

# Bristol and Kennedy: the 'take-home' messages for physicians

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The Kennedy report into children's heart surgery at Bristol Royal Infirmary demonstrates yet again that the needs of patients must be the primary focus of all healthcare delivery, and the ways in which these may be obscured by established practices. The report contains important lessons for physicians and all health care workers, but with 198 recommendations there is a need to prioritise a selection of the most urgent, lest their stimulus for change is lost in a mass of detail. Above all, the report demonstrates the need for good clinical governance, for teamwork, and an end to barriers to co-operation between different professional groups. It stresses the need for training in communication and leadership skills, with systems to ensure lifelong learning and continuing professional development. To restore public confidence in the healthcare professions we must heed these messages and demonstrate our willingness to address the necessary changes.

All too often in public services, the establishment of safe practices and their dissemination and monitoring, follow the stimulus of prior disaster. In the process tragic loss of life and much anguish and suffering are entailed. In this healthcare seems no different from transport or food production as several recent examples have shown. At least since Scutari and Florence Nightingale, the history of healthcare has been chequered by disasters from which we learn painful lessons. Bristol, long synonymous with good maritime practice, has lately become a byword for healthcare disaster. Now the long awaited Kennedy report<sup>1</sup> into children's heart surgery at Bristol Royal Infirmary has been greeted with relief in some quarters because it has refocused attention away from the few individuals already castigated and censured by the GMC, instead placing emphasis on failures of teams and systems. The report is remarkable in its fairness and the thoroughness with which it weighs the evidence gained, but it is over ambitious in the plethora of its 198 recommendations. The summary makes a better read and a good guide to what is needed.

Although the Kennedy report deals mainly with surgery, there are important general lessons for physicians, and others too. This article aims to extract such guidance for physicians from the recommendations of the report. Many of the report's

recommendations are already enshrined in the series of publications from the GMC collectively entitled *Duties of a doctor*, notably in *Good medical practice*<sup>2</sup> and *Maintaining good medical practice*<sup>3</sup>. The report reminds us again that we must place patients at the very centre of any process. Anyone tired of this oft repeated nostrum need only dip into the Kennedy report to realise how much of the problems at Bristol stemmed from such failure. The report also serves to emphasise the need for, and relevance of clinical governance as it has been formulated and adopted.

## The clinical process

In dealing with the consultation and treatment processes, the report recommends that patients should receive copies of any letters which are written about them, a practice that has been adopted by many, including myself, for some years. More contentious and potentially time consuming is the suggestion that patients should be offered the facility to make tape recordings of consultations. It seems advisable that the potential benefits of such a process should be subjected to appropriate trials and assessment before it is recommended for widespread adoption.

## Informed consent

The practice of physicians will also be affected by the recommendations that consent should be obtained for all examinations or procedures that involve any touching or physical contact with the patient. The report does not indicate whether such consent would be written or countersigned by the patient. This again will have considerable impact and burden for physicians, but it would seem advisable that Trusts develop local guidelines and recommendations for what consent procedures are advisable, with specific examples and categories, for example, should all imaging studies require signed consent?

## Working with other professional groups

In so much as the principles of clinical governance have been established within Trusts, physicians will be relieved to learn that many of the recommendations of

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the Kennedy report about working with other professional groups, continuing professional development and team working, have already been adopted, and in consequence many of the recommendations of the report only serve to underline the need for good clinical governance, and do not as such add unnecessarily to the burdens of practice.

### Professional competence

The report reveals many failures of communication with patients and colleagues affecting all professional groups and highlights the need for instruction in communication skills for all healthcare professionals. At a time when we are advised that the old 'apprenticeship' style of training is outmoded, it is paradoxical to find that Kennedy recommends 'shadowing for short periods' to enhance mutual respect for the different roles and work pressures of managers and clinicians.

The report, in emphasising the need for team work, recommends formal assessment of all aspects of competence including non-clinical elements of care, and places continuing professional development (CPD) at the very centre of systems for assuring competence. Not surprisingly, it also recommends that periodic appraisal, either with revalidation or appraisal, must be compulsory for all healthcare professionals.

### Local teams and professional barriers

The report highlights the increasing need for healthcare professionals to work in multi-disciplinary teams, presents many failures that arose from continued barriers between professional groups, and highlights how the existence of a closed 'club culture' proved a bar to inter-professional co-operation. Similar problems were encountered by the investigation into cardiac services in Oxford<sup>4</sup>. It is difficult to view this as other than a 'death knell' for the consultants' dining room, beloved of many. Amongst the measures recommended by the report are the value of shared learning across professional boundaries, clinical audit, reflective practice, and leadership. Kennedy reminds us that we all need to learn appropriate leadership styles and practices, and shed those that are inappropriate.

### Monitoring standards and performance

While acknowledging that clinical audit is widely practised within Trusts, Kennedy requires that it be placed at the core of a system for monitoring local performance, and the need for it to be multi-disciplinary. It urges that we must ensure that 'all healthcare professionals have access to the necessary time, facilities, advice, and expertise in order to conduct audit effectively'. While suggesting that every Trust should have a central clinical audit office, and that audit should be compulsory for all, examination of the report's findings emphasises the need to limit the range of audits in hand. This would ensure that they concentrate on major topics that threaten the lives and welfare of patients, and the need for such audit processes to be iterative to produce effective change in clinical practice. The report

emphasises the need for a sound, single information system for any Trust to ensure that there is no separation between administrative and clinical data systems.

### Adverse events and a 'no blame culture'

Kennedy recommends Trusts to ensure that individual employees shall be immune from disciplinary action when reporting adverse events. It suggests that a culture must develop where so called 'sentinel events' are reported within 48 hours in an open, non-punitive environment. In common with much else that has been written about this subject, the report fails to show how such an environment can be created, but it should be noted that changes in human nature are more difficult to achieve than changes to legal structures. However, it makes welcome recommendations for an end to our present adversarial clinical negligence process and its replacement by a central system for compensation of patients. The report highlights how the clinical negligence litigation process inhibits the emergence of useful lessons from cases of error, and thereby impairs learning for future safety. This section of the report (Section Two, chapter 26, pages 361–371) makes particularly useful and interesting reading for all involved in the provision of health care.

As to 'whistleblowing', while attention is given to the need to ensure a 'no blame culture', examination of the Kennedy report reveals the absence of guidelines and precedents available, and how and when an enquiry into services is to be conducted. Nor does it address the damage to individuals and Trusts which may follow unjustified whistleblowing. This occurred after the report of the enquiry into cardiac surgery at the Royal Brompton and Harefield Hospitals<sup>5</sup> and the allegations and report about research on children in Stoke on Trent<sup>6,7</sup>.

### The external climate of the NHS

The report also serves to highlight contributions to the Bristol tragedy made by under-funding and the concentration by governments on containing costs, changing structures, cutting waiting lists, and minimising fuss.

### Doctors and management

Welcome suggestions from the Bristol report that are of relevance to physicians include recommendations that doctors engaged in management should be given sufficient time within their contracted hours to carry out those duties; also that they should receive specific training for the work. The report also recommends that this involvement with management activities should be reflected in distinction award payments.

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## References

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- 7 Chalmers I, Hey E. Open letter to the Chief Medical Officer: Learning from Bristol: the need for a lead from the Chief Medical Officer. *BMJ* 2001;**323**:280–281.

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