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Doctors and others: reflections on the first Francis Report

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Introduction

In 2009, the Healthcare Commission identified numerous excess deaths in the Mid Staffordshire NHS Trust (Mid-Staffs) between 2005 and 2008. This led to the inquiry by Robert Francis QC (hereafter, 'Francis Report'), published on 24 February 2010.[1] Mid Staffordshire National Health Service (NHS) Foundation Trust paid a total of £1,029,000 over 'poor nursing and dignity issues' in 2010 and, in 2011, agreed to settle a further 17 cases. The Department of Health and the Trust Board accepted the recommendations of the enquiry in full. The second Francis Report, the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, published in 2013,[2] provided detailed recommendations: the principles on which they are based were defined in the first Francis Report, which made clear that the problems went far beyond an excess number of deaths. In this article, we briefly recapitulate the extent of the failings outlined in the first Francis Report, and consider the ethical underpinning of clinical practice.

The Francis Report emphasised that everyone has a part to play (doctors, nurses, commissioners, system managers and regulators) in safeguarding the quality of care of patients in the early detection and prevention of serious failures. Healthcare is a shared responsibility in which each profession should invite and review input from every other. It is a complex, interconnected enterprise where almost every decision has an impact on others, including the balance between prevention and cure, the location of facilities, priorities for capital investment and current spending, and even approaches to diagnosis and the choice of treatment for individual patients.

Before turning to the role of healthcare professionals, some comment on management is also relevant. The recommendations of the inquiry included replacing the Code of Conduct for NHS managers with a new statement of professional ethics. It further comments: 'A constant theme from evidence about the Trust Board has been a retreat to the justification that its members were responsible for strategic and not operational direction.' The Francis Report does not challenge that normally strategic direction would be the main Trust Board responsibility, but considered that:

> *it is no excuse for not delving into the operational during times when it was known that there were no governance structures in place or only developing ones. It should have been realised that until reorganisation was embedded and proved to be effective, it could not be relied on exclusively. It was necessary for directors to roll up their sleeves and see for themselves what was actually happening.*

A regulatory and accreditation scheme for senior NHS managers is needed that mirrors those in place for clinicians and nursing staff.

However, there were mainly criticisms of healthcare professionals, not only of nurses, but also of doctors. Although Francis conceded that it was an inquisitorial inquiry, he nevertheless stated that:

> *Evidence of multiple and wide-ranging incidents of bad care as described by patients and their families has been such that it is impossible to do other than accept that, in the vast majority of cases, events have occurred as they have described.*

A few quotations give the flavour of much of the Francis Report:

> *It was striking how many accounts I received related to basic elements of care and the quality of the patient experience, as opposed to concerns about clinical errors leading to death or injury. That is not to downplay the significance of the evidence I received on such matters, but to emphasize the importance in the minds of those who receive hospital services of the general quality of care they are offered.*

The Francis Report notes that these failings were not primarily about poor medical knowledge or guideline-focused care. Rather, they were human shortcomings:

> *I looked at this doctor holding my mother's head and I said: this is my mother. As cold and as calculated as anything, her retort as fast as anything was: I have got a mother too. There was no compassion in that woman whatsoever.*

The cumulative effect of these shortcomings led to an overall failure, not simply individual ones:

> *The accounts given by staff of their experiences at work strongly confirm the impression given by the evidence of patients and their relatives that there was a pattern of substandard service delivery, as opposed to a series of isolated incidents.*

There was criticism of the way in which senior doctors concentrated on individual activity to the detriment of the overall hospital community:

> *In the case of the medical staff, many appear to have been disengaged from the management process…There was an acceptance of standards of care, probably through habituation, that should not have been tolerated.*
>
> *…One consequence of this is lack of leadership and consultant presence would have been inadequate support to junior medical staff.*
>
> *A culture in which staff separated themselves from management some-*

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times prevented a coherent staff view from being presented. There was evidence of consultants not just being reluctant to join in management – a common enough cause for concern in hospitals in general – but also of being having little interest in the potential of such proposals to affect their own standards of service.

The Francis Report made a series of recommendations to improve matters, including training and changing the hospital culture. Although some of these recommendations are procedural, Francis emphasised that this is not a problem that can be 'solved' but a change in outlook that must be continuously promoted: that is, it is about attitudes and values, not about knowledge and expertise. On its own, no amount of administrative accreditation will change that.

This first Francis Reports generated much comment, including discussion in Parliament: 'We look to the [General Medical Council] to ensure that failure to act is regarded as a serious breach of professional obligation,' said Stephen Dorrell MP, chair of the Health Committee,[3] while Paul Flynn, of the British Medical Association, told the *British Medical Journal* (*BMJ*): '… perhaps those who stick their heads in the sand and deliberately don't look for problems should be held to account for it.'

However, these conventional disciplinarian comments were modified by an appreciation that this was not primarily about error and accountability, driven by yet more guidance by a regulator (of which there is no shortage):

In the end, the quality assurance method in a care system is not the regulator in London, it's your professional colleagues around you that themselves know what good, professional care looks like and know that it's their registration at risk if they tolerate second rate care going on around them. This wider responsibility for the overall quality of care delivered to patients is a part of what it means to be a professional. (Stephen Dorrell)

Ethics and practice

The responsibilities of doctors faced with poor services, an unacceptable hospital culture, bullying, a substandard performance by other professional groups as well as their own, might not have attracted enough comment hitherto. Despite published guidance, part of what might be missing is the creation of an institutional ethic (*sic*) with an understanding of, and a constructive reflection upon, the underlying ethics of practice.

The United Nations Declaration of Human Rights (1948), refers to the 'inherent dignity' of all members of the human family and the 'inherent dignity and worth of the human person.' Despite legal, cultural and historical variations, most nations have committed themselves to the idea that there is something special about humans. The doctrine of respect for persons underlies the commitment to human rights, as expressed by Immanuel Kant. His 'categorical imperative' gives us the basis for rational autonomous choice[4] and for the formula of respect for the dignity of persons:[4] act so that you treat humanity, whether in your own person or in that of any other, always as an end and never as a means only. However, doctors will want to go beyond the capacity for rational choice in taking into account other characteristics: emotions, capacities for empathy, trust, interdependence and so on. These are some of the areas where failure in Mid-Staffs can so easily be identified.

A second moral tradition is also relevant in this particular failure. Virtue ethics offers an approach to ethical judgement as concerning character.[5] Its underlying question is not 'what should I do?' but 'how should I live?' Aristotle writes that 'virtue is not merely a disposition in conformity with the right principle but a disposition in collaboration with the principle, which in human conduct is prudence.'[6] Kant too describes 'duties of virtue'.[7]* 'Fulfillment of them is merit, but failure to fulfill them is not in itself culpability but rather mere deficiency in moral worth'. For example, we are under no obligation to assist others at every opportunity, but we should assist others on occasions. To express this differently, we have an 'imperfect duty' of beneficence but cannot be culpable if we do not take every conceivable opportunity to do good.

'Virtuous physicians are the beacons that show the way back to moral credibility for the whole profession,' states the distinguished American ethicist, Edmund Pellegrino.[8] Our medical ethic requires a renewed emphasis on virtue, combining an approach from principles with one from character.[9,10] 'It pertains to the perfection of moral goodness that a man should be moved towards the good not only by his will but also by his sensitive appetite.'[11]

Professional guidance places its strongest emphasis on action and performance. This has been reinforced by protocols of guideline-driven care. However, only recently has the chairman of the General Medical Council reminded doctors (in a letter dated 21 November 2011) that they 'must deal with uncertainty and often work off-protocol.' Where the actions or attitudes of colleagues or the environment of practice are unsafe or unacceptable, we should take action and might be disciplined for failure to do so.

Failures in Mid-Staffs were not primarily about protocol-driven care. Rather, they were not only failures of practical morality, interpreted as respect for persons, but also failures of virtue, with instances of discourtesy and unkindness.

Contingently, doctors still carry the ultimate responsibility for patients. They are also among the best-educated and best-paid members of the hospital community. As a result, additional responsibilities are rightly demanded. Doctors should be expected to take action in the event of substandard practices. It should be a duty of each physician to seek actively to prevent ill-treatment or shoddy care of any patient, to counteract indifference to a patient's needs and to blow the whistle on healthcare colleagues whom they believe are not acting in the best traditions of caring and sensitive medical treatment.

How might doctors be made aware of these responsibilities and obligations? Has teaching in medical ethics got stuck in the 'Four Principles' approach, as if a toolbox of autonomy, non-maleficence, beneficence and justice can be mouthed in response to any situation? These principles are often presented without underlying justification and teaching in medical ethics remains rudimentary in many institutions. The Francis Report demonstrates

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(among many other issues) that this is not adequate. Yet, principles, rules and laws are a clear guide in difficult situations: for it is not enough to rely on the moral good sense or conscience of the average clinician. There is surely no reason to believe that doctors in Mid-Staffs lacked that.

Although much lip service is paid to multidisciplinary team working, this can often be a platitude for no more than involving a series of individuals from different disciplines. There is an urgent need to explore the moral interprofessional relation when things go wrong or when disagreement raises important issues with ramifications for patient care and safety.

Kindness

Anecdotally, many experienced commentators have said that what they have witnessed has been an absence of kindness: an attitudinal change that resulted in substandard care. Of all the virtues, kindness has most singly been lacking, for which the Francis Report provides evidence. In her Reith lectures, O'Neill made a related observation. Whereas in theory the new culture of accountability makes professionals more accountable, in practice it might achieve little except an increase in a culture of suspicion.[12] 'Currently fashionable methods of accountability damage rather than repair trust'. We return to the Platonic question posed by Meno:

> *Can you tell me Socrates – is virtue something that can be taught? Or does it come by practice? Or is it neither teaching nor practice that gives it to a man but natural aptitude or something else?*[13]

In a recent book on kindness,[14] it is asserted that, although people have perceived themselves as naturally kind, confidence in this has gone. In the west, Christianity sacralised people's generous instincts and its notion of *caritas* functioned as a cultural cement. Individualism (as in Hobbes' *Leviathan* of 1651) attacked Christian kindness as a psychological absurdity. Men, Hobbes said, were selfish, existence a 'warre of alle against alle'. Icons of kindness (Princess Diana, Nelson Mandela or Mother Theresa) are either worshipped as saints or gleefully unmasked as self-serving hypocrites.[14] Yet, nobody would want a return to a mawkish cult of feminised tender-heartedness, summed up by Thomas Carlyle as 'the tumultuous frothy ocean-tide of benevolent sentimentality.'

In our present-day NHS, recently celebrated at the Olympic games (described as 'an archaism, a dinosaur of public altruism that stubbornly refuses to lie down and die'):[14]

> *the pleasures of kindness shouldn't be those of moral superiority or domineering beneficence or the protection racket of good feelings. Nor should acts of kindness be seen as acts of will or effort or moral resolution: not a temptation to sacrifice ourselves, but to include ourselves with others in solidarity with human need, and with the very paradoxical sense of powerlessness and power that human need induces. Acts of kindness involve us in different kinds of conversations.*[14]

This has been explored in a recent book entitled *Intelligent Kindness* from The Royal College of Psychiatrists.[15] It is not about niceness or altruism; it avoids sentimentality. Rather, it attempts a partial answer to Meno's question in its demand to promote systems, structures and organisation that encourage the virtuous practitioner. Social change, such as the increased division between rich and poor in contemporary Britain, cannot be changed by doctors *qua* doctors, whatever the negative impact of less mutuality in relations across social divisions. Income inequality has a toxic influence in an affluent, consumerist society, is bad for health and bad for kindness between people. Our challenge is not to oppose but to realise the creative vitality of independence and individuality with kinship and collective kindness.[15]

To achieve both some understanding and some progress after an episode such as Mid-Staffs, we should acknowledge that motivation is usually complex. People do not go into careers in healthcare to be cruel. Attitudes towards one's work change and, for nursing colleagues in particular, the mess and damage of illness is all too apparent: the noisy, smelly, obstreperous, incontinent patient, repeatedly soiling themselves. We cannot ignore the distressing nature of much medical and (especially) nursing work.

Here then are some themes from *Intelligent Kindness*: acknowledge (and discuss) the psychological defence mechanisms that carers need to cope; recognise the consequences of over-identification, even in emotionally well-supported staff; appreciate the need to manage feelings of anger and indeed hatred to the most demanding of patients, given that the most unpleasant individuals do not become virtuous because they are ill; set up better communications between professionals to cope with the guilt and blame that might originate from uncertainty; accept that we should aim to be good enough and not perfect; and offer the right levels of support and supervision, encouraging interdisciplinary working. In the latter, there are particular roles for medical staff and for managers. There has been too much emphasis on the quasi-legal process based on protocols of care that are rarely read and even less often remembered.

Power corrupts and, in hospitals, the powerful are the professionals: healthy (not sick), expert (not lay), gatekeepers (not supplicants), who can rationalise their detachment because they are busy. Good people can do bad things if the environment and ethos permit it. That is one lesson of the psychological experiments of the 1960s, such as the Stanford prison experiment[16] or Milgram's obedience studies.[17†] *Intelligent Kindness* acknowledges the realities of human behaviour and takes us beyond regulatory approaches or preaching.

Intelligent kindness will flourish in teams with the right level of cooperative and collaborative working. There are well-established ways of promoting these. The Royal College of Physicians has done much work on professionalism, especially the meaning of vocation. There is more to do. In an age of exciting scientific advance, human kindness is not an optional extra to be the subject of a letter in the local newspaper. Ideas of professionalism can be taught and might require help from our humanities faculties.

> *The things that really matter to us – the secrets of the heart, of what it means to be an individual, the depths and heights of human experience*

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– all are accessible, if at all, only through literature and the creative arts. Science has no purchase on them.[18]

Or, as EM Forster writes:

Preachers or scientists may generalize, but we know that no generality is possible about those whom we love; not one heaven awaits them, not even one oblivion. Aunt Joley, incapable of tragedy, slipped out of life with odd little laughs and apologies for having stopped in it so long.[19]

Forster, observes O'Donnell, writes not about death but about Aunt Joley.[20]

The past few years have seen remarkable developments in medical humanities,[‡] such as the innovative programs included in certain medical schools, where the benefits are being continuously assessed. We believe that this should be encouraged. Two hours spent reading *The Death of Ivan Ilyich*[21] or the remarkable combination of drawing, poetry and narrative in *Three-three, two-two, five-six*[22] (to select one classic and one contemporary example) would offer more to kind healthcare and the issues raised by the Francis Inquiry than any amount of finger wagging or yet another protocol or regulatory rule.

Footnotes

*This contrasts with Duties of Right: reference[4].
†On 'situationism', see also the short essay by ED Pellegrino.[23]
‡Such developments also included the launch of the journal *Medical Humanities* and the four volumes of the *Companion to Medical Humanities*.[24]

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