Case in point: what can we learn from litigation?

A missed opportunity

Back in 2000 Sir Liam Donaldson wrote a piece of work commissioned by the then Secretary of State for Health entitled "An Organisation with a Memory". We are now 18 years on and still some of the recommendations from them have not been implemented.

Key comments from that work:

"Once potential and actual risks have been identified, they must be properly analysed to identify lessons for policy and practice. Lessons can be extracted from the pool of available information through analysis, but then need to be distilled – to make sure that the essence of the learning points is properly captured – and their validity tested in theory or practice."

"The second part of the learning process, once sound solutions have been derived, is to make sure that they are put into practice. Learning points need to be translated into practical policies and actions that can be implemented at the appropriate level. These practical changes then need to be prioritised, to provide a clear agenda for action, and disseminated to the relevant audience. Training is a vital tool in ensuring that information on change is both disseminated and acted on."

We are all encouraged to learn from our mistakes and also to learn from the mistakes of others. On top of this we have a duty of candour to patients to explain to them when we have made a clinical error. We hope that they would understand that we are human and we err, and yet still some cases go forward to formal complaints and then some to litigation. As a medico-legal expert I see the chain of events in full technicolour from the index incident, through the immediate explanation to the patient, the internal investigation and then the final end point of a letter of claim. Many of you will be involved in investigations yourselves and will appreciate the benefit of the retrospectoscope.

As an expert I review a case in the cold light of day from the comfort of my study and whether I act for the Defendant or the Claimant I see the sequence of errors which occurred and, in line with my overriding duty to the Court, I have to determine what errors happened and how. I often think to myself "there but for the Grace of God go I" and I *always* have sympathy for the clinicians involved.

My experience is that patients want an apology and to know that it will never happen again and we are good at instituting change locally to make sure the learning points are acted upon but we are not good at disseminating that information across the whole NHS.

The role of NHS Improvements

NHS Improvements (NHSI) does excellent work in detecting and implementing learning strategies that address system errors and serious incidents that result in death or serious harm, but fails to address lower level clinical errors which are still happening throughout the NHS and causing repeated avoidable harm to patients. Front-line clinicians are key stakeholders in patient safety and they need to be involved in the detection and reporting of clinical errors but also in the assessment of these errors, identification of common themes and learning points and the subsequent dissemination to the clinicians who need to hear these safety messages.

In ophthalmology we are fortunate in that we are unlikely to kill our patients and will not cause them to lose a limb. Our errors result in visual loss which can be devastating but often we are blessed that our patients have a spare eye. The litigation costs in ophthalmology pale into insignificance when compared to the big spend of obs and gyynae and orthopaedics. As such we are not a priority and yet we see patients coming to harm time and time again and this needs addressing. Often it is not a system error but a clinical error which recurs.

In my medico-legal work I see a lot of cases where a clinical error is repeated time and again and this is not being picked up. I have published articles on these issues here and also within the RCOphth *FOCUS* magazine. The simple clinical learning point is missed and the opportunity to intervene to prevent harm to another patient lost. I consider this to be a major system flaw within the NHS. Many hundreds of NHS manhours are spent investigating and undertaking root cause analysis, however, the learning points, which are often simple, are actioned locally but not disseminated throughout the NHS.

Don't get me wrong, from a selfish perspective I love seeing the same error happening as I can cut and paste from previous reports, the background research is already done and I can still charge my usual fee to make up for the cases where I unexpectedly get four lever arch files of notes to review on what I thought would be a simple case. However, it breaks my heart seeing the same avoidable error happening time and time again. How can we learn from these errors? A case report in a journal? Who really reads them? Present the case at a conference? Who's awake and listening?

Around 2,000,000 incident reports are received by the National Reporting and Learning System (NRLS) each year, on over 130,000 disease and injury types, 6000 medication types, 9000 treatment modalities and an almost uncountable range of medical devices used within the NHS (data from direct communication with NHSI).

Of the 2M incident reports per year submitted to NHSI, 30,000 are serious incidents or patient safety incidents which cause death or serious harm. There are also 200 'dives' which look at approximately 20,000 lower harm incidents. Taking out these 50,000 incidents which are scrutinised there are 1,950,000 incidents reported per year that receive no scrutiny whatsoever and are not read by anyone outside the local Trust. This means that 97.5% of all clinical incident reports via the NHSI are not scrutinised externally at all and all those potential learning points are missed and not appropriately disseminated. Assuming that only 1% of those unscrutinised incidents refer to avoidable clinical errors, this means that there are 19,500 episodes of clinical harm due to avoidable errors per year that are going unrecognised. Not addressing that gap is letting patients down, increasing the risk of harm, hampering doctors' abilities to learn from others' mistakes and increasing our litigation bill. NHSI are aware of this and trying to address the issue but their resources are limited and stretched.

Addressing the gap

Clearly the key is identification of these learning opportunities and currently NHSI does not have the facilities or systems to assess every clinical error. We need a mechanism of identifying which incident reports have a clinical learning message and targeting those for particular attention. Rather than scrutinise them after the fact, the logical route is to ask those clinicians / allied professionals submitting the report to identify if there is a clinical learning point, thereby flagging up their importance so they can be singled out for special scrutiny and any learning points picked up. The new data

processing systems being developed by the NHSI give us an ideal opportunity to facilitate data entry processes which can make it easy for those entering data on incidents to highlight any potential learning points.

Albeit potentially delayed for several years, due to the length of time litigation takes, we have a system already in place whereby the worst clinical errors which cause harm to patients and may be negligent are already picked up and assessed by highly skilled clinicians in the field, i.e. consultant ophthalmologist expert witnesses, some of you. Part of our work as an expert is to determine where things went wrong and work out whether there was a breach of duty. So, we, as experts in the field, have already done the hard work and identified the error and the learning point. We work on the front line and can determine what is truly an avoidable clinical error and determine what learning point should be disseminated to our fellow ophthalmologists. We may relay this information in a case report, or a poster at the College Congress, or as part of our Friday afternoon educational meeting. We may sit in the theatre coffee room and relay the case to a colleague. Moorfields Hospital has an occasional alert from the medical director about a particular topic. Surely if a message is important enough to be disseminated to clinicians working in Moorfields it is important enough to be relayed onto a clinician such as myself?

A clinical error was made, a patient came to harm, there is a clinical learning point which, if appropriately disseminated to the front-line clinician, could prevent harm to another patient. A medical expert witness will determine this as part of their work and, I hope, be keen to help disseminate this message to their colleagues and trainees within their speciality.

How should this valuable and patient centred information be disseminated? The Colleges play a vital role but there is inconsistency in the delivery of these important messages. Not everyone is a College member and arguably those who are not may be the ones who we need to target the most with patient safety messages. For the Royal College of Ophthalmologists, approximately 90% of ophthalmology consultants, 50% of middle grades and all trainees in recognised training posts are members. It is not known how many trainees in non-recognised posts are members. These clinicians do not receive communications from their College. Do we accept that, even if the College systems are robust in disseminating this information, these clinicians are left out?

The College of Optometrists should also be engaged as we are all dealing with eye health and we need to wrap care and learning from errors around the patient from the start of their journey to the end. They may have valuable lessons for us as we may have lessons for them. We need to work in partnership with our fellow allied professionals.

A new system

Work has already commenced with NHS Resolutions creating a mechanism to study the ophthalmology litigation and distil out recurrent errors in the hope of feeding back learning points to the wider NHS.

All ophthalmology expert witnesses will be asked a simple question; "Was there a clinical error that caused harm?" If the answer is yes, then the expert will be asked to describe the learning point in less than 250 words. This anonymised report will be sent to an ophthalmology expert (myself for our speciality) and I will try to determine whether there is a learning point or whether an error is being repeated. Once I generate a report it will be ratified by the RCOphth and then disseminated quarterly to all ophthalmology specialists, regardless of geographical location, grade or membership, via their General Medical Council (GMC) registered email addresses. Thereby we have a robust system of detection of errors, learning and dissemination to the clinicians on the front line who need to hear the message.

We are a small speciality but we will be spearheading this and we will hopefully be able to act as an example to others in every speciality. The aim of this work is not to develop definitive guidance or proscriptive learning points, but rather to disseminate points for practice reflection.

The same clinical errors are happening again and again. They do not reach the serious harm criteria for patient safety alerts and some are not system errors (which the current NHSI / NRLS processes handle well). They do not warrant National Institute for Health & Care Excellence (NICE) guidance or National Patient Safety Alerts or recommendations / guidance from the RCOphth and so they get left behind and patients are coming to harm time and again from avoidable clinical errors. Some of the worst cases of harm result in litigation and only a few go to Court where a formal judgment is reached. All, however, go through the hands of NHS Resolutions (NHSR) and an ophthalmology expert and the knowledge of those clinical errors and any learning points therein are being missed. We have the opportunity to make a difference and protect patients from harm through cooperation and a teamwork approach with NHS Resolutions and the wider NHS.

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