Doctors and others: reflections on the first Francis Report

John Saunders, on behalf of the Committee for Ethical Issues in Medicine, Royal College of Physicians

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 was the 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-

John Saunders, consultant physician;1 chair, Committee for Ethical Issues in Medicine2

1Nevill Hall Hospital, Abergavenny; 2Royal College of Physicians of London

© Royal College of Physicians, 2013. All rights reserved.
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 proce-
dural, Francis emphasised that this is not a problem that can be
‘solved’ but a change in outlook that must be continuously pro-
moted: that is, it is about attitudes and values, not about knowl-
edge 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, 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 regu-
lator (of which there is no shortage):

In the end, the quality assurance method in a care system is not the regu-
lator in London, it’s your professional colleagues around you that them-
selves 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 unac-
ceptable hospital culture, bullying, a substandard performance
by other professional groups as well as their own, might not have
attracted enough comment hitherto. Despite published guid-
ance, part of what might be missing is the creation of an institu-
tional 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 and for the formula of respect for
the dignity of persons 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, interde-
pendence 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. 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.’ Kant too describes
‘duties of virtue.’

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, 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 regu-
lator (of which there is no shortage):

In the end, the quality assurance method in a care system is not the regu-
lator in London, it’s your professional colleagues around you that them-
selves 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 unac-
ceptable hospital culture, bullying, a substandard performance
by other professional groups as well as their own, might not have
attracted enough comment hitherto. Despite published guid-
ance, part of what might be missing is the creation of an institu-
tional 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 and for the formula of respect for
the dignity of persons 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, interde-
pendence 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. 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.’ Kant too describes
‘duties of virtue.’

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, 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 regu-
lator (of which there is no shortage):

In the end, the quality assurance method in a care system is not the regu-
lator in London, it’s your professional colleagues around you that them-
selves 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)
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 confidence in humanity and thus their ability to trust one another. In the east, philosophies such as Confucianism provided a cultural cement. Individualism (as in Hobbes’s 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 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 quo 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 experiment16 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.

© Royal College of Physicians, 2013. All rights reserved.
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. Or, as EM Forster writes:

Forster, observes O’Donnell, writes not about death but about Aunt Joley. 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 or the remarkable combination of drawing, poetry and narrative in Three-three, two-two, five-six 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. Such developments also included the launch of the journal Medical Humanities and the four volumes of the Companion to Medical Humanities.

References

3 Jaques H. Doctors should be held to account for behaviour of colleagues, say MPs. BMJ 2011;343:d4794.