What's the appetite for clinical risk?

BY DUBHFEASA SLATTERY

The first Professor and Chair of Medical Professionalism at RCSI and BSHS, **Dubhfeasa Slattery** provides an overview of how a desire for better healthcare at all levels can be harnessed and nourished, leading to a potential life-long interest in reducing clinical risk by incorporating patient and carer safety.

Clinical risk differs from other risks, such as financial, because the stakes are much higher: if something goes wrong, patient harm or possibly even death, may result. The clinical risk which any individual or organisation is prepared to accept is dependent on his risk appetite.

Healthcare organisations attempt to replicate the constant preoccupation 'High Reliability Organisations' (e.g. nuclear power plants) have with the possibility of failure by putting systems in place to mitigate against risks as much as possible, because the consequences of an incident may be catastrophic. In health, due to the human factor component, risk can never be completely eliminated.

Figure 1. Prof Jo Shapiro, Director of the Centre for Professionalism and Peer Support and Consultant Otolaryngologist at the Brigham and Women's Hospital and Harvard Medical School, as guest speaker at Ireland's inaugural conference on medical professionalism at RCSI in Dublin, 12 April 2018.

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Accurate data helps identify high risk areas to target for intervention. This is performed at a national and organisation level with varied levels of effectiveness. Five years of national data on clinical incidents, claims and cost was recently published, by the State Claims Agency [1]. This report contextualised Irish data with international data, identified key learning and provided risk management suggestions to circumvent identified clinical risks.

At an individual level, healthcare professionals have accountability. Reduction of clinical risk involves maintenance of competence through appropriate training and continuous professional development, in addition to maintaining wellbeing, essential to delivering patient centred care. Clinical working environments that are under-resourced, combined with increasing patient numbers, complexity and expectations, may be stressful. 'The National Study of Wellbeing of Hospital Doctors in Ireland' identified that 24.4% of consultants had evidence of burnout, but of even more concern was that this figure was 38.4% in the more recently qualified basic speciality trainees [2]. In comparison, a large US study identified that physician burnout had increased from 45.5% in 2011 to

Figure 2. Sir Robert Francis QC, Chairperson of the Mid-Staffordshire NHS Foundation Trust Public Inquiry 2013, as guest speaker and Prof Dubhfeasa Slattery, Chair of Medical Professionalism at RCSI and BSHS, at Ireland's inaugural conference on medical professionalism at RCSI in Dublin, 12 April 2018.

54.4% in 2014 (p<0.001) [3].

The ramifications and costs of significant clinical risk are multiple and must be viewed across the whole spectrum: firstly the cost to the patient from a morbidity viewpoint; secondly the cost to the healthcare professional from a 'burnout' viewpoint – from the stress of clinical claims, and potential for the 'second victim phenomenon' when things go wrong; thirdly the cost to the tax payer from a financial viewpoint regarding cost of clinical claims; and fourthly the cost to the organisation from a reputational viewpoint, which has significant implications, nationally and internationally.

All of the above leads to poor patient satisfaction and poor staff morale, culminating in issues with recruitment and retention which may lead to a drop in standard of healthcare professionals available and a further lowering in standards of healthcare for patients.

As clinical risks increase so do clinical incidents, claims and indemnity costs with significant ramifications for both the public and the private health system. The cost of indemnity for GP out of hours work in England has become prohibitive and it was announced in October 2017 by the Secretary of State for Health that a state backed indemnity scheme for GPs in England would be developed. On the private healthcare side, a breast surgeon Ian Patterson (incarcerated for 20 years for performing unnecessary breast surgery), was an NHS employee but worked in a private healthcare system too, where he had 'privileges'. Spire Healthcare initially tried to sue the NHS but ultimately paid £27.2 of the £37.2 million paid in compensation [4].

In Ireland currently, indemnity costs for certain specialties exceed €100,000 per annum for a practising consultant working in a full time private capacity. Costs may increase significantly if a number of claims occur over a period of time. Soaring indemnity costs have resulted in an absence nationally of consultant obstetricians working in full time private practice. Indemnity costs for a spinal surgeon whose private work makes up more than 50% of his/her clinical commitment are €105,789 * but reduce to €42,979 if public work makes up more than 50% of his/her clinical commitment. Similarly for otolaryngology, indemnity costs range from €62,879 to €27,729 depending on private work commitment. Without private practice would the public hospitals' Accident and Emergency Departments be able to cope with the increased volume of patients? And how much longer would waiting lists be for elective surgery?

Rising claim numbers and indemnity costs have multiple knock on effects: consultants in full time private practice and private healthcare services may have a lower clinical risk appetite and be less interested in performing complex procedures, thereby increasing complex workload on public healthcare services; certain specialties may become less attractive to high calibre trainees, resulting in some vacant training positions in our public hospitals and a potentially reduced ability of medical schools to attract high quality, hard-working students. All of this culminates in a health system that is reactive when triggered by things going wrong, but often lacks the resources to be proactive in planning and implementing prevention.

At an organisational level there is an onus on the healthcare service to provide some training and education for healthcare professionals to deal with the stresses of under-resourced, clinical working environments.

Professionalism has at its core patient centred care, incorporating patient safety and healthcare professional safety; the latter includes prevention of burnout and prevention of clinical claims. Centres of excellence in North America, such as Harvard and the Mayo Clinic are world leaders in professionalism. The first chair and professor of medical professionalism was appointed at the Royal College of Surgeons in Ireland (RCSI) and the Bon Secours Health System (BSHS) in 2017. A unique 'Programme in Professionalism' has been developed that spans the continuum from undergraduate, to postgraduate and to continuous professional development. A new explicit, integrated curriculum in professionalism has been developed and will be interwoven across the undergraduate medical curriculum from year one to final year.

The dedicated, postgraduate component of the programme in professionalism has been developed incorporating elements from Harvard and other centres of excellence and is being implemented across the BSHS. It is unusual in that it is aimed at clinical and non-clinical staff. It includes communication and information dissemination; presentations on professionalism delivered by the professor on each hospital site with feedback from all staff regarding key opportunities for improvement; and a work place behaviour questionnaire (kindly shared by Prof Jo Shapiro, Harvard) results of which inform education and research. It also incorporates Ireland's inaugural, national conference on professionalism at RCSI (April 2018) with international world leader in professionalism, Prof Jo Shapiro (Consultant Otolaryngologist and Director of the Centre of Professionalism and Peer Support at Brigham and Women's Hospital, Harvard Medical School) as keynote speaker (Figure 1) and Sir Robert Francis QC, who chaired the Mid Staffordshire enquiry and authored the Francis Report (Figures 2 and 3). In excess of 450 delegates from disparate backgrounds attended

Figure 3. (L-R) Prof Cathal Kelly, CEO of RCSI, Daniel Sokol, Medical Ethicist, Barrister and author in BMJ, Prof John Hyland, President of RCSI, and Sir Robert Francis QC, discuss professionalism at Ireland's inaugural conference on medical professionalism at RCSI in Dublin, 12 April 2018.

Figure 4. Ireland's inaugural conference on professionalism entitled, 'Professionalism: Why it matters for patient safety, quality and risk' at RCSI in Dublin, 12 April 2018, was attended by in excess of 450 delegates, including members of the National Directorate of the Health Service Executive and the Department of Health, healthcare professionals (physicians, surgeons, nurses, pharmacists, quality and patient safety managers), legal professionals, patient advocates, educators and academics.

this conference (Figure 4). In addition, the programme includes the first national, postgraduate course on professionalism, incorporating leadership, quality, risk and claims (RCSI, May 2018) and onsite 'Interdisciplinary Professionalism Seminars' featuring tricky case scenarios and practical tools to address them. The final component of the programme involves a 10 year analysis of medico legal claims taken against the BSHS, including comparison of results with national and international data and development of risk management recommendations, fed back to all relevant stakeholders.

SUMMARY

The key aims of the programme in professionalism are to inculcate professionalism in medical students and practising healthcare professionals so that it becomes part of their DNA, thereby improving patient centred care and patient safety, while helping reduce clinical risk.

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