IMPROVING QUALITY IN HEALTHCARE

QUESTIONING THE WORK FOR EFFECTIVE CHANGE

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Supporting Human Systems at Work

In this chapter we aim to explore principles to overcome Failure Demand under a domain that we have termed "Defensive Pressures". Our proposition here is that these pressures, which often go completely unnoticed – can drive unhelpful patterns of behaviour that significantly affect relationships and adversely influence the context of care. They detract significantly from the purpose of the work and eat up precious capacity – in short, they are extremely wasteful. They impact all the elements of quality we have been considering through our use of the Institute of Medicine's definition of quality – that of Safety, Effectiveness, Patient Centredness, Timeliness, Efficiency and Equity (Institute of Medicine, 2001). Worse still, they fracture – sometimes irrevocably – the crucial bond of trust between caregivers and citizens, not only at the level of service delivery but also in families, our communities and society more generally – the human cost is therefore immeasurable. In an environment of growing health inequity and unmet need in many communities, we need to promote the absolute opposite: creating greater clarity in expectations to build trust, and to use all the knowledge available in the therapeutic context to build more collaborative and equitable relations. Unless we do this, our current systems risk collapsing under a combination of growing cost pressures, unmet needs and rising levels of mistrust. Importantly, we also risk expunging the desperately needed humanity from our caring systems.

The good news is that evidence suggests that these pressures can be proactively addressed, but we first need to acknowledge their presence and understand their impact. There is also plenty of scope for intervention and development in these areas, although significant commitment to both philosophical and practical change is often needed.

Recognise the effect of the strange moral and psychological world of healthcare:

- Appreciate social systems defences against anxiety
- Promote the conditions for interpersonal risk and organisational health
- Institutional reflective practice and restorative approaches

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Figure 10.1 Supporting human systems at work

In this chapter, we suggest four key areas for focus – see Figure 10.1. Firstly, we need to understand that providing healthcare is high risk work that takes place in a strange moral and psychological environment. Secondly, we need to understand the rise in defensive medicine and the associated medico-legal pressures that shape a great deal of daily practice and experience. These are both real and imagined, but either way the impacts are enormous. Thirdly, we need to address some key issues associated with the punitive culture in healthcare – both real and perceived. Finally, we want to draw attention to healthcare harm including our understanding of what constitutes safety improvement. Associated with this we need to address the notion of compounded harm that arises when the response to harm is poor quality. This involves understanding the need for both "healing" as well as "learning" when harm occurs. In this area, we also must explore the difficult and pervasive cultures of blame and shame, which are toxic for all concerned. Our argument is that insufficient attention has been given to this domain, and the systems of regulation and inspection that are intended to help, in practice, often seem to make the situation worse, not better.

Of course, while often marginalised in terms of real-world application, a focus on supporting human systems at work to improve quality is not new. As we discuss in detail in Chapter 2, W. Edwards Deming – the so-called "father of quality thinking" highlighted the critical influence of human psychology on achieving quality. This could be seen as Deming's direct reaction to the dominance of Taylorism as his theoretical position was predicated on the idea that best quality was achieved when individuals are respected, well-motivated and self-managed. Deming however still considered that managers could manipulate the system conditions through rational choice and design, and that this in turn leads to the desired changes in a logical and reliable manner – ironically this also included the introduction of self-management. The idea is contested by those who adopt a postmodern perspective, where a much messier appreciation of the emergent possibilities exists. Our own position is that whilst we recognise that leaders have a crucial role to play in creating the conditions of work, that unless we aim to engage all those with knowledge in the network of relationships that constitute "the work", then our picture will always be too narrow and unnecessarily partial. Recent evidence suggests that high degrees of collaboration across distributed networks of relationship are a major factor in successful quality improvement

programmes (Burgess et al., 2022). A focus on the relational practices which support the development of the networks of relationships are crucial if we are to support the human system at work (Malby & Anderson-Wallace, 2016).

High-Risk Work and the Strange Moral and Psychological World of Healthcare

Healthcare is by its very nature a high-risk activity. This is generally well understood by those who work in healthcare but is a well-kept open secret beyond that. The stubbornly high levels of avoidable iatrogenic harm – that is harm caused by treatment, intentionally or not, in healthcare (WHO, 2019) – tends to come as a great surprise to most citizens, who quite understandably tend to think of healthcare as inherently safe. Clinicians engage in very intimate and often highly invasive work, both physically and psychologically. Much of what is done entirely legitimately in a healthcare context would in any other situation be seen as abusive or harmful. This inversion of the norm creates an unusual set of relationships and expectations, as well as a special bond of trust unlike most others in life, where those who need their help must trust others to act in their best interests, at times when they cannot do this for themselves (Shale, 2011). They often do this without any pre-existing relationship.

As sociologist Dan Chambliss eloquently points out:

> In the hospital it is the good people, not the bad, who take knives and cut people open; here the good stick others with needles and push fingers into rectums and vaginas, tubes into urethras, needles into the scalp of a baby; here the good, doing good, peel dead skin from a screaming burn victim's body and tell strangers to take off their clothes… The layperson's horrible fantasies here become the professional's stock in trade. (Chambliss, 1996)

This complex and often troubling moral world invisibly underpins the very recognisable everyday routines of healthcare delivery. These rituals and routines shape relationships in ways we have all become very accustomed to, and they are rarely questioned precisely because they appear so "normal" in the context. All of this is generally unnamed and unexplored, until something unexpected happens, at which point everyone's actions – including their moral positions – are called into question. Without active mitigation, the relational conditions created can easily become toxic. At best, this can lead to a lack of compassion and/or empathy

between professionals and citizens – in both directions – and at worst, adversarial actions including neglect, abuse and litigation.

Social Systems Defence against Anxiety

Isabel Menzies-Lyth was a psychoanalyst and social researcher, who tried to develop a theory to understand how a lack of compassion could develop in caring organisations. She conducted ground-breaking research exploring the working conditions of nurses in an acute healthcare environment. The central thesis of what she discovered was that paradoxically, it was the motivation to care that could sometimes make health organisations uncaring. Menzies-Lyth (1960) identified a series of complex natural defences that as human beings we develop to protect us from the anxiety provoked by difficult and emotionally challenging work. In the healthcare setting, this often includes having close contact with people that are severely injured and whose bodily functions are often completely out of control. In the course of their daily work, healthcare workers meet illness, physical degeneration, disfigurement, psychological disturbance, emotional distress and death. Menzies-Lyth saw these experiences as "taboo" and concluded that performing this kind of work over time exposes those involved to a level of ambient anxiety. If over-exposed, she believed that the impact and consequences could be significant, if not catastrophic.

Menzies-Lyth argued that in response to this – as an act of protection – organisations try to prevent carers from becoming overwhelmed. Inadvertently, this frequently occurs by structuring the work in ways that enable – and occasionally even encourage – detachment from the patients as individuals. This can at first manifest in ways that seem quite benign. For instance, work becomes task-driven and is often carried out by several different people, making it uncommon for one staff member to follow a patient throughout their entire care journey. She noted that because both patients and staff were often transferred between care settings, all of them can be commodified and objectified through the language that is used to describe them. This often involves reducing the identity of staff members to their job roles and patients to their bed number or disease state.

Note that the points in the list in Figure 10.2 all serve to fragment care and create multiple handoffs – once of the sources of Failure Demand we explored in Chapters 6, 8 and 9.

As Jocelyn Cornwell, the founder and former Chief Executive of The Point of Care Foundation comments, "there is something deeply paradoxical about the dehumanising way in which patients are treated by organisations that are supposed to be people- and patient-centred". She posits that "it is because modern medicine is so successful technically, that patients' suffering seems to have been pushed from centre stage into the background" (Cornwell, 2021).

Examples of dehumanising, objectification and mechanistic approaches created as the social system's defence against anxiety:

- Splitting of caregiver relations – no continuity of care, shift arrangements, staff treated as moveable resources, task rather than person-centred care
- Depersonalizing and categorization of patients and staff – referring to "the med reg" – "the fractured NOF in bed 3"
- Failure to define fully who handles a patient's care leading to fragmentation and multiple hand-offs
- Delegation upwards of responsibility for task leading to alienation and mechanical delivery of care

Figure 10.2   Examples of dehumanising, mechanistic and objectifying approaches

In a mixed methods study exploring the impact of the COVID-19 pandemic on ICU staff in Spain, participants reported levels of the "dehumanization of care" (Moreno-Mulet et al., 2021), and whether this is an example of the social system's defences against anxiety or as discussed by Delany and McDougall (2023) is because of moral injury, the results are the same.

In the most extreme situations these defensive behaviours become normalised and institutionalised, and as we have seen repeatedly over time, large-scale cultural collapse can ensue. The many reports of care scandals over the years inevitably describe dehumanisation, objectification and harm to those who use services, their families and the staff involved (Willis, 2020). In 2013, Sir Robert Francis, who led the Public Inquiry into the care failings at Mid Staffordshire NHS Foundation Trust, highlighted the dangers of losing sight of human concerns in healthcare (Francis, 2013). In his landmark report, he emphasised the importance of listening to patients and staff, and the risks to patients when the delivery of care becomes highly de-personalised. During the Inquiry, one junior doctor – now a consultant – told the hearing that the A&E department at Stafford Hospital had become "immune to the sound of pain" (Lintern, 2023).

Dame Elizabeth Buggins in her evidence to the Francis Inquiry commented:

In healthcare organisations, calm confidence is prized and the system has honed its ability to achieve it. Emerging issues, which exacerbate anxiety – like safety concerns, near misses and actual errors – are therefore often not welcome.

In this context there is a risk that people are too keen to be easily reassured and therefore close down difficult conversations and questions too early. This frustrates those who have concerns and speak up, while others become accustomed to deficiencies and dangerously accepting and passive.

Many believe that the hard truths learned through the Francis Inquiry are in danger of being forgotten in the light of unprecedented, continuing and seemingly endless service pressures. The ambient anxiety that is created as a result – unless mitigated – will inevitably have a rapid and negative effect on quality. A decade on from the publication of his report Francis continues to express concerns about a culture of fear and persecution at the highest level of the NHS, with an over-emphasis on top-down command and control approaches to management. He has also expressed significant concern about the lack of basic attention to staff wellbeing, commenting: "The pressure on the human beings who provide the service is such, from top to bottom in any given organisation, that inhumane things are bound to start happening and are happening on a much wider scale than we had at Mid Staffs" (Lintern, 2023). Others argue that some evidence exists for aggregate improvement across the healthcare system since Mid Staffs, citing a number of policy initiatives that were launched in the wake of the Public Inquiry. However they remain uncertain as to whether these were driven by the policy response (Martin et al., 2023).

Francis emphasised the urgency of transforming the culture of NHS organisations away from one that is fearful and defensive and towards one that is open, honest and willing to listen. But perhaps this exhortation for cultural change misses the fundamental point of Menzies-Lyth's work. That is to say that she saw these issues not as individual moral or cultural failures, but as entirely understandable structural defences of the system, built up to protect staff against the worst effects of their emotional labour in specific contexts. Although Menzies-Lyth conducted her research in 1960, her observations feel as relevant today as when they were first published.

Unconscious Processes and the Primary Task of Caring Organisations

Drawing on similar psychoanalytical thinking as Menzies-Lyth, Lawrence (1977) postulated that the primary task that people perform in institutions can be distinguished in three ways. First is the normative task, which is what the institution is explicitly designed to do at a conscious level. Second is the existential task, which is what employees think they do and how they interpret the work and give meaning to their roles and activities. And finally, the phenomenological or the observed task, which relates to what – through observation – they can be said to be doing. Skowrońska (2023) reminds us that when considering the primary task of caring institutions, we must also consider the way that societies unconsciously assign them special functions, which are often associated with the containment of universal human fears. By assigning

specific roles to these institutions, she argues that we exempt ourselves from having to deal with difficult issues. As we have already discussed, healthcare environments can become saturated by exhausting and unbearable emotional experiences, and some would argue that the healthcare system serves as a socially sanctioned form of the collective denial of death, with an unspoken promise to treat and extend life no matter what. The phrase "we'll do everything we can" is a well-rehearsed part of the script, which probably means quite different things to professionals than to patients or their families, and yet the meaning is largely unexplored.

Within the group analytical tradition (Foulkes, 2018) the notion of the matrix or the social unconscious (Hopper, 2003; Roberts, 1982) is used to describe the place where we store such connections; a "pattern of intersubjective narrative themes that organise and are organised by the experience of being together, formed through repetitive patterns of communicative action between human bodies" (Stacey, 2003, p. 238). Through healthy projection and mirroring mechanisms – the processes through which a person sees themselves, or part of themselves literally reflected in the interactions of other group members – people share their anxieties, making them easier to bear (Anderson-Wallace, 2017). Creating the spaces and relationships to enable this to happen safely becomes especially important. Furthermore, a clear awareness of the burden created by the inevitable suffering of these environments is crucial. Obholzer and Roberts (1994) describe the need to create the proper conditions for the "psychological dust" generated to be metabolised, rather than simply inhaled. In addition, they remark that clarity about the organisation's task and authority structure, with clear opportunities for the teams to take part in the decision-making process, is also important when working in psychologically demanding settings.

Personal Defences and Wounded Healers

Skowrońska (2023), continuing in the group analytical tradition, argues that an added source of difficulty stems from the fact that it is not uncommon for people who engage in caring work to choose the work as a way of working on their own unresolved problems. She argues that the emotional impact of their work can trigger their specific personal defence mechanisms, which affect functioning not only in relation to patients but also within the teams that they work. As a result of the impact of unrecognised projective processes – the mechanism by which we displace our own feelings and locate them in others – teams can become "caught" in these dynamics without being aware of it. Furthermore, people who choose a helping profession often have experienced relational trauma in their development, especially

role reversal. Thus, they develop a kind of "helping self" which enables them to cope by helping others rather than paying attention to their own needs. This can mean that they are paradoxically less likely to seek help to process difficult feelings and responses, and then if these important stories of identity become compromised by their inability to cope, the results can be catastrophic. Nitsun (2001) describes something similar in considering the wounded healer phenomenon, developing an archetype first developed by Swiss psychiatrist Carl Jung. He notes that wounded healers are often intuitive and insightful but can also be vulnerable. Their suffering often starts with overwork and the exhaustion it causes. This, in turn, results in feelings of helplessness and frustration, followed by guilt, and feelings that they have failed in their caring role. They can also feel trapped by the complex and sometimes contradictory needs of their patients (Nitsun, 2001), and grasping this complexity is difficult and takes time – time that is often not available in busy caring environments (Skowrońska, 2023). As the goal of caring well for people becomes unreachable, the risk of people retreating into professional personas and becoming emotionally distanced is heightened. As important elements of personal identity – their aspirations, hopes and dreams for their caring work – are denied and repressed, work becomes devoid of meaning. If not recognised the level of mental distress can become unbearable. According to Viktor Frankl, a psychiatrist who managed to survive the Nazi concentration camps, there is no reason for healthcare professionals to be ashamed of their suffering. Skowrońska (2023, p.10) citing Frankl argues that "just like destiny or death, suffering is a fundamental human experience. If life has meaning, then suffering must necessarily have meaning too". According to Frankl, when a person accepts their destiny and suffering, this can provide life with a profound sense of meaning (Frankl, 1985).

If we accept the immense psychological and emotional risk that is associated with caring work, and we accept that suffering is a central dimension of the caring role, then it follows that we must develop the organisational frameworks, routines and practices to support this. The institutionalisation of practices that lessen the pervasive anxiety of caring work, ending the need for these structural defences, should therefore be a priority to ensure quality.

Balint Groups, Reflective Practice and Schwartz Rounds

Practices that aim to tackle the emotional and psychological challenges of healthcare work have been present in the NHS for a long time. Balint groups – named after the psychoanalyst Michael Balint – originated in the 1950s when groups of family doctors met on a regular basis with a trained facilitator to discuss any subject that came to mind outside of their typical clinical encounters (Balint, 1955). These groups could have several aims, but the central belief was that by having a better understanding of how they were affected by the emotional content of caring for

patients, doctors would be better able to actively process – and thus successfully provide – relationship-centred care. Numerous studies have shown that taking part in a Balint group can improve the participant's capacity for coping, psychological awareness and patient centredness (Kjeldmand & Holmström, 2008; Kjeldmand et al., 2004). In mental health settings long-term staff support groups are common and it is argued that such work done diligently over time gradually changes the team culture (Skowrońska, 2023). That said these groups take time to mature, but if the teams can safely explore the various levels of the group matrix (Foulkes, 2018) and make healthy connections between them, then it is possible not just to contain difficult feelings arising from the work, but also to enrich the professional work of team members.

Schwartz Rounds are organisation-wide forums that prompt reflection and discussion of the emotional, social and ethical challenges of healthcare work, with the aim of improving staff wellbeing and patient care. They were introduced into the UK in 2009 to support healthcare staff to deliver compassionate care.

According to the Point of Care Foundation (n.d.), that led the UK development and spread of the approach, the purpose of "Rounds" is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care. They claim that Rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles. Evidence shows that staff who attend Rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. They also help to reduce hierarchies between staff and to focus attention on relational aspects of care. The underlying premise for Rounds is that the compassion shown by staff can make all the difference to a patient's experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work. The network expanded in the aftermath of the Francis Inquiry, and Rounds are now run in hundreds of healthcare organisations all over the NHS. Evidence is emerging that this approach, which encourages an explicit focus on the emotional toll of caring work, is valuable.

Each Round has a topic or patient focus and a title that is shared in advance in publicity material, and lasts for one hour, is preceded by food and begins with a multi-disciplinary panel presentation. Each panel member focuses on their own experiences in relation to the emotional and psychological impact of caring for patients and their families and any issues arising in terms of working with colleagues. Together with a clinical lead, a trained facilitator guides the discussion of emerging themes and issues, allowing time and space for the audience and panel to reflect and talk about similar experiences that they have had. Attendance is voluntary, open to all and staff attend as many or as few Rounds as they would like, with attendance varying from 10 to over 100.

Robert et al. (2017) conclude that Rounds were typically adopted to improve staff wellbeing and that adopting organisations scored better on staff engagement than

non-adopters. Among adopting organisations, those performing better on existing patient experience measures were more likely to adopt earlier. A generally favourable set of innovation attributes (including low cost), advocacy from opinion leaders in different professional networks, active dissemination by change agents and a felt need to be seen to be addressing staff wellbeing led to Rounds being seen as "an idea whose time had come". More recent adoption patterns have been shaped by the timing of charitable and other agency funding in specific geographical areas and sectors, as well as several forms of "mimetic pressure" – the processes that encourage imitation within and between organisations and encourage staff through peer processes to conform. A realist-informed mixed methods evaluation of Schwartz Rounds in England concluded that healthcare staff who regularly attended Rounds to share the emotional, social, or ethical challenges they face in the workplace experience less psychological distress, improved teamwork and increased empathy and compassion for patients and colleagues (Maben et al., 2018). A subsequent study quantified this, suggesting that attendance was linked to a 19% reduction in psychological distress adjusting for covariates. Dawson et al. (2021) concluded that as an organisation-wide intervention, Rounds constituted an effective, relatively low-cost intervention to assist staff in dealing with the demands of their work and to improve their wellbeing (Dawson et al., 2021).

Moral Distress and Injury

If we accept that the quality of the care is highly dependent on the members of staff being psychologically and emotionally, as well as physically, present, then it follows that if they are put under very sustained pressure, they may feel unable to offer the care they believe is needed. This predicament has been described as a position of "moral distress", where the tension of not being able to act in ways that feel morally right becomes overwhelming. Research has shown that in these situations staff sensitivity to stress and burnout is significantly heightened (Morley et al., 2019). This has obvious implications and ultimately risks creating a situation where it becomes incrementally harder to provide high-quality care as precious capacity is continually reduced by sickness, absence, recruitment and retention, leading in turn to further pressure on those "still standing".

Much of the literature regarding moral injury has arisen from the trauma experienced by those working in conflict zones. Specifically cited is the clinical research relating to existential crises experienced by war veterans. This work describes the "character wounds" that annihilate trust and have a detrimental effect on a person's moral foundations (Shay, 2003, 2010). The clinical presentation is thought to be distinct from post-traumatic stress disorder and to be more intricately linked to the systemic effects of managerial and executive decisions, where there is a sense of betrayal that someone in a position of legitimate authority has not acted to

safeguard the conditions necessary for safe, effective and individualised care (Shay, 2014). This can also involve intentionally making choices that place practitioners in the role of perpetrators; those who fail to stop acts, as well as bearing witness to or learning about activities that go against their sincerely held moral standards and expectations (Litz et al., 2009). This clash of moral worlds can be readily seen within public services and has become the focus of increased study and reflection during and after the COVID-19 pandemic (Shale, 2020). Shale emphasises that moral injury can be experienced by anybody – including patients and family members – by introducing a larger concept of moral injury based on moral philosophy. According to this definition, moral harm results from a variety of causes, such as injustice, cruelty, status degradation, and a grave violation of accepted moral standards. Shale describes how our everyday moral life is shaped by normative expectations, or our views about what "should" happen paired with predictions about what "will" happen. She contends that when these expectations are realised, people can have faith, hope and confidence in the future, and when they are not, the risk of moral harm is increased and confusion, embarrassment and resentment are all too easy to feel (Shale, 2020). There is an obvious link here to harm in the healthcare context as it is fundamentally linked to breaches in normative expectations (Anderson-Wallace & Shale, 2014a). Citing Greenberg and Tracy, Shale (2020) points out that preventive psychological approaches to supporting staff in healthcare environments can help to mitigate the risk of occupational moral injury. This entails strengthening relationships between co-workers and supervisors, successfully providing for the basic requirements of the workforce, and being alert to the first indications of distress. Also, they stress the significance of viewing responses as genuine and meaningful rather than "medicalising" or pathologising them.

Importantly, psychological debriefing methods – particularly those which are reactive and one-off – have been found to be ineffective, and in some cases actively harmful (Rose et al., 2003). It is therefore important to give attention to how these types of interventions can be institutionalised; where responsibility is taken at an organisational and not merely individual level; and where the remedies are built into the everyday workflow.

Shale proposes an approach to moral repair which can be preventive as well as reparative and aims to re-establish a sense of moral equilibrium within individuals and between people (Greenberg & Tracy, 2020, cited in Shale, 2020). Two specific leadership proprieties are identified as central to this process. The first is the inquisitorial, which promotes a fair and impartial process of investigation which "enables an objective record of the morally relevant facts" (Shale, 2011, p. 141) to be established. The second is the restorative, which focuses on the processes that help return moral relationships to balance. This involves bearing witness to the narratives of wrong; accepting grief and anger as a normal part of the process of healing, and clear notions of categorical apology (Smith, 2008) and forgiveness (Cantacuzino, 2015). Delany and McDougall (2023) discuss this further, citing the

developing evidence that facilitated ethics discussions in groups can increase the sense of moral agency and professional integrity. They further argue that building a sense of a moral community can help professionals to develop a stronger collective voice, enabling greater advocacy for organisational and policy changes. It is interesting to note the emphasis that is placed on the need to develop a strong sense of genuine curiosity in this work; a theme that we strongly advocate throughout this book.

Defensive Practice

In a context of rising demand and shrinking resources, it is easy to see how a complex mix of ambient pressures can push clinicians, managers and other staff to behave defensively, and in ways which to the lay person seem antithetical to the delivery of compassionate, patient-centred care. Much has been written about the effects of the perceived increases in litigation and complaints in the healthcare context and the defensive response from practitioners (Ortashi et al., 2013; Studdert et al., 2005; Toker et al., 2004). Accounts of ambulance-chasing lawyers and demanding or entitled patients who are unable or unwilling to accept the limitations of services or their own conditions all feed into a narrative that can drive defensive practice.

The definition of defensive medicine is when a doctor departs from accepted practice to lessen or avoid complaints or criticism (Toker et al., 2004). Clinical experts claim that this results in unnecessary referrals and deferrals, excess diagnostic testing, and overtreatment. According to studies, 78% to 93% of doctors practise defensive medicine, so the potential cost associated with this is not difficult to imagine – pure Failure Demand. According to Berwick and Hackbarth (2012) around a third of medicine is waste, with no measurable effects or justification for the considerable expenditure incurred. This is a stark figure when considered carefully. The crucial point here is whether this defensive positioning exposes patients to added risk from the unnecessary and often invasive treatments, risks which may be higher than that of missing an unlikely diagnosis.

Thorpe (2004) argues that paternalism and self-regulation have long been a part of medicine and as citizens become more self-assured and informed about their options, some doctors, who are unaccustomed to having their ethical standards and professional judgement questioned, have experienced significant difficulties adjusting to this. Ortashi et al. (2013) argue that citizens have also grown more risk-averse while becoming better informed, often refusing to acknowledge the generally low likelihood of unfavourable outcomes associated with medical treatment and interventions. Brilla et al. (2006) claim that this encourages medical personnel to avoid potentially dangerous activities, prompting them to adopt a defensive

position and request tests not for medical reasons but rather to lessen the possibility of complaints or legal action. If there is litigation, a "more defendable" case is produced, at the very least (Brilla et al., 2006). According to Chen (2007), this tactic is complicated by the assumption that courts often depend on investigational evidence rather than declarations of experience or medical judgement (Chen, 2007). Moreover, negative defensive medicine (such as limiting or denying care or treatment to patients deemed too "risky" by physicians) may be a factor in health system inequality.

There is no doubt that clinicians hold one another and themselves to exacting standards. Despite the clear prevalence of human error, no one likes the idea that they have made a mistake, and the stakes are higher when someone may be hurt as a result – possibly gravely or fatally. But there is also a clear undercurrent in professional cultures that is founded on the idea of infallibility and characterised by intolerance for any departure from it (Goldman, 2010). One of the main reasons offered for not reporting clinical incidents is the fear of being personally blamed (Vincent et al., 1999). Despite being rare, recent prosecutions for gross negligence manslaughter have led to an elevated sense of fear and anxiety, producing tremendous disquiet throughout the healthcare professions (Williams, 2018). According to Lucian Leape, the so-called father of patient safety, the single biggest obstacle to improvements in patient safety is the effects of medical culture.

The Fear of Litigation

At present medical injury claims in the UK can be made through tort litigation, with payments obtained by court orders or out-of-court agreements. When clinicians receive a complaint or are involved in litigation, the reaction is often intensely personal. Affected clinicians may experience feelings of rage, remorse, embarrassment and loss of confidence, and some even consider leaving the profession (Robertson & Thomson, 2014). The negative effects on claimants' physical and mental health, as well as their incomes, are also well documented (Delbanco & Bell 2007; Vandersteegen et al., 2015).

The NHS in England spends more than £2 billion annually on paying people who were harmed during treatment, and the system costs have been increasing at an alarming rate. Ten years ago, the NHS paid damages totalling £900 million; in 2022, it was £2.17 billion, which is equal to the annual operating expenses of the largest hospital trust in England. During the next ten years, this amount is expected to quadruple with legal fees accounting for about a quarter of these expenses. Clinical negligence costs the English NHS 2% of its overall revenue (Health and Social Care Committee, 2022). The same Select Committee Inquiry concluded that processes that are supposed to deliver justice and incentivise improvements fail to do

either, with lessons rarely being learned, and for families accessing compensation the experience was slow, adversarial, stressful and often bitter. Furthermore, they claim that the outcomes are often arbitrary – based not on need but on whether clinical negligence can be proved.

To counter the negative effects of litigation and to limit the costs to the public purse, several countries – most notably in the Nordic countries and New Zealand – have introduced no fault compensation schemes (NFCS) that enable harmed patients to be compensated without the need to prove negligence. These schemes and the motivation for having them are complex but importantly include:

- The more precise targeting of compensation for intended beneficiaries (Davis et al., 2002)
- The impacts on physical and mental health outcomes (Cameron et al., 2008) and health system costs (Dickson, 2016)
- The more equitable access to justice (Bismark et al., 2006a, 2006b) and healthcare (Dubay et al., 1999)
- The importance of procedural justice (Siegal et al., 2008)
- The possibilities of improved patient safety (Wallis, 2013)

Measuring the effectiveness of schemes to meet all these aims is, however, extremely complex. A recent review of litigation reform proved that the effects of these schemes remain highly contested (Health and Social Care Committee, 2022).

The Review's main proposal was for the NHS to implement a fundamentally different system for compensating harmed patients, one that shifts away from a system centred on assigning blame towards one which places a higher priority on learning from mistakes.

In the most serious circumstances, they propose that a separate administrative authority – not the courts – should oversee conducting investigations and deciding who qualifies for compensation. The Bar Council for England said that to suggest that clinical negligence should generate learning "is to misunderstand the purpose of tort law (addressing wrongs) which is to compensate the victim and not to punish or prevent recidivism by the Tortfeasor" (Health and Social Care Committee, 2022, p. 20), and that to introduce a new statutory administrative scheme would be "a project of phenomenal ambition" (Health and Social Care Committee, 2022, p. 24).

Safety and Healthcare Harm

Since the Institute of Medicine (IoM) report "To Err is Human" (Donaldson et al., 2000) the issue of system safety and reducing healthcare harm has been in focus for health

systems all over the world. In the NHS, the IoM report was mirrored by the landmark report from the Chief Medical Officer (Donaldson, 2002; Eva & Regher, 2000) which looked at what was known about the scope and character of healthcare harm in the UK, as well as what might be learnt from past mistakes. Both reports introduced notions of clinical error for the first time and placed an emphasis on unified reporting channels, a more open culture and ensuring that lessons learned were incorporated. A systems-based approach to reducing error was proposed, drawing on knowledge and experience from other high-risk industries, but in practice many argue that the focus on clinical error achieved the exact opposite (Wears & Sutcliffe, 2019).

In the NHS in England, the National Patient Safety Agency was set up, whose role was to implement the findings of the report and ensure that lessons were learnt and fed back into practice. A cornerstone of the new approach to patient safety was a system of reporting, recording, analysing and learning from error. Over the next 20 years, significant efforts were made to develop such systems all over the world, and yet despite all the activity, investment and improvement effort, rates of healthcare harm appear to have remained stable and progress in reducing harm has been glacially slow (Illingworth et al., 2022; Wears & Sutcliffe, 2019).

Hollnagel et al. (2015) argue that this can be attributed to the way in which safety itself has been defined; making a distinction between what they call Safety I and Safety II, which can be summarised as shown in Table 10.1.

They argue that there is an urgent need to modify our approach to safety considering the rising demands and expanding system complexity. While a Safety I failure can still be used to understand many adverse events, this perspective neglects to consider the fact that human performance almost always goes according to plan. Things go well not because people act appropriately (i.e. correctly follow the rules or processes), but rather because they modify their behaviour to suit the circumstances of their particular work scenario. These modifications become more crucial to maintain acceptable performance as systems become more interdependent and complex. Understanding how adaptations are made, or how performance typically goes well despite the uncertainties, ambiguities, and goal conflicts that permeate complicated work circumstances, is the challenge for safety improvement.

Whilst the distinction between Safety I and Safety II is now common in the literature, much of the organisational and institutional practice is still predicated on the former, despite the conditions suggesting the latter may be more beneficial and effective. Wears and Sutcliffe (2019) argue that the reason for this is that the patient safety movement in healthcare remains dominated by the disciplines of medicine and management and has failed to properly integrate and use the knowledge of other domains, which have been highly influential in safety science in other industries – especially psychology, sociology and engineering.

Table 10.1   Safety I and Safety II (adapted from Finkel, 2011; Hollnagel et al., 2015)

	Safety I	**Safety II**
Central beliefs about causation	Things go wrong because of identifiable failures or malfunctions of specific components, be they technology, procedures, the human workers or the organisations in which they are embedded	Things go right most of the time due to system flexibility and resilience. Complexity and interdependence mean effects can be described but linear causation is impossible to establish
Approach	Ways of working that minimise the likelihood of accidents and incidents and reducing the level of risk to an acceptable level	Ways of working that enhance the system ability to succeed under varying conditions. Building resilience into system design enables safety to become a system property
Focus	Focus efforts into methods that ensure that 'as few things as possible go wrong'	Focus on method that ensures that 'as many things as possible go right'
	Manage people and conditions to prevent them making mistakes in the future	To facilitate everyday work, anticipate developments and events, and to maintain the adaptive capacity to respond effectively to inevitable surprises
	Respond when something happens or is categorised as an unacceptable risk, usually by trying to eliminate causes or improve barriers, or both	
View of humans	Humans are the most unpredictable variable, and whether acting alone or in groups are therefore primarily seen as a liability or hazard. Humans are the "weak" points in the system	Humans are basically good at making the everyday performance adaptations that are needed to respond to varying conditions – this is why things go mostly right. Humans are the "glue" that makes things work
Tools and techniques	Risk assessment aims to predict problems and control variation ahead of things going wrong. Identification of violations in standard operating procedures allows for corrections to be made	Dynamic risk assessment to understand conditions where performance variability becomes difficult or impossible to control. Identifying patterns that are resilient and flexible and amplifying them
Approach to investigation	Discover the root causes and contributing elements of undesirable outcomes. Make specific recommendations to resolve them	Learning to develop an understanding of how things usually go right, since that is the basis for explaining how things occasionally go wrong

Compounded Harm

There is little doubt that we have some significant problems when it comes to providing consistently safe and reliable care. When things go wrong our current models often inadvertently make the restoration of trust and the repair of the relationship both more difficult and costly in both financial and human terms.

Numerous patient safety inquiry reports over recent years have consistently provided powerful evidence that people who have already suffered the most devastating consequences of unsafe healthcare are also routinely caused further harm by the way the system responds (Francis, 2013; Kirkup, 2015; Vize, 2022). In a recent survey conducted by the Harmed Patient Alliance over 80% either "disagreed" or "strongly disagreed" that they had been "seen and heard as if they truly mattered since the harm happened". Not a single respondent felt that they were treated with the care, compassion, kindness and respect they had expected from the NHS. Many described being forced to fight for answers, with prolonged and profound impacts including serious mistrust in their ongoing relationship with healthcare; 86% reported impacts on working life, 83% on physical health and 69% on personal relationships. More than 90% of respondents said that the organisation's response negatively impacted on their mental health and/or emotional and psychological wellbeing, and 94% stated that they had to find and/or pay for emotional, practical or psychological support to help try to recover from what happened to them – harm that was created by the service that was there to heal them. In summary, the responses indicate that for most, the organisation's actions caused "compounded harm" with significant negative impacts on healing, wellbeing, trust and relationships (Titcombe et al., 2023). They argue that dealing with "harmed" patients and their families appears in some way exempt from the obligations expressed in the NHS values, evidenced by a lack of systemic action to avoid compounded harm. Whilst being honest when things go wrong and showing compassion when participating in learning or investigative processes are crucial, minimising "compounded harm" is about much more than that. The report calls for a more fundamental rethinking of what is required to "heal" (to restore wellness, trust and just relationships following healthcare injury); as well as for organisations to assume proper responsibility for their actions in the interests of justice (Hughes et al., 2023). Although "restorative just culture" has featured more prominently in the patient safety discourse of late, this has been seen largely as an antidote to the "blame game" that is believed to suppress staff openness and therefore impact on organisational learning (Cribb et al., 2022). Recent literature is largely silent on the issue of attending to the healing needs of patients and their families, remaining focused on primacy of organisational learning or staff wellbeing (Dekker et al., 2022). If we consider the aftermath of harm as being about staff and harmed patients and family wellbeing, as well as organisational learning, then a "just" response they argue must include a complex process of moral repair that is an expression of the espoused values of the NHS (Hughes et al., 2023).

Restorative Approaches

The restorative approach is based on the philosophy that justice is created not by punishing those who broke the rules but by repairing the harm caused. It recognises that clinical staff are often very deeply affected by events, and strategies aimed at ensuring their wellbeing, trust and relationships with their employer, colleagues and role after things have gone wrong are critical. It therefore follows that harmed patients and families also deserve a "restorative and just" response to their wellbeing, trust and relationship needs too, and a failure to do this will further compound harm and generate an even greater sense of injustice. It is tempting to think that we can plan, train, measure and/or regulate ourselves out of this situation, and whilst these elements may have a part to play, a more fundamental disruption of the prevailing institutional attitudes and beliefs is needed, including significant investment in infrastructure. This is a challenging "ask" in the current circumstances, but the human and moral arguments are compelling, and the financial costs to the system undeniable. A much deeper conversation about healing – the restoration of wellbeing, trust and just relationships with all those affected after healthcare harm – is needed. This is likely to be a difficult conversation, which touches on many "taboos" and challenges to the existing public discourse around safety in healthcare. It is a conversation that will need the commitment of many across the public, political, clinical and regulatory space.

Promoting Organisational Effectiveness

Many argue that building organisational health and developing restorative just cultures are crucial to this argument (Dekker et al., 2022). These approaches focus on the creation of psychological safety in the workplace conditions, enabling interpersonal risk in relationships, and encouraging ethical frameworks for practice, including the freedom to name issues before they become a considerable risk (Edmondson, 2018; Martin et al., 2021). There is no doubt that proactively supporting those who raise concerns is also considered to be important and this type of prosocial organisational behaviour (Miceli et al., 2008; Shale & Anderson-Wallace, 2020) can also help to create the conditions for a shift away from "comfort seeking" approaches to risk, towards more pro-active "problem sensing" methods (Cullen, 2016; Dixon-Woods et al., 2014). However, there is a broader context and all of this must be supported by an intelligent, fair and compassionate approach to professional regulation, and a just approach to support and investigation when things go wrong (Wailling et al., 2022). Dekker et al. (2022) consider the experience of Mersey Care, a large provider of Mental Health and Community Care support in the Northwest of England, as an exemplar of an organisation that has used the aim of building a restorative just culture to build organisational resilience. There is little doubt that the work has been impressive with tangible outcomes in terms of practical

and economic benefits (Kaur et al., 2019), however despite significant publicity the models used do not appear to have become widespread.

Anderson-Wallace and Shale (2014a) conducted an analysis of the Francis Public Inquiry report and found 50 recommendations that refer to work that care organisations should be doing on a continuing basis to help rebuild trust following perceived failures in the care they provide. They suggest seven ethical practices that organisations should focus on when aiming to build an environment of quality in response to healthcare harm. At the heart of these practices is a research-based understanding of the moral relationship that exists between patients and healthcare organisations. The ethical practices provide an integrated account of the steps that it is necessary to take to build and, when necessary, rebuild, confidence, trust and hope, and promote a proactive approach to making amends and supporting professional staff, so that the consequences of healthcare harm are less devastating for everyone involved. Each practice has a detailed descriptor that addresses all three dimensions of quality – effectiveness, safety and experience – by asking core questions as outlined in Figure 10.3.

Effectiveness:	Safety:	Experience:
Why are we doing this, and therefore what should our actions focus on?	What do we need to do to ensure safe care for this and other patients?	How do we want people affected to experience our actions?

1	Attentiveness to negative perceptions of care, and supportive action in response to complaints
2	Supportive disclosure to patients and their supporters
3	Support for clinicians, clinical teams and other affected staff
4	Transparent, impartial and authoritative enquiry
5	Implementation of actions approved and collaboratively developed with patients and supporters
6	Restorative approach to restitution
7	Institutional and individual accountability

Figure 10.3   Seven ethical practices (Anderson-Wallace & Shale, 2014b)

Many of Francis' proposals were put into practice as part of the policy response. The need that providers select a "freedom to speak up" guardian to promote openness and guarantee people's complaints are heard, and the legislative responsibility of candour on the part of provider organisations when patients are harmed, were both swiftly adopted. The method of inspection used by the Care Quality Commission was changed. Frameworks for responding to patient safety incidents also underwent two significant changes. But many of the recommendations did not result in changes to policy. For instance, guidelines on minimum staffing ratios

have still not been implemented despite mounting evidence (Griffiths & Dall'Ora, 2022) and long-term financial and workforce issues, combined with post-pandemic strains on services, have made safe staffing increasingly politically problematic. As Martin et al. (2023) note, evaluations of the changes made are uncommon, and when they have been done (for instance, on openness initiatives in trusts) organisational commitment and capability have varied. More than ten years on from the publication of the Francis Public Inquiry report, implementation of the 50 recommendations that Anderson-Wallace & Shale refer to in their ethical practices framework has been extremely limited.

Blame, Shame and Justice

The culture of "blame" and "shame" that persists discourages openness and learning (Waring, 2005) and although there is a growing awareness of the needs of both families and of professionals involved in harm events, the practical infrastructure to support alternative ways of working are generally not available. Of course, the situation is complex as there are many audiences – coroners, commissioners, professional and system regulators – who may not share the same interests and/or have statutory roles to play which conflict with others. As Cribb et al. (2022) note, organisations may officially support "no blame" rhetoric but in day-to-day operations personnel may still feel they are being treated unfairly. They might also formally admit that the system caused the injury, but a family might view this as a way of individuals being held accountable and as an avoidance of proper sanctions. Families and professionals may also be concerned about the efficacy or value of some types of "moral repair" when there does not appear to be a sincere admission of fault on anyone's behalf. Cribb et al. (2022) argue that we need to make many of these debates more concrete and advocate "real world" policies and practices that ask what ideas about justice (in which combinations) they embody. This conversation could explore proportionate sanctions, shared learning and accountability, and repairing damage, as well as asking about the relative importance of these different values and how best to balance and combine them in practice. In conclusion, they suggest that everyone involved in enhancing the safety of healthcare should carefully and openly consider the ethical balancing acts requiring interpretations of justice through retributive (with sanctions), distributive (no blame or qualified blame) and reparative (focused on healing) lenses.

Aubin and King (2018) consider healthcare as an ecosystem that is perfect for growing shame. They define shame as a complex array of cognitive, perceptual and emotional phenomena, as an "assault of the self" (Van Vliet, 2008, p. 237), and "one of the most powerful, painful and potentially destructive experiences known to humans" (Gilbert, 1997, p. 113). Shame is the result of comparing oneself to an internal standard or ideal; it follows that the higher the standards one

has, the more likely a person will encounter the feeling of shame. As previously discussed, healthcare professionals have exceptionally exacting standards overall, and coupled with the "yoke of perfection" (Hilfiker, 1984) and a general lack of acceptance of fallibility, the conditions for shame to thrive are obvious. The dynamic of both internal erosion of identity and the external exposure associated with admissions of error has an unmasking effect. But shame can also be a force which enables reassessment and a reconnection with one's own sense of humanity, assuming that it is handled in the right way by colleagues and collaborators. Aubin and King (2018) argue that what is required is not a "just culture", but an empathetic one, as empathy can help to reshape the mask of infallibility and act as a reminder that healthcare professionals are not alone in their struggle in a complex, unpredictable and demanding profession.

Conclusion

In this chapter we have considered a wide range of issues that create the context for unhelpful patterns of behaviour that significantly affect relationships, adversely influence the context of care and create defensive practice, and have reflected on a range of evidence-based approaches which can make a considerable difference. We have spent a good deal of time considering healthcare harm, which is one of the biggest areas of Failure Demand in the healthcare system. A great deal of emphasis is placed on the need for "lessons to be learnt" in relation to this domain, yet all of the formal systems developed to report and learn have failed to deliver the expected results. The tacit transfer of complex knowledge between actors within the work system is crucial to this, and investment in developing social and relational systems is of critical importance. We have argued that the institutionalisation of approaches to ethical, restorative and reflective practices is a prerequisite for this type of learning and is more likely to support sustainable changes. Contemporary notions of professional accountability and a context of greater sharing of responsibility, knowledge equity and decision-making amongst all those involved in care – including patients, their families and wider social networks – can help reframe the work and improve quality (Elwyn et al., 2012; Gilbert, 2019). It is clear however that these approaches are in their infancy in most organisations in the NHS.

Acknowledgements

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