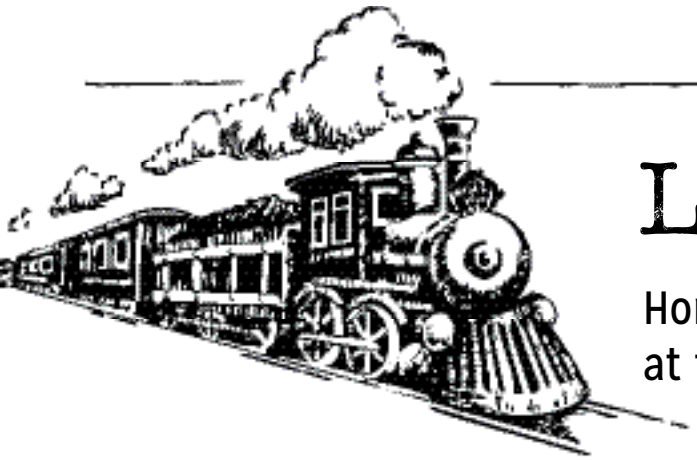

Letting off steam

Honest opinions from surgeons operating at the coalface of our health service.

Cognitive dissonance, blame culture and the 'second victim'

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Few of those who work on the clinical side of healthcare would fail to acknowledge the increasing dissociation between their day-to-day practices and the management structure and culture to which they are held accountable. There appears to be little or no reciprocal accountability.

Perhaps the historical reluctance of clinical staff to report clinical errors or near-misses was part of a 'closed loop', but is now perpetuated and reinforced by the desire of the management culture to apportion blame in an attempt to be perceived as improving patient safety for the purposes of audit and CQC inspection. All of these cultures and behaviours are currently enshrined with closed loops and cognitive dissonance.

It is helpful to understand what is meant by a 'closed loop'. A 'closed loop' in a clinical environment is typified by a situation wherein an error has occurred but is not reported, owing to either a reluctance to acknowledge failure or a fear that reporting will lead to unfair blame before an appropriate and full investigation is undertaken. It is not uncommon for blame to be attributed to a member of clinical staff when there are serial failures in or absence of institutional policy. The outcome in both instances is that learning opportunities are lost and the behaviour is reinforced.

This is not to say that accountability and disciplinary sanction is never justified and serious errors, as highlighted in the Mid Staffs enquiry, should not be condoned. However, any attempt to improve and learn will flounder unless the culture is one seen as fair and just by employees. Clinical and human error should be seen as learning opportunities, rather than episodes where individuals are stigmatised. What is clear is that the apportioning of blame for corporate objectives (perhaps politically imposed) is unfair, unjust and highly damaging to morale.

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'Cognitive dissonance' was a term introduced by Festinger to describe the feelings an individual is subject to when their beliefs are challenged by evidence, and they feel subsequently at risk of their status being threatened or their reputation and ego being damaged. Instead of acknowledging their failure or mistake, the individual remains in denial, manipulates their position, and ignores the error. This behavioural trait is frequently condoned when overseeing regulatory institutions or governance bodies do not act.

In Matthew Syed's excellent book *Black Box Thinking*, he illustrates this concept in relation to Tony Blair and the weapons of mass destruction (WMD) affair. In Blair's first statement to the House of Commons on the Iraq war, his stance was that there was unequivocal evidence of WMD. Then his position shifted to focus on the fact the inspectors had not had sufficient time and that the WMD would be found eventually. Further reinforcement of this denial came later, with the statement that the WMD must have been moved out of Iraq. The final act of spin was to dismiss WMD altogether and instead insist that the world was a better place without Saddam Hussein. An earlier acknowledgement that the advice upon which he acted might have been flawed could have saved many lives (both civilian and military) and billions of pounds in resources.

A further example – and perhaps the example *par excellence* – is described in great detail in the book *The Great Deception* by Christopher Booker and Richard North. This highly researched in-depth account of the history of the European Union uncovers serial closed-loop thinking and cognitive dissonance. Two particularly disturbing features of this behaviour are reiterated throughout the text. First is how each failure or setback in the process towards political and monetary union since the 1920s is not viewed as anything

other than an opportunity to reinforce the political intent. No attempt has been made to learn from failure but rather to continue the deceit and strengthen supranationalism. Second, how readily politicians and others who held Eurosceptic views soon became ensnared in the culture of the union once immersed in it and then re-emerged as some of the EU's strongest advocates. This is typical of the top-down management culture of the NHS and it defies the benefits of a bottom-up culture.

All of those who have worked in clinical practice for a reasonable period of time will recognise how clinical errors (of varying degrees of seriousness) have been explained away to patients, rather than used as learning opportunities to disseminate knowledge and reduce the risk of recurrences.

How often has recurrent dislocation of a hip replacement been attributed to a patient's actions rather than to malpositioning of the components? Larger head size components were introduced at least in part to reduce dislocation rates rather than to address errors in surgical technique or reduced levels of surgical experience. Again, how often has failure of intertrochanteric fracture fixation been explained away as resulting from poor bone quality, rather than failure of reduction before fixation?

The focus, however, more recently has quite rightly been drawn to the inappropriately named 'never-events' (serious untoward incidents) and duty of candour. Few, if any, experienced surgeons will not have been involved in a similar episode. So when they hear of another colleague's involvement, they breathe a sigh of relief: 'There but for the grace of God go I!' Their sympathy could be tempered if their involvement in a similar incident had been sensitively investigated and the lessons learned disseminated to others, as occurs in the airline industry. A 'never-event' implies human error is no more than a figment of the imagination and to be involved in one can only be the result of negligence.

There will doubtless be variation across trusts both as to how clinical staff and management/executive structures respond to clinical incidents. Such well-established policies as Maintaining High Professional Standards in the Modern NHS (MHPS) highlight how frequently internal policies and procedures are at fault or misrepresented in disciplinary or potentially disciplinary proceedings against a staff member. Failure to follow due process in the legal or tribunal system will almost inevitably lead to collapse of the proceedings, but not in the NHS. How often is a case manager, case investigator, hospital executive or human resources representative disciplined for failure to follow due process and ensure fairness?

I have certainly witnessed circumstances in which genuine human error, despite honest recognition and Datix reporting, resulted in a 'witch hunt' that led to the member of staff being removed from clinical duties, subject to a flawed investigative process that knowingly misrepresented documented policy, refused her rights to call witnesses and a disciplinary sanction imposed on her. The employee's representative was summoned by the executive hierarchy and bullied for upsetting a member of HR for insisting that policy was not followed and deliberately misrepresented. It was a classic example of an executive body wanting a culture of clinical openness ('open loop'), intent on apportioning blame but working in a severely closed loop of their own – despite having visited The Virginia Mason Institute in Seattle on two occasions at the taxpayers' expense.

Reports from the Virginia Mason Institute have revealed extraordinary increases in the reporting of incidents and subsequent decreases in indemnity premiums. The converse is true in the NHS, where indemnity and compensation payouts increase year-on-year.