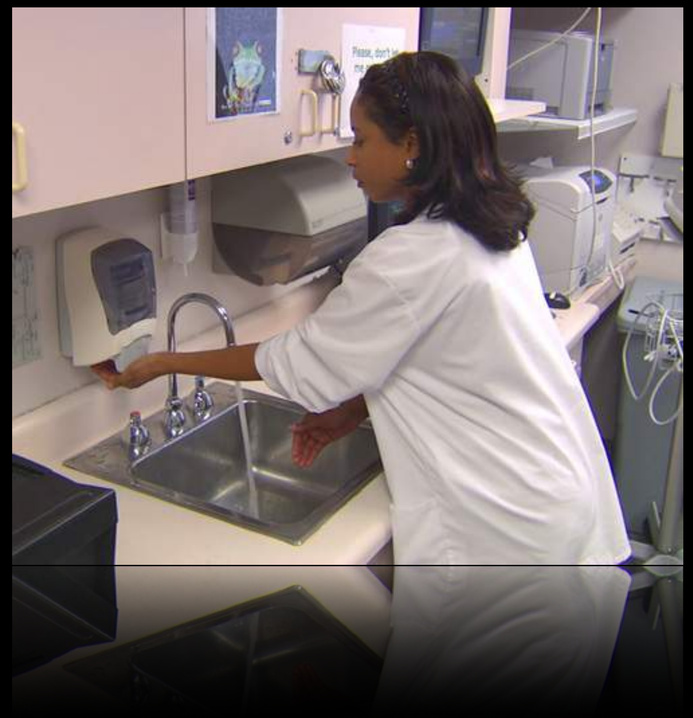

- washing hands reduces infection risk
- doctors often worst offenders
- rarely > 70% hand washing rates

- **everyone forgets occasionally**
- how do we identify the **repeat offender?**
- what do we do about **repeat offenders?**

Wachter RM, Pronovost PJ.
Balancing "No Blame" with Accountability in Patient Safety.
NEJM 2009;361(14):1401-06.

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Dr Gerald Hickson
Vanderbilt University

2 to 8% of physicians per discipline are responsible for up to **30%** of all malpractice claims

Hickson introduced **regular risk assessments,** and a series of '**difficult conversations**'

*"Our goal is to let some of our physician colleagues know 'you're driving 45 in a 30 mph zone, and **we thought you'd want to know.**'"*

In 13 yr at Vanderbilt, ≈ **100** high-risk physicians have been identified

"**70** have done well. **14** have departed, and the rest are getting 'additional assistance'"

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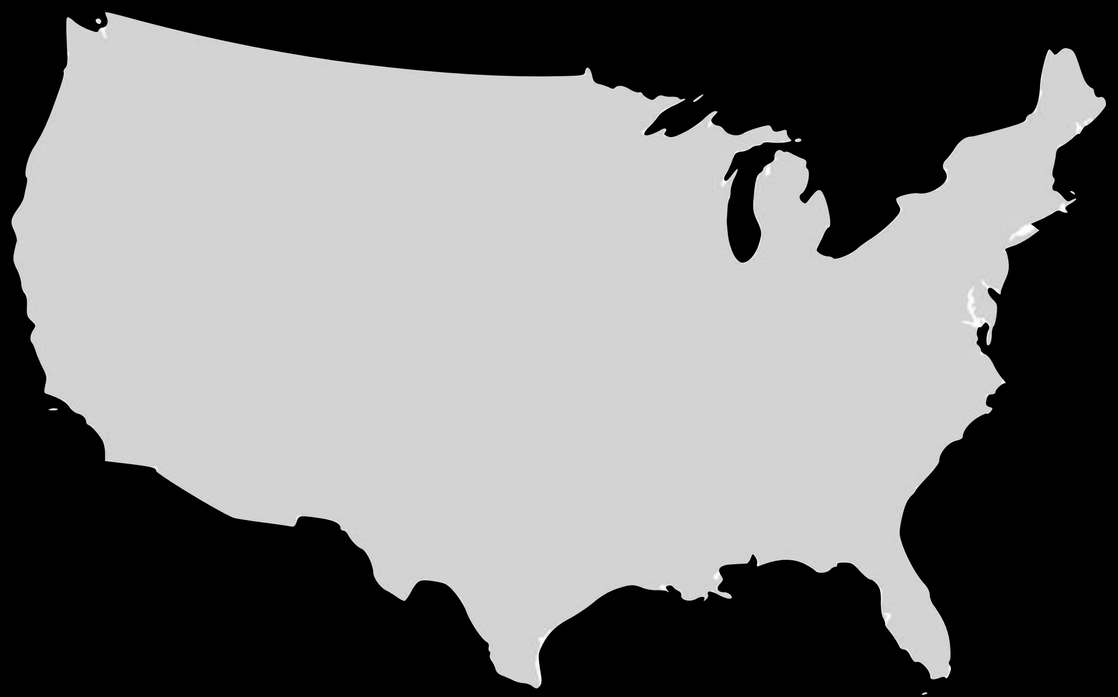

pay for performance (quantity & quality)
contracts reviewed regularly
tough appointment process

equal pay
tenure from year 1
simpler appointment process

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Two Tribes

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we all make errors

errors are frequent, negligence is not

harm + negligence = compensation

repeated errors are a warning

litigation is expensive, but ‘shines a light’

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no-fault compensation is fair and logical

no-fault compensation is ? too expensive

we should concentrate on LOCAL actions to reduce harm, cost and the repetition of error

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Defining the borders of “bad behaviours”
(From P. Stastny *Sixth GAIN World Conference*, Rome, 18-19 June, 2002)

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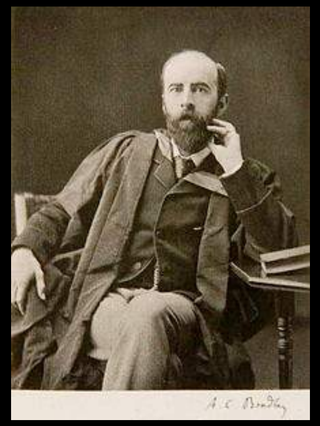
Thank You

culture



rules

A.C. Bradley (1851-1935) in a 1904 lecture on the Tragedies

“It all comes back to **consequences**.”

“The irony of all this is that, ultimately, the tragic consequences of Hamlet’s inaction are the multiple unintended deaths he causes.”

JM Pressley 2013

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