MEDICAL TRANSPARENCY

HAS HEALTHCARE FINALLY REACHED ITS TENERIFE DISASTER?

Recent events both locally and in the UK – such as the Inquiry into Hyponatraemia-related Deaths and the Bawa-Garba case – have the potential to be the turning point which our health service has been waiting for and the catalyst for long-awaited change. Do we want to keep blaming healthcare professionals for human error and demanding retribution without looking at the broader human factors picture of the environment they function in when we analyse why events happen? Niall Downey FRCSI sheds some light.

Niall Downey

In March 1977, 583 people died in a plane crash at Los Rodeos Airport in Tenerife. Approximately 3,000 people were dying each year in aviation accidents – an unsustainable trend. Analysis found that the accident (like many others) was due to human error on multiple levels.

THE TURNING POINT

Tenerife became the turning point in aviation history. Error is now accepted as inevitable in this complex, rapidly changing environment, and the focus is on resilience to intercept the error before it evolves into an accident.

The success of this approach is evidenced by the huge reduction in aviation accidents since. Deaths worldwide annually are now generally measured in the hundreds despite roughly four billion passenger movements per year – a 16-fold increase since 1977. Indeed 2017 passed without a single death in worldwide commercial jet aviation

HEALTHCARE AND HUMAN ERROR

Healthcare also has an issue with human error. Accurate figures don't exist, and adverse events due to error aren't reported reliably or consistently. However, there are studies going back over 40 years worldwide. The most recent, from Professor Marty Makary of Johns Hopkins University in Maryland, was published in the BMJ in 2016. It placed error as the third highest cause of death behind only cancer and heart disease. Extrapolating figures from the various studies to the Northern Ireland health service would be a sobering exercise, but could establish a baseline.

Locally, the Hyponatraemia Inquiry recently delivered its report on the avoidable deaths of four local children. This report took 14 years to reach publication. It's scathing about the culture of healthcare, its lack of transparency, and its inability or unwillingness to learn from error.

WHY DOES THIS CULTURE EXIST?

We, as a society, have to shoulder some of the responsibility. When an error occurs, we generally call for someone to be held responsible and demand retribution and compensation.

Understandably, staff are advised by their employers not to admit liability, leading to frustration on both sides – patients not getting the answers they want, and staff not able to provide the care they would like to. Litigation is generally the only means of breaking the log-jam. Expensive, lengthy legal cases ensue, taking a heavy toll on both staff and patients.

The multiple causes of the error are rarely teased out and the opportunity to learn is missed.

Compensation has averaged around £35 million annually in the province in recent years, much of which goes to the legal teams, not the patient. Total costs are estimated at three to four times this. This is not sustainable. If we want a 21st Century health service, we need to embrace change which involves acceptance of error by us all. The 'name, blame and shame' culture hasn't worked. Our hard-working, dedicated staff deserve better. We need to decide whether we are brave enough to move to a better model. We need to accept that error is inevitable in complex, high-stakes environments, including health, and isn't necessarily evidence of incompetence.

THE BAWA-GARBA CASE

Recently in the UK, an event occurred which has mobilised doctors like never before. This tragic case involves a six-year-old boy called Jack Adcock and his doctor, senior paediatric trainee, Dr Hadiza Bawa-Garba.

Jack was admitted to Leicester Royal Infirmary in February 2011. Dr Bawa-Garba mis-diagnosed him, missing signs and test results suggesting sepsis which should have set off alarm bells. That evening, Jack suddenly deteriorated, and he was

being resuscitated as Dr Bawa-Garba arrived to his room. She mistakenly identified him as being not for resuscitation and called off the intervention – although it was subsequently deemed that Jack's condition was unrecoverable by this stage, so this didn't affect the final tragic outcome.

Dr Bawa-Garba met with her consultant in the following days and analysed what went wrong and what could be learned from the case. There were multiple failings at a systemic level in the hospital, including staffing levels, senior supervision, and IT issues, among others. The Crown Prosecution Service deemed that she had no case to answer and she worked for several more years without incident.

However, in 2015 following the inquest, it was decided to pursue the case after all. She was convicted of manslaughter and sentenced to two years in jail which was suspended. She was investigated by the General Medical Council's (GMC) Fitness to Practise body, the Medical Practitioners Tribunal Service. They suspended her from the medical register for 12 months. The GMC, however, decided that as a result of the conviction of manslaughter she should be permanently removed from the medical register.

An appeal was heard in January 2018 which up-held this decision, leaving Dr Bawa-Garba to shoulder responsibility without reference to the many human factors issues which contributed to her errors. An unprecedented ground-swell of outrage from the profession led to crowd-funding of a Supreme Court appeal which raised £160,000 in one day and over £360,000 within weeks.

Significantly, the notes from her meeting with her consultant where she reviewed her errors (known as reflective practice and now part of regular training progress reviews) were shown to the prosecuting legal team. The emergence of this new hostile environment has not been lost on doctors and their representative groups.

This has particular significance given the recommendations issued by Mr Justice O'Hara in the local inquiry where the lack of acceptance of error and inability to reflect on it were highlighted. 96 recommendations were made, including a duty of candour for clinicians to be open about errors and to learn from them. It's difficult to see staff embracing this very laudable idea if these same 'reflections' will be admissible in evidence against them leading to possible manslaughter convictions and erasure from the register for genuine errors in an otherwise exemplary career. Turkeys are unlikely to vote for Christmas!

SO, WHAT'S NEXT?

Aviation has been held up for many years as an example of how healthcare could be structured, but with little buy-in – staff arguing that there aren't enough similarities between the two industries for valid comparisons. Perhaps it's time to revisit that idea?

Aviation's system is built on the foundation of 'Just Culture'. Error is accepted as inevitable, not an indication of incompetence or inability. When staff make an error, as long as they report it and co-operate with investigating how it happened, no disciplinary action ensues. This extends to formal statements in air accident investigation reports which are inadmissible as evidence against the individual in any subsequent legal proceedings. It's not a 'get out of jail free card' though – it's invalidated in the case of deliberate sabotage or gross negligence. Healthcare staff are often criticised for withholding information and not apologising for errors. Changing this will require transparency, promoting a lack of fear on the reporter's part – a situation now set back a decade or more by the recent event in the UK. Legal protection similar to that in the aviation industry would be a starting point in addressing this.

THE ROLE OF THE PUBLIC

The public have a part to play also. Error needs to be accepted as inevitable in a complex, rapidly changing, safety-critical industry, such as healthcare. We can't simply rush to apportion blame and demand retribution if we want this toxic culture to change. Our staff deserve better. Many patients find litigation their only option to pursue what they see as justice for themselves or loved ones. Mediation is an option which often provides a much faster, less stressful and ultimately more positive outcome for all sides. If we fail to evolve, our health service is doomed to keep repeating the same mistakes. As the Bengoa Report emphasised, we are on a burning platform – the status quo is no longer an option.

A SYSTEMATIC CHANGE

Staff also need to be trained in managing error early to prevent it escalating and to redesign systems to avoid repetition. Healthcare needs to do more than simply pay lip-service to learning from other industries and actually start applying the lessons learned at great cost elsewhere.

Contrast the 14-year time frame of the Hyponatraemia Inquiry with the Air France AF447 crash in 2009. Airbus issued modified procedures for stall recovery alongside instructions for physical modifications to the aircraft within weeks despite the Black Box flight recorders not being found until two years later. This information was promulgated to all A330 operators worldwide simultaneously. Aviation has superb safety tools which are largely transferrable to healthcare with a little modification. Early studies showed that 40 to 80 per cent of adverse events could be intercepted, saving possibly hundreds of lives per year here and significantly reducing the workload and financial burden on our health service.

The Bengoa Report concluded that the health system we currently enjoy in Northern Ireland is unsustainable. The culture and structure of our health service needs to change. Do we keep blaming staff for human error without looking at the broader human factors picture of the environment in which they function? This simplistic blame culture hasn't served our society well.

Bengoa proposed transformation over 10 years. Learning from other industries which have transformed, especially aviation (often seen as the gold standard in error management), seems a good starting point. Recent events both locally and in the UK have the potential to be the turning point our health service has been waiting for.

Healthcare has finally had its Tenerife moment. We owe it to the children who lost their lives not to miss the opportunity to accelerate the transformation their cases have already kick-started. The foundations have been laid – let's start building!

ABOUT THE AUTHOR

Niall qualified as a doctor from Trinity College, Dublin in 1993. He trained as a surgeon in Belfast and received his FRCSI in 1997 before returning to Dublin where he worked in the National Cardiac Surgery Unit. He subsequently retrained as an airline pilot with Aer Lingus in 1999 and combined aviation with medicine by working as an Accident & Emergency doctor for six years before focusing fully on aviation. After operating as a co-pilot on both the European and Trans-Atlantic fleets, he qualified as a captain in 2010 and is currently captain on the Boeing 757 Trans-Atlantic fleet based out of Dublin. In 2011, he formed Frameworkhealth Ltd, a company providing aviation safety training modified specifically for healthcare.

For more information, visit www.frameworkhealth.net.