To Blame or Not To Blame

elliott

professor of cardiothoracic surgery at UCL
paediatric cardiothoracic surgeon at GOSH
professor of physic at Gresham College

ProfMJElliott
martin.elliott@gosh.nhs.uk
The NHS in 2014/15

- 1 million patients every 36h
- 16 million admitted to hospital
- 10 million had operations
- 22 million went to A&E

- Negligence claims made in ≈ 0.05% of NHS activity
- Serious incidents reported in ≈ 0.5% of NHS activity

Serious incidents and negligence claims make up a small fraction of NHS activity.
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?

ProfMJElliott
martin.elliott@gosh.nhs.uk
Never Event

Oops
compensation..... it wasn’t your fault

investigation...... what really happened

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

support.......... for everyone involved
The duty of CARE

The duty of CANDOUR
The Duty of **Candour**

long-standing *ethical duty* of doctors

after the Francis Report (2013)

a *legal obligation* for doctors AND organisations
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

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

empathy, explanation and an apology may not be enough
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
Part Two: Underpinning Principles

1. Seven Key Principles

This Framework endorses the application of 7 key principles in the management of all serious incidents:

- **Open and Transparent**: The needs of those affected should be the primary concern of those involved in the response to and the investigation of serious incidents. The principles of openness and honesty as outlined in the NHS Being Open guidance and the NHS contractual Duty of Candour must be applied in discussions with those involved. This includes staff and patients, victims and perpetrators, and their families and carers. The Department of Health has introduced regulations for the Duty of Candour. It requires providers to notify anyone who has been subject (or someone lawfully acting on their behalf, such as families and carers) to a 'notifiable incident' i.e. incident involving moderate or severe harm or death. This notification must include an appropriate apology and information relating to the incident. Failure to do so may lead to regulatory action. Further information is available from http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1.pdf
1. Overview of the Serious Incident Management Process

- Incident occurs
  - Report on LRMS/ NRLS and to other bodies such as safeguarding lead as applicable
  - Manage in line with local risk management policy
  - Engage with those involved/affected
  - Report on STEIS
  - Complete initial review and submit to commissioner where possible this should be the provider’s ‘lead commissioner’ who can liaise with others as required. This should be outlined in the RASCI model.

- Is it a serious incident?
  - No
    - Review and discuss with commissioner
  - Yes
    - Report/notify other stakeholders as required e.g. safeguarding, CQC, TDA etc.
  - Unknown
    - Within 2 working days
    - Review and discuss with commissioner

- Is it a serious incident?
  - No
    - Review and discuss with commissioner
  - Yes
    - Report/notify other stakeholders as required e.g. safeguarding, CQC, TDA etc.
  - Unknown
    - Within 3 working days
    - Complete initial review and submit to commissioner where possible this should be the provider’s ‘lead commissioner’ who can liaise with others as required. This should be outlined in the RASCI model.

- Within 2 working days
  - Manager in line with local risk management policy
  - Engage with those involved/affected
  - Report on STEIS
  - Complete initial review and submit to commissioner where possible this should be the provider’s ‘lead commissioner’ who can liaise with others as required. This should be outlined in the RASCI model.

- Within 3 working days
  - Manager in line with local risk management policy
  - Engage with those involved/affected
  - Report on STEIS
  - Complete initial review and submit to commissioner where possible this should be the provider’s ‘lead commissioner’ who can liaise with others as required. This should be outlined in the RASCI model.

- Support and involve those affected (including patients, victims and their families and staff)
Basic Steps of Root Cause Analysis

The 5 Why’s

Fishbone Analyses

http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/
Patient discharge planning included prophylaxis. Patient information/dischARGE advice provided. Patients’ GP advised of VTE prophylaxis (mechanical or pharmacological) at time of discharge.

Why it happened: scrutinising problems

Each identified problem should be scrutinised individually to establish what factors have contributed to that problem. There are several frameworks available to aid this. The NPSA Root Cause Analysis toolkit suggests the fishbone tool as shown in Figure 2.

Figure 2. Fishbone tool

Each part (or factor) of the fishbone prompts a series of questions (components) about the event. Table 2 is a list of factors with their associated components for consideration when applying the Fishbone tool specifically to a VTE Root Cause Analysis.

@ProfMJElliott

martin.elliott@gosh.nhs.uk
60 Days
blame culture

a culture that

names, shames and blames

those who make errors
The Media Seek to Blame
Who’s to blame for this?
Reason's Swiss Cheese Theory

Levels of defence

Active errors
(Patient safety incident)

Latent conditions
poor design, procedures, management decisions etc.
BMA
Blame Must be Allocated

the surgical trainee

ProfMJElliot
martin.elliott@gosh.nhs.uk
Feel free to celebrate Boss’s Day by blaming me for one of your many mistakes today.
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.

@ProfMJElliot
martin.elliott@gosh.nhs.uk
“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
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
Doors’ experiences of adverse events in secondary care: the professional and personal impact

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

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

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

Multiple factors are thought to contribute to this, including feedback, systems change or local improvement or chance or because it is intercepted'.

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The **NHS** is extremely **Complex**
will they change anything? how will we know?
“That could never happen here!”
Investigate ✔
Report ✔
Recommend ✔
Act ❓

Compensate?
Moind's Fourth Postulate

The degree of certainty in one's level of competence is inversely proportional to the actual level.
In the NHS in England the only way you can get compensation is to take legal action by making a claim of medical negligence

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
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

unfairness

negligent act

£££

000

disease state

ProfMJElliott
martin.elliott@gosh.nhs.uk
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
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

Breach of Duty

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

ProfMJElliott
martin.elliott@gosh.nhs.uk
the evidence
THE 6 TYPES OF PHYSICIAN HANDWRITING

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

Patient seen and examined

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


TYPE 3  THE "EVERY-OFFER-WORD-MAKES-SENSE"

Bun critical RR X STAT!

TYPE 4  THE INTOXICATED -- OR PROBABLY JUST ON PERCOCET


TYPE 5  THE DEBONAIR SANSKRITE -- 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
intuitive - pattern recognition

Aoccdrnig to a rseearch at Cmabridge 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.
intuitive - pattern recognition
Copying, on an industrial scale
Electronic Medical Record

the lost narrative
is what we see correct?
a clinician

*takes* risk & makes decisions (many)

*under pressure*

a lawyer

*analyses* risk & decisions

*at leisure*
Deciding without Data

Jeffrey R. Darst, MD¹, Jane W. Newburger, MD, MPH¹, Stephen Resch, PhD², Rahul H. Rathod, MD¹, and James E. Lock, MD¹

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

Abstract

Introduction—Physician decisions drive most of the increases in health care expenditures, yet virtually no published literature has sought to understand the types of evidence used by physicians as they make decisions in real time.

Methods—Ten pediatric cardiologists recorded every clinically significant decision made during procedures, test interpretation, or delivery of inpatient and outpatient care during 5 full days and 5 half days of care delivery. The basis for each decision was assigned to one of 10 predetermined categories, ranging from arbitrary and anecdotal, to various qualities of published studies, to parental preference and avoiding a lawsuit.

Results—During the 7.5 days, 1188 decisions (158/day) were made. Almost 80% of decisions were deemed by the physicians to have no basis in any prior published data and fewer than 3% of decisions were based on a study specific to the question at hand.

Conclusions—In this pilot study, physicians were unable to cite a formal evidence source for most of their real-time clinical decision making, including those that consumed medical resources. Novel approaches to building an evidence base produced from real-time clinical decisions may be essential for health care reform based on data.

Introduction

Every day, physicians make real-time decisions to order tests, medications, procedures, hospital admissions, and clinic visits. These decisions fuel the large majority of US health care expenditures, contributing to utilization of unnecessary tests and ineffective treatments. They can also be integral to learning and medical innovation, especially in treatment of unusual diseases with limited treatment options. Yet virtually no published literature has sought to understand the types of evidence used by physicians in their real-time clinical decision making. In this pilot study, we explored two questions: how many clinically
### 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.
Table 2

Basis of Decisions

<table>
<thead>
<tr>
<th>Basis of Decision</th>
<th>Number of Decisions</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience/anecdote</td>
<td>441</td>
<td>37.1%</td>
</tr>
<tr>
<td>Arbitrary/Instinct</td>
<td>175</td>
<td>14.7%</td>
</tr>
<tr>
<td>Trained to do it</td>
<td>173</td>
<td>14.6%</td>
</tr>
<tr>
<td>General study</td>
<td>146</td>
<td>12.3%</td>
</tr>
<tr>
<td>First principles</td>
<td>146</td>
<td>12.3%</td>
</tr>
<tr>
<td>Limited study</td>
<td>61</td>
<td>5.1%</td>
</tr>
<tr>
<td>Specific study</td>
<td>34</td>
<td>2.9%</td>
</tr>
<tr>
<td>Parental preference</td>
<td>6</td>
<td>0.5%</td>
</tr>
<tr>
<td>For research</td>
<td>4</td>
<td>0.3%</td>
</tr>
<tr>
<td>Avoid a lawsuit</td>
<td>2</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

n = 1188
Decision Making

The Retrospectoscope
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
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”
The NHS in 2014/15

- 1 million patients every 36h
- 16 million admitted to hospital
- 10 million had operations
- 22 million went to A&E

Negligence claims made in ≈ 0.05% of NHS activity

Claimant costs for lower value claims are disproportionate and excessive. For claims where compensation is less than £10,000, claimant lawyers recover almost three times more in costs on average. This disproportion has increased from 2013/14 to 2014/15 at every level of damages, but in particular, at the lower end. Defence lawyers work to fixed costs arrangements, with significantly lower costs than Claimant lawyers at every value range.

Figure 4: Disproportionate Claimant Legal Costs

Figure 5: Average Claimants legal costs as % of the total claim value (where damages are below £100,000)

@ ProfMJElliott
martin.elliott@gosh.nhs.uk
Figure 11: Clinical negligence expenditure including interim payments 2014/15

£1.2 billion
Amount Set Aside for Claims by NHSLA 2014/15

- Provisions at 31 March 2014: £26,103
- New Claims: £1,565
- Change in provision for existing claims and PPOs: £1,598
- Payments made in year: £-1,223
- Increase in provision for IBNR: £567
- Provisions at 31 March 2015: £28,610

£28.6 billion

10%

25%

NHS England Commissioning Budget

NHSLA Annual Report 2014-15
Legal Costs in 2014/15 were £300m excluding costs met by claimants themselves or the Legal Services Commission.
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
Annual Clinical Negligence Cover Premiums at GOSH

$y = 1.0555e^{0.2039x}$

$R^2 = 0.9443$

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

@ProfMJElliott
martin.elliott@gosh.nhs.uk
Professional Indemnity Schemes

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

personal communication, Prof Terence Stephenson

martin.elliott@gosh.nhs.uk
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’
Clinical & Medical Negligence Solicitors | No Win No Fee...
www.slatergordon.co.uk/clinical-medical-negligence

Medical Negligence Claims Explained | Slater and Gordon...
www.slatergordon.co.uk/clinical_medical-negligence

Medical Negligence Claims | No Win No Fee | Irwin Mitchell...
www.irwinmitchell.com/personal/medical-negligence

Medical Negligence Claims | No Win No Fee Clinical...
www.medicalnegligencecoaset.co.uk

Can I make a medical negligence claim on a no win no fee...
www.claims.co.uk
The life-long costs of harm can be enormous
Brain AVM
severe brain damage
life-long, 24/7 care
Cost to NHSLA will be £24,000,000

the case took four years

ProfMJElliott
martin.elliott@gosh.nhs.uk
the operator
I was greatly impressed with the rigor with
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*
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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[Contact Information]

martin.elliott@gosh.nhs.uk

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[Disclaimer]

ProfMJElliott
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”

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
New Zealand

Trust in the System

for levy payers 60%
for clients 76%

@ProfMJElliott
martin.elliott@gosh.nhs.uk
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
If the current system too costly and disliked, & no-fault schemes are unaffordable, what else can we do?
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
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
Alternative Dispute Resolution

early apology  mediation  arbitration

Mediation worked in Drexel & Pittsburgh, with successful resolution in 85% cases

arbitration acrimonious and expensive

physicians fear of NPDB

2000 Woolf Report

only 1-2% of cases get to court

ProfMJElliott
martin.elliott@gosh.nhs.uk
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
Is Litigation Changing Behaviour?

Figure 8: Changing Average Annual payments under PPOs

<table>
<thead>
<tr>
<th>Settlement year</th>
<th>Average Initial Annual Payment – actual</th>
<th>Average Initial Annual Payment – 04/05 prices</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/05</td>
<td>£160,000</td>
<td>£140,000</td>
</tr>
<tr>
<td>05/06</td>
<td>£120,000</td>
<td>£100,000</td>
</tr>
<tr>
<td>06/07</td>
<td>£80,000</td>
<td>£60,000</td>
</tr>
<tr>
<td>07/08</td>
<td>£40,000</td>
<td>£20,000</td>
</tr>
<tr>
<td>08/09</td>
<td>£0</td>
<td>£0</td>
</tr>
</tbody>
</table>

High value claims are usually settled by way of periodical payments which means that the claimant receives a lump sum for their immediate needs up front, followed by annual payments for life, usually for the costs of care. Currently, the law allows these to be awarded on a privately funded basis. This often means adapted accommodation, specialist education and a privately funded care regime. Both the 'up-front' costs and the annual costs have risen dramatically over the last 10 years. This is partly driven by underlying inflation but there is a significant increase over and above that.

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

<table>
<thead>
<tr>
<th>Notification date</th>
<th>Number of claims</th>
<th>Total Claim Value (£M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/05</td>
<td>300</td>
<td>£1200</td>
</tr>
<tr>
<td>05/06</td>
<td>250</td>
<td>£1000</td>
</tr>
<tr>
<td>06/07</td>
<td>200</td>
<td>£800</td>
</tr>
<tr>
<td>07/08</td>
<td>150</td>
<td>£600</td>
</tr>
<tr>
<td>08/09</td>
<td>100</td>
<td>£400</td>
</tr>
<tr>
<td>09/10</td>
<td>50</td>
<td>£200</td>
</tr>
<tr>
<td>10/11</td>
<td>0</td>
<td>£0</td>
</tr>
</tbody>
</table>

Maidstone and Tunbridge Wells NHS Trust Caesarean death 'avoidable'

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
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

@ProfMJElliot
martin.elliott@gosh.nhs.uk
doctors don’t like being told what to do

they don’t feel ‘employed’
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**
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
• 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.
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’”
pay for performance (quantity & quality)
contracts reviewed regularly

equal pay
tenure from year 1

simpler appointment process
Two Tribes
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’
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
Definition of Negligence: involved a harmful consequence that a 'reasonable' and 'prudent' person would have foreseen.

Definition of Recklessness: one who takes a deliberate and unjustifiable risk.

Reason (1997) believes that the line between "culpable" (or "unacceptable") and "acceptable" behaviour should be drawn after 'substance abuse for recreational purposes' and 'malevolent damage.'

The following figure (Figure 2) illustrates the borders between "acceptable" and "bad" behaviours, where statements in the safety policy can deal with human error (such as omission, slips etc), and where laws come into play when criminal offenses and gross negligence are concerned. Procedures and proactive management can support those situations that are less clear, at the borders.

Figure 2. Defining the borders of "bad behaviours" (From P. Stastny Sixth GAIN World Conference, Rome, 18-19 June, 2002)

2.5 Determining 'culpability' on an individual case basis

In order to decide whether a particular behaviour is culpable enough to require disciplinary action, a policy is required to decide fairly on a case-by-case basis. Three types of disciplinary policy are described below (Marx, 2001). The third policy provides the basis for a Just Culture. Reason's Culpability Decision-Tree follows.

Malevolent damage

Substance abuse for recreation

Substance abuse with mitigation

Negligent error

Unsafe acts

UNACCEPTABLE

BEHAVIOUR

"ACCEPTABLE

BEHAVIOUR"

BLAMELESS

BEHAVIOUR

Management Statement in Safety Policy

Procedures & Proactive Management

Procedures & Proactive Management

blame does not help

Defining the borders of "bad behaviours"
(From P. Stastny Sixth GAIN World Conference, Rome, 18-19 June, 2002)
Thank You
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.

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

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