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(1) Reflecting on the Francis report: How we can develop more human systems of care

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The United Kingdom has recently been rocked by a series of reports and scandals relating to the care of patients in hospitals and in care homes. The independent inquiry in 2010[1] led by Robert Francis[2] into the failings of the Mid Staffordshire hospital followed by the Public Inquiry reported in 2013 make for painful reading.[3] The statistics – up to 1200 preventable deaths – are shameful, but it is the personal stories that truly shock us. The relatives' accounts of the degradation, neglect, callousness and even cruelty experienced by patients create a picture of a living hell.

How did it come to this? How did the healthcare professionals so comprehensively lose their moral compass and eschew their fundamental duty to care for and protect their patients from harm and unnecessary suffering? How on earth can we make sense of it all? Above all, how can we learn from this, such that the words 'never again' do not ring hollow in a few years time? It is sobering to reflect that a Public Inquiry report in 2001 on failings of a hospital paediatric cardiac unit identified similar problems – a target-driven closed culture, with command and control management and lack of resources as key issues.[3] As in the Francis report, a shift to an open no-blame culture was mandated.

It is clear that the prioritisation and focus on financial and managerial targets rather than patient safety and well-being were contributory factors to the Mid-Staffordshire tragedy. This was combined with weak or coercive leadership and insufficient or poorly trained staff creating a culture where flaws were hidden or ignored, bullying was rife and patients suffered grievously. Staff members described a climate of fear. Those who had the courage to speak up were ignored or even punished. Those retaining a professional ethic describe suffering intense moral distress.[4] The gap between their moral vision and their actions – what they were actually able to do in the harsh circumstances – became wider by the day. Some gave up and left, and others became inured. The brutalised became brutalising.

Compassion can be described as a deep awareness of the suffering of another coupled with a commitment to relieve it.[5] It is a complex mentality that includes awareness, perspective taking, distress tolerance and a motivation to relieve suffering.[6] In the neuropsychology account, humans have three emotional regulation systems: the affiliative or compassion system linked to our attachments and our capacity for nurturing and soothing, the incentive system and the threat system. The latter, key to our evolutionary survival, is by far the most easily activated and the most powerful at times of stress. Crucially, fear shuts down our capacity for compassion. We are hunkered down in a self-orientated survival mode, our attentiveness is narrowed and our creativity reduced.[7] If we are distressed, tired or overwhelmed, our capacity to cope is weakened and our compassion and clinical effectiveness impaired.[8] Another very important finding from social psychology is our tendency to conform to authority, even if malign and contrary to our values.[9] Neuroscientists such as Damasio[10] have synthesised a model that integrates emotions with our values, moral decisions,

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relationships and behaviours. But well before the advent of neuroimaging, Aristotle had developed a virtue-based ethical theory that grounded ethics in both emotion and reason.[11] A case can be made that professionalism is underpinned by an ethic of virtue, and that compassion and caring are key virtues in the context of clinical medicine.[12]

The evidence strongly suggests that for compassion and creativity to flourish, we need to create high-trust and low-threat environments and focus on consolidating relationships, enabling collaboration and promoting flexible responsiveness.[13] We need to recognise that humans are not like Pavlov's dogs to be motivated by threats or incentives. Indeed, these are likely to be counter-productive in a clinical setting. The virtues, however, can become attenuated or corroded in a threat-based, fear-driven 'toxic' culture. The greater the mismatch between the proclaimed values of an organisation and those that are enacted on the ground, the greater the scope for distress, demoralisation and disengagement.[14] Blaming the foot soldiers and taking retributive and coercive actions will not solve the problem or prevent recurrence. We need to look deeply into the underlying causes and work out bottom-up and top-down strategies that reinforce the strengths and virtues of those who have chosen to act in a healing and caregiving role and those that constrain or corrupt them.[15] Healing is an essential and irreplaceable aspect of clinical professionalism, even though it does not sit well with management-speak or a commercialised and commodified view of healthcare. But unless we talk differently, we cannot think differently.

Professional and institutional values need to cohere, and organisational systems need to be designed to enable clinical excellence, moral sensitivity, compassion and care, integrity and wisdom to flourish. Empathy is intrinsic as is the professional aspiration to do good for patients. We need to restore the relational and moral dimensions of care – the recognition that illness represents an existential assault and involves emotional and spiritual suffering – which cannot be reduced to a biomechanical problem to be fixed.[16] For this, we need resonant and authentic leadership at all levels,[17] strong teams, adequate staffing, a nurturing learning environment and willingness to acknowledge errors and to learn from them. We need to support our learners and provide them with good role models. We need to ensure that healthcare professionals feel valued and respected, the emotional labour and complexity involved in their work acknowledged and their well-being promoted. Hospitals are living human systems, not car factories or supermarkets. Rather than focussing on threat-based systems of control, or perpetuating widget medicine, we should use our collective practical wisdom and our scientific knowledge and understanding to tap into the goodwill, resourcefulness and intelligence of all those who work and reside in hospitals and other healthcare institutions. Together with our patients, we can co-create more humane systems of care.

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(2) The Francis Report: Implications and consequences

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There has been much discussion and analysis of deficiencies in healthcare in the wake of the Francis Report. Now may be is the time to ask, at a more fundamental level, 'What do public enquiries really achieve?' Do they not merely summarise what has already happened? And 'Is it possible to change the National Health Service (NHS)?' The Mid Staffs tragedy, as the Francis Report states, lay in the degree of negligence and insensitivity demonstrated by staff, but also in the length of time for which this had persisted, despite so many systems to ensure accountability and regulation of care. David Nicholson, Chief Executive of NHS, England, told the Inquiry that the NHS is no longer a unified system, but a complex organisation comprising multiple cultures, values, aims, expectations, disciplines and practices, and made up of hundreds of national, regional and local organisations. This was borne out by the witnesses at the Francis Inquiry who gave many accounts of what they believed the NHS to be, and while there was agreement, there was also considerable disagreement about what the NHS should be seeking to achieve and how. Therefore, attempting to change, it presents huge challenges.[1]

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