

# **All-Party Parliamentary Group on Patient Safety Reversing the Blame Culture: Can the NHS Learn From the Experience of Other Industries? March 14 2006**

## **Overview**

Chief Medical Officer Liam Donaldson has said that in the developed world, the risk of being killed in hospital as a result of a medical error was 1 in 300, compared with 1 in 10 million chance of being killed in an air accident. The aviation industry has learnt the hard way and has redesigned systems and educated teams that rely on each other with safety as the core focus.

The APPG on Patient Safety facilitated a discussion around the concept that healthcare now needs to learn, using the example of the aviation industry, how a system of reporting errors in which medical practitioners are not worried about unreasonable consequences, will lead to improved patient safety. This meeting provided an opportunity to discuss the experience of the aviation industry and how healthcare can be redesigned so that it is flexible enough to absorb human error and improve patient safety. The meeting also explored how we can lessen the blame culture and make safety recommendations intended to prevent the recurrence of adverse patient safety incidents.

Speakers were:

- Captain Jock Lowe, aviation consultant and former Chief Pilot at British Airways
- Professor James Reason, Professor Emeritus at the University of Manchester
- Sue Osborn, Joint Chief Executive, National Patient Safety Agency (NPSA)
- Professor Sir Graeme Catto, President, General Medical Council (GMC)

Dr Howard Stoate MP, Chair of the group, opened the meeting by stressing that the safety practices adopted by other industries is something that healthcare needs to consider in order to foster improved patient safety. He hoped that the following discussion would facilitate further debate around this issue, whilst providing a useful insight into how other industries, such as aviation have approached the issue of safety.

Captain Jock Lowe, aviation consultant and former Chief Pilot at British Airways, explained that the safety practices adopted in the aviation industry could be applied to changing the “blame” culture that exists in healthcare and subsequently improve patient safety. Captain Lowe suggested that it was necessary for the healthcare industry to “recognise and accept that the issue of safety is an integral part of good customer service.”

He went on to state that patient safety could be achieved by appointing a single regulator across the industry, holding organisations to account and regularly ensuring that individuals are fit to practice. Unlike the aviation industry, Captain Lowe believed that there were too many regulatory bodies operating in healthcare, creating complications and reducing the clarity of safe practice. Every six months pilots have to prove their competency to fly to the aviation regulator. Captain Lowe suggested that a similar process might want to be considered for those working with patients in healthcare.

Rather than placing sole responsibility for safety on specific individuals, the aviation industry has created a culture that encourages teamwork and shared responsibility for when things go wrong. Through confidential reporting, individuals are encouraged to report safety violations. This has increased the reporting of dangerous incidents, allowing an analysis of what has gone wrong and how such situations can be avoided in the future, without individuals fearing severe

repercussions. This has moved the aviation industry away from blame directed at individuals to a culture of shared responsibility.

Professor James Reason, Professor Emeritus at the University of Manchester, built on the comments made by Captain Lowe by stating that a safer culture for patients can be “engineered” within healthcare, by adopting a team based approach to safety throughout the industry.

However, Professor Reason argued that creating a totally “blame free culture” in healthcare was impossible. Individuals still need to be held responsible for the safety of their patients, especially in the context of preventing criminal cases of patient abuse.

Professor Reason accepted that the aviation industry had made huge strides in improving passenger safety and that ensuring healthcare staff to report safety violations more readily was necessary. However, it is also important he said, to recognise that the two are completely different industries and that a “line has to be drawn between what is and what is not possible within healthcare.” The nature of delivering a service in healthcare is more diverse and personal than in the aviation industry.

Sue Osborn, Joint Chief Executive of the NPSA, agreed that huge lessons can be and already have been learnt from other “safety conscious industries.” However, Ms Osborn also echoed the comments made by Professor Reason, stating that the concept of “no blame” is not acceptable in the healthcare industry.

Ms Osborn argued that individuals working within healthcare need to be accountable, as a minority of individuals do not adhere to the rules surrounding patient safety, yet she recognised that systems for dealing with individuals who put patients’ safety at risk need to be consistent and transparent. Ms Osborn stated that reporting systems have been successfully implemented in certain areas of the industry, but conceded that more needs to be done in the area of primary care.

By moving away from “knee-jerk” reactions in disciplining healthcare staff, reducing the authority to suspend within the industry and recognising the past injustices that have been occurred by staff within health services, Ms Osborn argued that a culture can be developed in which organisations gain a “memory” and where staff can learn and gain a greater understanding from when things go wrong.

Lastly, Professor Sir Graeme Catto, President of the GMC endorsed a move towards a “collective consciousness” within the industry where staff work more closely as a team to improve patient safety as a collective goal. The concept of people feeling that they can actively come forward to report safety issues needs to be encouraged.

Professor Catto said that it was important for individuals to regulate themselves and accept personal responsibility for their actions, but that it is also necessary for people to receive greater support through team working. He also recognised that healthcare staff should be “fit to practice” and suggested that doctors, like pilots, should have licenses that are not finite and instead subject to renewal.

This discussion was followed by a Q&A session between the panel and attendees.