The NHS is still failing to learn from things that go wrong. Could it happen again? **Michael Keighley** senses a feeling of *déjà vu*

The Spectre of Bristol

Never before has the medical profession been under such close scrutiny. The media love it, surgeons (or maybe surgeons and gynaecologists) take centre stage; blunders, botched procedures, mistakes, irreparable damage hit the headlines. Only foot and mouth and a general election stemmed the flow.

Many would agree with the editor of *The Lancet*, Dr Richard Horton, when he said that the profession as we had known it would never be the same again after Shipman, Alder Hey and Bristol. All three were emotive; murder in the afternoon in the doctor's chair, organ snatching from the dead and babies dying after surgery. Society expects perfection; they see it on three or four hospital soaps a week so that any perceived imperfection is definitely the result of human failure.

The Bristol enquiry lasted three years, it involved the examination of 2,056 case records, evidence from 577 witnesses and has cost the taxpayer £14 million. Few will forget the flysheet of the June 1998 *BMJ*; pictures of grey shoe boxes bearing white crosses carried by weeping relatives. The issues are complex but the excess mortality in paediatric cardiac surgery (PCS) at Bristol seems undeniable and confirmed from the UK cardiac surgical register.[1]

The report begins by stating 'It is an account of people who cared greatly about human suffering and were dedicated and well motivated' but, 'some lack insight, there was evidence of flawed behaviour, poor leadership, an inability to work in teams and there was poor communication.'

Photo: PA

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The causes

These are general and local. The general feelings of the NHS are appropriately highlighted, 'the inadequacy in resources for PCS in Bristol was typical of the NHS as a whole'[2] - but Professor Kennedy does not think that the Bristol affair was wholly caused by lack of resources because units elsewhere in the country performed more successfully. The report highlights insufficient safety, poor buildings, defective equipment, inadequate IT to capture accurate data; 'in the NHS there are no clinical standards, no benchmarks, no system for collecting or monitoring data'.[2] Then there was the new Trust culture. The competitiveness of the internal market so that babies from the southwest would no longer be shipped to the capital; 'Bristol had to be at the leading edge'.[3] For me, the most frightening statement was that the surgeons just kept going, hoping that things would improve (that a paediatric surgeon, an ITU and a children's hospital would materialise) rather than stopping so that the politicians and the health economists would do something. Nobody did anything.

There were concerns as early as 1986. The whistle blowing started in 1990 but everyone passed the buck; it went from the College of Surgeons to the Department of Health (DOH), back to the Trust and on to the Supraregional Advisory Group. At the DOH, Dr Doyle was given the data, 'he did not read it, but put it away in a filing cabinet without further scrutiny'.[2] An investigation did not start until July 1994 and PCS in Bristol was only stopped in 1995.

The local issues included inadequate facilities; two sites, no paediatric ITU, nursing shortages, poor organisation and management; in short, Bristol was 'frankly not up to the task'.[2] No wonder they were unable to appoint a paediatric cardiac surgeon of calibre. The outcome was that they expected adult cardiac surgeons to secure the contract for the Trust, one of whom was of an age when many of his colleagues would be wanting to wind down.

Bristol's catalogue of failure

- Failure in the duty of care
- Failures of safety
- Poor communication
- Inadequate counselling
- Errors and no process of learning from them
- Lack of surgical skill
- Lack of accountability or assessment of competence
- Failure to keep learning up to date
- Learning on the job, not by training
- Lack of transparency
- Irresponsible management
- Many, many more

Photo: PA

It could all happen again

As I observe NHS planning, or lack of it, and as I sit on appointment committees, I have a feeling of déjà vu, another Bristol waiting to happen. 'The NHS is still failing to learn from things that go wrong'.[2]

Nor does the report entirely go to the heart of our failing NHS.[4] There is only tacit reference to an under-resourced service. Despite 'the NHS plan' we still spend less of our GDP than any other EU country (with the exception of Greece) on healthcare. There are still far too few doctors to provide comprehensive care for our ageing society. Our buildings are old and dirty, our equipment often defective and we still have inadequate numbers of ITU beds.[5] No wonder morale in the NHS is rock bottom. We are likely to be silenced if we write to the Chief Executive pointing out glaringly obvious defects in (a) facilities, (b) the process, and (c) safe staffing levels. Most doctors keep on going to try and make it work but this is exactly what Wisheart and his colleagues were criticised for in Bristol.

The political agenda

Bristol provided an opportunity for the media and the public to blame the profession for a failing service. Wisheart was interviewed on the *Today* programme and wrote in the *BMJ*, 'In a sense the problems experienced at Bristol are like a microcosm of the NHS, doctors, surgeons, battling against difficult circumstances with inadequate resources and in a culture where finding a scapegoat appears to be put before the finding of solutions …'.[6] John Studd in a commentary in the *Telegraph* said 'The NHS is now lurching from one disaster to another with the politicians deflecting the blame onto anyone but themselves. If there is no money they will find scapegoats. It is just like Admiral Byng who was shot for neglect of duty, on his own quarter deck … two consultant cardiac surgeons from Bristol and one medical man were publicly humiliated and destroyed as scapegoats (by the GMC) for a rotten under funded Health Service'.[7] I believe that the GMC action was heavy handed. The surgeons were not deliberately failing and they were being expected to take on work outside their training brief.

A Christian response

Our first concern must be to our patients and our example is Jesus. His life was one of service despite living in a corrupt police state. He cared for those he met. He loved all people irrespective of their background, their past failures, their age, their race or intelligence.

Our workplace will never be perfect but we can still do our best to lead by example and to ensure that the candle keeps alight. It will splutter when we fall and when we are buffeted by evil, but we have a responsibility, a calling to shine as a light in the world. Humility is not a bad quality, although it may not come easy to cardiac surgeons or any surgeons for that matter. 'For everyone who exalts himself will be humbled, and he who humbles himself will be exalted'.[8]

Christians should certainly be in the forefront of standard setting and be concerned about quality. Many Christians feel they must do their best and run the extra mile by taking on work and a whole host of extra responsibilities. But we will not do these tasks well and we will not give patients the time that so many require unless we stand back from time to time.

We cannot distance ourselves from the Bristol issues.[9] We must be players in a better service giving an example of care and dedication to others be they patients or colleagues or tomorrow's doctors, because those we treat are created in the image of God.

Christians should not be afraid to speak out against what is unjust, what is clearly a lie, when the public are assured of competence and the facilities on offer are unsafe. Christians should constantly remind those in authority that health is not just a business. The NHS may have replaced a culture of care by a culture of economic expediency, but those who work in it can take a different perspective. Individuals can and still will share a sense of hope and love. 'I am the Lord.'[10] 'I the Lord search the heart.'[11] When the workplace is frustrating, when we seem constantly to battle against impossible demands, poor facilities and a run down service; when we seem to lose our way through lack of vision; when we ignore God's grace and love, it is important to remember some of the Bible's many promises: 'Trust in the Lord with all your heart and lean not on your own understanding; in all your ways acknowledge him, and he will make your paths straight'.[12]

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KEY POINTS

Locally, both individual and organisational failings were responsible for the undeniable excess mortality in paediatric cardiac surgery at Bristol. But this high-profile scandal is also a microcosm of the wider NHS where the blaming of already under-resourced and overworked staff takes precedence over the finding of just solutions. As Christians our first concern must be for our patients. Jesus' life was one of humble service despite living in a corrupt police state. But service involves more than being prepared to walk the second mile; it also means speaking about against injustice and exposing deception when economic expediency has compromised care.

References

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