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AS WE WERE...
Reflections

I've been anaesthetising patients now for 39 years, 32 of them as a consultant. My friend Jenny reminded me this week that, when we started as SHOs doing the 'easy D&C' list, general anaesthesia involved the following sequence: stick 250 mg of thiopentone on a green needle into the antecubital fossa, swap the syringe for another containing 75 mg of suxamethonium, pull needle out and fold the arm up, push the patient across the corridor into theatre, legs up, operation, patient breathes, back to the ward. I've seen a few changes since then.

As I wind down, I've been thinking about mistakes. If you, gentle reader, haven't made one yet, you surely will, for to err is human. As a casualty SHO I once discharged a patient because I thought he was faking; the day shift found him six hours later in freezing temperatures still sitting outside the emergency department, femur still fractured. Some years later, I gave a large dose of muscle relaxant to a child instead of reversal, and had to ventilate him in the recovery unit for hours. Far worse, I once put a central line into a sick patient on a general medical ward and somehow mistook the dilator for the internal jugular sheath, leaving it in place. After a few days he died suddenly, and the post-mortem showed perforation of the right atrium. I was taken aside and ticked off; I doubt that the family were ever told and there was certainly no inquiry. Had it happened now, there would have been a serious incident review, a root cause analysis, an inquest, and recommendations to the manufacturer to prevent a recurrence. I would in all likelihood have undergone a period of structured retraining; the GMC might have been involved and even possibly the Crown Prosecution Service.

I have no doubt that the NHS I am leaving is a much safer place than the NHS I joined. Some of this, but not much, is down to legislation, regulation and technological development: much more is down to a change in culture and attitude. But I also know that improvements in patient safety have been slow, haphazard, often misdirected, and inefficient. So many initiatives have been launched in a blaze of glory, only to misfire and come ignominiously crashing back to earth. When we found that nobody had joined the dots between the multiple deaths following intrathecal administration of vincristine, the National Patient Safety Agency was formed to collate incidents, look for common themes and ensure national learning. It folded some years later, and fatal system errors continue to occur, apparently without triggering the 'organisational memory'. Patients are still dying or suffering severe cerebral damage as a result of dextrose being inadvertently used to flush arterial lines giving falsely high blood sugar results leading to insulin overdose. We still don't have an effective – let alone foolproof – solution to this.

Distressingly, patient safety has too often been purchased at the expense of staff morale and wellbeing. In my own specialist area of obstetrics, a pendulum constantly swings between scandal and inertia. Morecambe Bay, East Kent, and Shrewsbury shock us into action. A National Maternity Fund is delivered by the Government to provide training, and then withdrawn. Multidisciplinary safety training is made mandatory, then midwives are withdrawn from it to fill in acute staffing gaps. And blame is cast by social media commentators, who know no better, and by politicians, who certainly should. Staff morale plummets, retention and recruitment suffer, and gross understaffing becomes the norm. And then, as night follows day, bandwidth is overwhelmed: more errors happen, more families are harmed, more inquiries are held, more mutually incompatible standards set, more blame cast, more redundant and repetitive reporting introduced, and more healthcare workers break down or burn out. The multiple regulatory, investigatory and inspection bodies which have proliferated in a seemingly random manner over the last 10–15 years need to be ruthlessly pruned. A single overarching body responsible for patient safety must be established to act as an upward conduit for all incident reporting, and as a downward filter for all guidelines, recommendations and standards.

Above all, the tendency to blame individuals must be curbed. Dr Bawa-Garba was placed in the stocks in the public square and left to the mob, and her case was far from unique. Even doctors who try to make things safer are targeted; we recently heard about a trust trying to fingerprint medical staff to identify a whistleblower. Very few healthcare workers start the day intending to harm their patient, but very many end up desperately fire-fighting with a blunt axe, a hose full of holes, and low water pressure. We can achieve excellent patient safety while still valuing and respecting staff: indeed, we cannot achieve it without. What we can't do is frighten healthcare workers into safe practice, and it's time we stopped thinking that we can.

Enough. Having vented my spleen, the time has come to step down from the specialty which it has been my joy and privilege to practice for the last 40 years, and head off down the Trent and Mersey Canal at the helm of the Lady Mondegreen. My thanks go to my long-suffering mentors and colleagues, but especially to my patients, nearly always a delight, often a challenge, and sometimes an inspiration. I might still pop up on the safety, ethical or medicolegal front from time to time, but no more passing gas – or at least that is Mrs Bogod's fervent wish.