PATIENT SAFETY: IRISH AND INDIANS

Earlier this month (6 July) we were launching the Northern Ireland Division of BAPIO (www.bapio.co.uk) in Belfast and I had to talk about patient safety. Two things struck me and formed the basis of my talk.

First, it seemed like taking coals to Newcastle since my initiation to patient safety (although the term did not come in until much later) was through two Irish doctors. Brendan Devlin, who is little remembered now sadly, the surgeon behind CEPOD was a very early influence as I started training in public health in northeast England after moving from orthopaedic surgery, and then Liam Donaldson, the Guru of patient safety himself, who was the Regional Medical Officer in Newcastle and oversaw the training and the overall public health system. That early exposure led to my going over to Mayo Clinic and coupled with my involvement in Cochrane Collaboration, amongst other things, set me on the quest for quality and patient safety. So, I (and so should the NHS) do owe thanks to folks of Irish origin (interesting aside, is there something about surgeons and safety – they were both surgeons, and I also did orthopaedic surgery originally).

Secondly, after nearly 25 years I have been wondering what has happened in the NHS. On the one hand I am proud of our achievements in promoting patient safety – no other health care system (not individual organisation, as the USA experience shows) has managed to so comprehensively address the various facets of patient safety from producing evidence to NPSA to regulatory mechanisms, for example. But on the other hand, given Mid-Staffs and 'Keogh' Trusts, and almost daily horror stories of patient neglect and harm, it seems that we have lost it in the NHS. How did we get it so wrong? Have we started believing our own spin- and become hubristic? Is it that medicine is so bad and we have only just started the journey to improvement? But most of all what is the way forward? And it was this final bit that I wanted to share.

Basically, the situation reminded me of the story about two types of problems in life: the simple ones and wicked problems. So, going to the moon was a simple problem since most of the issues were well understood and it was a matter of design and production. Sorting out the NHS and patient safety, on the other hand, is a wicked problem since it is hard to know what the aim of the NHS is (despite the rhetoric and NHS Constitution) or what makes a safe system (or rather how to make it safe- the cultural change). And it seemed to me that rather than approach the issue as a complex one we have taken the lazy way to patient safety and treated it as a simple problem – by mechanistic, target driven and inspectorial approaches whereas the four key elements for solving wicked issues always have been clear goal, leadership, time and ruthless pursuit of excellence.

So, how can we bring about the necessary change and using the KISS (Keep It Simple, Stupid principle) I have boiled it down to three basic requirements.

The first requirement is about staff safety- in our focus on patient safety we seemed to have lost sight of the most important issue and which is that we need to look after our staff – see more at http://m.hsj.co.uk/5065355.article . The current treatment of

whistle blowers is deplorable and our study of suicide by clinicians involved in incidents and investigations shows how much more needs to be done to support them - http://www.cln.nhs.uk/ourwork/supporting-clinicians.html .

Partly linked to the above, the second important issue is to do with values: the current situation shows the huge values deficit in the NHS, and society by large. So much so that the CNO in England has started the 6Cs project to rejuvenate the professional values, but this cannot be done in silos. It is pleasing to see that 6Cs are being rolled out across the NHS - http://www.cln.nhs.uk/6csforeveryone/ , but there is still a wide gulf between the NHS and politicians and society- the recent scandals of abuses involving celebrities or politicians for example or the almost daily horror stories of the treatment of the elderly.

And finally once we have done the above two - looked after the staff and have the right values - the training in QI and Patient Safety methodologies can kick in, and system capability is then the third thing needed. The recent reorganisation and loss of memory and institutions like the NPSA has been a serious setback, and will take time to recover.

So, where does the Indian part come in? I suggest that the Indian doctors are crucial for the necessary transformation to deliver safer care, and indeed could be the 'missing link'. Just consider the following.

Indian doctors are the largest group amongst international medical graduates and indeed with second generation of Indian origin their numbers are growing. But currently, they do not feel safe, a disproportionately higher number of them are involved in disciplinary procedures and much harsher sanctions are meted out to them. The recent RCGP exam fiasco shows the discrimination - http://www.bapio.co.uk/justice-for-gp-trainees - and the extent of the discrimination is system wide, including all the way to 'Snowy peaks' with fewer in leadership positions - http://www.mdx.ac.uk/aboutus/news-events/news/snowy-white-peaks.aspx . The NHS needs to protect, support and develop them and it is not just about being fair, it is actually a BIG LOSS for the reasons next.

Indian doctors bring certain crucial qualities to solve complex problems. Despite being caricatured as economic migrants, and whilst not denying the financial necessity what is forgotten is that many actually chose to work in the NHS because of its values. We rejected market driven systems and wanted to work in free at the point of need, universal health care coverage NHS. We are Indians true, but first and foremost we belong to the NHS – a BIG PLUS; we are almost the custodians of NHS values (not the sole ones, of course). In addition, we bring that tenacity, that pursuit of excellence, and as in the famous words of Churchill – We, never, never, never, give up; some of us have fought relentless discrimination, the glass ceiling after glass ceiling and keep persisting (see paper on my time at the GMC for example at http://leadershipforhealth.com/resources/). But most importantly for the NHS, we (as immigrants) are naturally 'thrill seekers' and innovators – not only do we know about low resource settings, we are inclined to explore alternatives – Indians are masters of 'Jugaad' - http://jugaadinnovation.com/

And finally, with growing numbers there is a lot of expertise amongst Indian doctors- I personally know of people who have been involved in NPSA, NIII, NCAS, been to IHI and other systems, the professional and system regulators and so on. With the right opportunities they can be a real force for change – so, USE US or LOSE US (and lose the NHS).

I hope that the BAPIO NI Division will play its part in the health services there and that BAPIO members will do the same where ever they work. It is OUR NHS, and we will all be patients at some stage.

Going back to Ireland was also personally very exciting since I have a strong affinity, having worked there during my surgical training years (albeit in the Republic) and we have an 'Irish' daughter (Tara was born in Drogheda on 12 July!).

Thank you to all who attended and to all who are and will be taking the work forward.

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14 July 2014

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