A just culture after Mid Staffordshire

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ABSTRACT

There has been much public and media outrage in the wake of the scandal about the standard of healthcare delivered at Stafford Hospital. Using published evidence in the safety literature, we examine the distinction between our need to understand what happened, the practical need for preventing recurrence, and the age-old philosophical need to explain suffering. Investigations of what happened can identify the many detailed explanatory factors behind a particular outcome—including the actions and assessments of individual caregivers. These, however, do not necessarily constitute the change variables for preventing recurrence, as those might lie elsewhere in the governance of a complex system. And neither says much about the nature and apparent randomness of suffering in the particular circumstances of individual patients, even if that might be a most pressing question people want answers to in the wake of such a scandal. To promote safety and quality, we encourage a sensitivity to the differences between understanding, satisfying demands for justice, and avoiding recurrence. This might help a just culture in the wake of Mid Staffordshire, as it avoids expectations of an inquiry—independent or public—to do triple duty.

INTRODUCTION

In the wake of Mid Staffordshire, we need to understand what happened, try to prevent recurrence, and confront the real suffering of many patients. These three are quite distinct. Conflating them, as often happens in a public and media outrage,[1] is unlikely to help any of them. Investigations of what happened can identify the many detailed explanatory factors behind a particular outcome—including the actions and assessments of individual caregivers. These, however, do not necessarily constitute the change variables for preventing recurrence, as those might lie elsewhere in the governance of a complex system. And neither says much about the nature and apparent randomness of suffering in the particular circumstances of individual patients.

THE HISTORICAL QUESTION OF WHAT HAPPENED

Independent of the resources and energy invested in an inquiry, it is always difficult to establish what happened historically. Particularly when harm has occurred, our assessments of other people's behaviour get coloured negatively by outcome and hindsight biases.[2–4] Knowledge of outcome affects our evaluation of the quality of decisions, whereas, hindsight increases retrospective estimates of the foreseeability of the outcome. Outcome bias has been demonstrated in healthcare practitioners who make judgments on the appropriateness of care. Besides the harshness of judgments, it is also the sheer willingness to make judgments that increases when there is a severe outcome.[2 5] As Anthony Hidden QC cautioned in his report on the Clapham Junction railway disaster:

> There is almost no human action or decision that cannot be made to look more flawed and less sensible in the misleading light of hindsight. It is essential that the critic should keep himself constantly aware of that fact.[6]

To control hindsight bias, every act should 'be read in the light of the circumstances that brought it forth. To understand the choices open to people of another time, one must limit oneself to what they knew; see the past in its own clothes, as it were, not in ours.'[7] Forensic human factors research calls this the local rationality principle.[8] What people did made sense to them at the time (otherwise they wouldn't have done it), given their goals, focus of attention and knowledge of the situation. One way to do this, is to start from the other end—not that of the many bad outcomes received by first victims (patients and their families), but of the second ones. Second victims are practitioners involved in an incident that harmed or killed other people, and for which they feel personally responsible.[9] Guilt, trauma and powerlessness

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are common responses.[10] Sometimes, caregivers get configured in accountability relationships that encourage a clinical dive to the bottom; that erode care in the name of efficiency; that creepingly, incrementally legitimate neglect, and that eventually create the conditions of possibility for patient dehumanisation. Consistent with research on the systemic and institutional origins of abuse, this says less about them as individuals than about the circumstances in which their assessments and actions made sense.[11 12] The history of multiple external inquiries at Mid Staffordshire since 2001 point to circumstances that enabled a wholesale drift into organisational failure.[13] What did not help was the antinegative type of clinical governance, driven by incentives to make evidence of bad things (eg, infections, morbidity, mortality) go away. Along the way, this may have obscured opportunities to learn and improve, and negated the reality of suffering by first victims.[14]

THE PHILOSOPHICAL QUESTION WHY SUFFERING OCCURS

A most pressing explanation people want in the wake of a scandal like Mid Staffordshire is that for the suffering of individual patients in particular circumstances. Such an explanation helps locate the suffering in time and space, and the people responsible for it. It offers an area of mental and emotional bivouac. Suffering can be given meaning, and the frightening possibility of repetition is removed. The guilty, after all, are found, exiled, punished. It also putatively works as a deterrent *pour encourager les autres*.[1] Such responses are characteristic of many public responses to healthcare scandals and other disasters. These have sometimes even been accompanied by hostile or violent reactions against healthcare workers.[15]

It is satisfying to find a particular person or group as cause for suffering. It is often also unjust and historically inauthentic. Because when you actually conduct an inquiry of more than a thousand pages, which 'cause' do you pick? The public 2013 Francis Inquiry identified many blameworthy parties, not just individual caregivers, but an insidious negative culture that tolerated poor standards, disengaged managers and leaders, an ineffective trust board, the problem of national access targets, financial balance goals and the seeking of foundation trust status.[16] Who gets to say what is responsible, or who finally is 'guilty' out of all those possibilities? Scott Snook, vexed by the loss of 28 lives in a friendly fire accident over Northern Iraq in 2003, came to a similar question. And he didn't like it one bit:

> This journey played with my emotions. When I first examined the data, I went in puzzled, angry, and disappointed—puzzled how two highly trained Air Force pilots could make such a deadly mistake; angry at how an entire crew of controllers could sit by and watch a tragedy develop without taking action; and disappointed at how dysfunctional [the] Task Force must have been…Each time I went in hot and suspicious. Each time I came out sympathetic and unnerved…If no one did anything wrong; if there were no unexplainable surprises at any level of analysis; if nothing was abnormal from a behavioural and organizational perspective; then what—?[17]

Snook's inquiry was historically authentic—but philosophically scary. Whenever he found a source of failure in some person or team, he pushed in 'hot and suspicious.' An assiduous investigator, however, he saw one 'cause' after another evaporate into the banality of normal work. He would find normal people, doing normal work in what looked like a normal organisation (even the dysfunctional could have become the new normal). 'Unnerved and sympathetic,' he'd see the putative cause disappear, and beyond it—nothing.

Finding a single cause may satisfy an urge to locate the source of suffering. But it sacrifices the complexities and contradictions of the multiple interleaving narratives that build a troubled event. The 'truth' of Mid Staffordshire does not reside in a single story. It lies in acknowledging the diversity of multiple perspectives.[18] Of course, the more diverse the recounting, the less of a 'good story' (a simple, singular account) is left to give meaning to the suffering; but in diversity, lie many different points of change that can help produce a better system, thus reducing the risk of future recurrences.

HOW TO AVOID RECURRENCE

The factors that explain a particular instance of system failure may not be the same factors that cause similar events elsewhere. *Explanatory* factors are not necessarily levers for *change*.[19] The explanatory factors for a medication misadministration, for instance, may include the ergonomics of labelling, naming and packaging, prescription practices, fatigue, decimal confusion, handover routines and patient idiosyncrasy. The change lever might be a reduction in staff rotation, double shifts, or an abolishment of short-term contracting. An inquiry's narrative can help find such levers by looking ahead, not back. This is forward-looking accountability[20]: what should we do about the problem and who should be accountable for implementing those changes and assessing whether they work?

Yet, there were serious shortcomings in the way some hospital staff cared for patients.[16] Is blame or backward-looking accountability appropriate there?[21] Schemes for dispensing such backward-looking accountability are in rotation today—culpability trees and 'just culture' algorithms. They see the social and moral environment as a target of rational managerial control, where, like disease symptoms, 'evidence' of various kinds of malpractice and neglect can be met with appropriate and equitable interventions.[22] None

of this, however, solves the hard psychological or ethical problem. Neither science nor law can unequivocally read the intentions of people into their actions (eg, reckless): an algorithm with a few categories is unlikely to crack it either. The ethical problem is who gets to assign observations of others' actions into categories of culpability. Their supervisor? The hospital's risk manager? An independent or public inquiry? The media or politicians? There is no neutral party in this. There is, however, evidence that accountability is illegitimate if exacted by people without intimate knowledge of the messy details of what it takes to get the job done.[23] There is also evidence that backward-looking accountability schemes become less just, the lower down the medical competence hierarchy one goes.[24] Justice depends, in other words.[22 25] Finally, it is extremely rare for a healthcare worker to come to work with the deliberate intention of harming or killing a patient.[4] When that does occur, it falls into a separate category entirely (sabotage, criminality) that calls for management by a specific pathway.

CONCLUSION: FROM RECRIMINATION TO RECONCILIATION

One idea of justice is that if the acts hurt, then the response to it should hurt as well. But instead, if the acts hurt, we can also decide that the response should heal. In the wake of Mid Staffordshire, transforming recrimination into reconciliation is a big task, even though there is an encouraging history of constructively resolving smaller-scale adverse events.[26] For this to work, however, those involved in reconciliation must be meaningfully and justly engaged, listened to, cried with. Reconciliation is a process, not an act, and it should not nullify any social or relational obligation on the part of the caregiver. A valuable kind of accountability can arise from this process, as it creates the space for stories and perspectives of how things unfolded, how they went wrong, how they were experienced from multiple sides. Those windows onto the worlds of fellow human beings can be starting points for healing, rather than triggers for more hurt. The future can stop being mere compensation for the past. This is the integrity of completion. It offers an eventual detachment from the wrongful acts and a pathway to move forward.[27] Justice, or a just culture in healthcare, is not limited to Mid Staffordshire, its workers or its eventual fate. Beyond Mid Staffordshire, a national conversation is needed that is sensitive to the political, economic and demographic complexities of getting healthcare delivery 'right' in a mature democracy, and which understands that the risk of error and failure is the inevitable byproduct of pursuing success in a resource-constrained, goal-conflicted world.

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