

# Culture of blame in the National Health Service; consequences and solutions

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*The single greatest impediment to error prevention is that we punish people for making mistakes.*

Dr Lucian Leape, Harvard School of Public Health

A culture of blame has been inherent to human civilization. For centuries now, society has attempted to find a scapegoat for any perceived wrong within its precincts. In the more logical and methodical field of science, one would have hoped to find some reprieve, but even these large corridors of human intellectual activities are often rocked by this deplorable culture of fault finding and blame. Charles Darwin and Galileo were blamed and suffered hardships because their new scientific concepts challenged the established beliefs. The health industry has its share of this culture, as have the aviation and nuclear industries.

On March 17, 1987, the Los Angeles Times reported that the officials involved in the Chernobyl disaster were to be tried. The reality of the system failure leading up to the nuclear catastrophe was to come to light much later. As a result of a similar blame culture, the aviation industry has lost some conscientious pilots. The industry has since investigated the incidents, and has pioneered and revolutionized the way in which failings are handled. It has moved away from blaming individuals to recognizing the reality of systems failure and has made its internal error reporting and management of faults more robust. The Aviation Safety Reporting System<sup>1</sup> provides a platform to self-report safety incidents, with the incentive of immunity from prosecution.

Recently, a system failure in a London hospital resulted in a young nurse taking her own life, fearing humiliation and blame. Many others in the health industry have lost jobs or have suffered serious stress and health issues after errors for which they were blamed.<sup>2</sup> Under the directive of its Chief Executive, the General Medical Council recently conducted an internal review of instances where doctors who were under fitness-to-practice investigations had committed suicide. The 28 suicides reported are believed to be merely the tip of the iceberg, because it does not reveal the full scale of the stress suffered by many others under similar investigation.

## What should change?

To bring in change, we need to look at the present state of the health industry and the way in which human errors are handled.

High-fidelity industries, such as the aviation, nuclear, and health industries, are prone to error. 'To err is Human'<sup>3</sup> reported a high incidence of human errors in the health sector. The figure of 44 000–98 000 deaths per year in the USA was recently corrected

to an even higher figure of 400 000 per year in the Journal of Patient Safety.<sup>3</sup> An estimated 1000 people per day could die in the USA because of medical errors, and they are the third largest killer after cancer and cardiac disease. In the National Health Service (NHS),<sup>4</sup> nearly 900 000 incidents and near misses are reported every year, and 2000 of these result in death.

In complex systems, there is always error; it is embedded in the system like grains in a loaf of bread. It is impossible to create a completely error-free system. Error in a system will sooner or later manifest itself through a human act. Unfortunately, the culture is to blame the individual for the error rather than to try to understand the various processes in the system that lead to the fault.

## What happens when a doctor or a nurse commits an error?

The person committing an error often has to face his or her professional body governed by a set of beliefs, the medical paradigm. Beyond this, the person may have to face another set of issues related to law, the legal paradigm. How do these two professional paradigms deal with human error?

### The medical paradigm

The medical paradigm demands that the practitioner practises to perfection, and if the person falls short of this high standard, then the person is to blame.<sup>5</sup> It maintains that error is a moral and ethical failure that constitutes an unprofessional act, which should be punished; the last person to touch the patient should be blamed if there is an untoward result. This person is also expected to own up to the error. This approach puts significant pressure on the individuals by demanding perfection with the ever-present danger of 'blame'. Given that errors are not treated as human, errors may not be reported for fear of professional insults or legal reprisals.

The medical paradigm does not appreciate that there are often two victims to a medical error, the patient and the person committing the error. The patient may suffer the consequences of error, but the person committing the error is often tortured by guilt and may suffer considerable mental anguish. The consequences are even more devastating for the person committing the error than for one on whom the error was committed. The suicide of Jacintha Saldhana, who took upon herself the blame of leaking information regarding the royal couple, is a sad but most recent example of this. The 46-yr-old was found dead at home near the hospital, where she had worked as a nurse for 4 yr. The mum-of-two's suicide came after she was duped into putting through to Kate Middleton's nurse a hoax call by two prank callers

pretending to be the Queen and Prince Charles. A failure in the system had allowed such a call to be transferred.

Is there still a potential for the re-occurrence of such an incident?

Julie Thao, a senior midwife, was found guilty of manslaughter<sup>6</sup> for connecting an epidural bag i.v. to a 16-yr-old pregnant mother. That the nurse had worked for more than 16 h the night before, and the fact that the bags looked similar did not help her defence. It did not come to her aid that for 19 yr she had given a blemishless service to the health industry, when it was weighed against the emotions surrounding the death of a 16-yr-old young mother. The culture demanded that 'Someone should pay for this tragedy'. The nurse did. The fact that there have been several similar incidents in labour wards across the world is a pointer to the fact that the fault is inherent and embedded in the system and should be tackled differently. However, proponents of the medical paradigm would disagree.

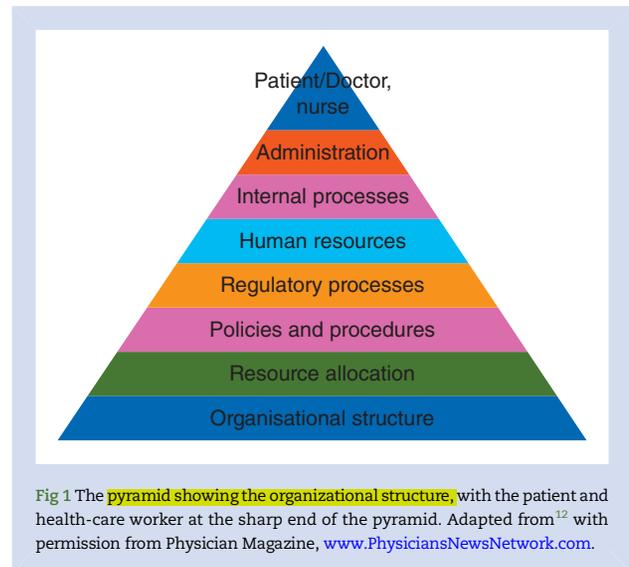
### The legal paradigm

The legal paradigm's approach to ensuring safe medical care delivery is by the **rules of malpractice, or negligence.**<sup>7</sup> The proposition has been made more attractive with the **'no win-no fee' banners.** It is founded on principles of ethics. Bad things happen because individuals make mistakes, so by dealing with the wrong-doer the error is dealt with. The error can also easily be dressed up by the legal system and made to look like a punishable offence. Bryan Liang<sup>8</sup> puts it most effectively: **'Legal process taints data by zealous advocacy – manufactures data to support one side's case.'** It does not understand that the professionals are trapped in a complex system that from time to time is prone to error.

The sum total of these two professional paradigms is that the individuals feel victimized and, for fear of being blamed, would not report errors.<sup>9</sup> It inhibits frank and accurate discussions about error and systems weakness. It limits lessons learned, and the lessons are not disseminated amongst the health providers. The error remains undiscovered in the system and might from time to time reappear.<sup>10</sup> Similar errors may be repeated,<sup>11</sup> providing a deadly delivery environment for the patient. As the facts are buried, the patients may not get adequate compensation. The medical and legal paradigms generate an environment of distrust among the patient, provider, and legal system.

### Systems paradigm

The systems paradigm is based on the principle that **humans are fallible and that human errors are likely to occur in the best organizations.** Errors are the end result of a series of failures in the system and therefore they are **consequences and not the causes.**<sup>5</sup> This is best explained using **a pyramid (Fig. 1).** The pyramid represents the system and is made of several layers. Each of these layers in turn represents a particular layer of the organization. In a typical hospital set-up, these may be management, medical personnel, financial institutions, staffing levels, training structure, theatre set-up, ward set-up, and so on. On the **sharp end of the pyramid are the medical staff, such as doctors, nurses, physiotherapists, or midwives, delivering care to the patient.** **Errors are generally reported at the sharp end.** The systems paradigm looks at the error as a cause of failures at several levels. While the layers may have protocols and guidelines to prevent errors, they also have deficiencies. **Each of these layers** can be likened to the layers of cheese in the **James Reason's Swiss cheese model.** Each layer of cheese has **active holes** and **latent holes.** While the errors are trapped by the layers, on a bad day



the **holes line up** and a **mistake will travel through,** resulting in a clinical incident. The systems paradigm encourages the people at the sharp end of the pyramid to report errors so that the **root cause** of the error can be **identified** and dealt with. It does **not apportion blame** and does **not believe in the 'name and shame'** approach of the **medical and legal paradigms.** When an event occurs, **it is not about who committed the error but why the defences in the various layers failed.** Staff in such a set-up are more likely to report error without fear. This would give the organization an opportunity to identify error and strengthen areas so that it does not happen again. The system benefits because it grows more robust, simultaneously creating a good work environment and ethics. This would be in keeping with the **Berwick Review<sup>13</sup>** and the **Francis report,<sup>14</sup>** which encourage a change: to rid the system of blame and introduce a **culture of openness.** Wilful, reckless, or criminal acts are very rare and need to be dealt with appropriately, but the system should not hold to task the managers or health-care professionals when an error occurs that is beyond their control.<sup>13</sup>

### Wisdom, solutions, and change

Since the tragic loss of Elaine Bromiley and Gordon Ewing to anaesthetic incidents, and the failures at the Mid-Staffordshire NHS Trust, a greater wisdom is slowly seeping through the health sector in the UK. The **Clinical Human Factors Group (CHFG)** initiated by Martin Bromiley has had a profound effect in bringing to light the system failures in the clinical sectors that lead to errors. In bringing about this change, Mr Bromiley led by example, by asking the medical profession to analyse the reasons behind his wife's tragic death and make the report public. No charges were brought against individuals, and all the professionals involved in the case remain to serve and help the system to avoid similar errors. Francis and Berwick in their respective reports identified the several factors that could lead to failure and the need for an open culture where incidents can be reported without fear of reprisals.<sup>9</sup>

The NHS has an urgent need to change in order to implement the systems approach. Currently, it is easier to blame an individual than to blame the system. This attitude will only make the industry lose members who committed errors in the wake of their duties. The error will continue to flourish and

might propagate itself at the cost of other staff who may likewise be blamed. To identify the error, it must be reported promptly and honestly. A **robust critical incident reporting<sup>15</sup> system is** the key to improving patient safety. A system that encourages **data input, data analysis, and feedback** without fear of punishment is likely to grow stronger, with more errors reported and processes established to eliminate and mitigate the consequences of error. The **data input should be without too many closed** questions and allow the staff to give a **true account of the event in free words**, so that the chain of factors leading up to the event can be identified. The staff themselves may require support in the form of training or counselling.<sup>13</sup> The **National Patient Safety Agency's quick decision tool** called the **'incident decision tree (IDT)'** is aimed to support managers and to have a consistent and fair approach to management of the staff. The IDT<sup>16</sup> would guide the manager in decision making after an incident and would highlight alternatives to suspension. This tool could help to identify and isolate malicious harm from those caused by system errors. Every effort must be made to retain staff. Such an approach would be more productive to the industry, the society, and the country. A trained staff member discarded from the health sector will only add to the statistics of stressed, unemployed individuals in the country. They had trained hard to gain employment to serve in a noble way but have now been maimed by an error in the system.

Medical and legal paradigms are likely to put shackles on the health-care industry, whereas the systems approach is clearly the way forward<sup>8</sup> that should take us out of the dreaded 'culture of blame'.

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