High reliability organisations

Keep the celebrations short

R L Wears

“Success without victory” in patient safety

Patient safety seems irritatingly positive. Its scientific literature and conference proceedings are replete with tales of improvement and stories of success. This is partly understandable. It is difficult to move people and organisations to change when the outcome is uncertain; hospitals and funding organisations do not like to hear that projects in which they have invested have failed; “safety champions” — the individuals who are the driving forces for change — passionately want to succeed; publication is not eagerly sought when high hopes have been derailed; and editors may fear inducing a paralysing “learned helplessness” in readers. Like Cassandra in ancient Troy, the few lonely voices cautioning that the road to safer care might be long and hard, that the outcome is in doubt, and that “success” (however we define it) once achieved might be difficult to hold, have largely been marginalised, drowned out by the upbeat chorus. An observer from another planet reviewing safety conferences, newsletters, proceedings, and papers over the last 5–10 years might approach the continuing papers over the last 5–10 years might perceive the fragility and evanescence of safety papers in health care. Their case study of how highly safe performance in an organisation was gradually lost due to changes in leadership, personnel, and philosophy underscores the fragility and evanescence of safety in complex systems. It emphasises that, while safe performance can be difficult to attain, it can easily be lost, and that such losses can come as the result of good intentions.

Although there were many dimensions to the organisational changes that were temporally associated with the degradation in performance in this case study, two seem particularly relevant — the reversion to a more hierarchical “command and control” model of organisation and the replacement of contextually sensitive, loop based decision making methods — “sensemaking through action” — by normative rationalised protocols. These two changes are ironic because they were intended to improve care and because they follow the standard medical model of organising; but they had the opposite effect. Worse, the organisation did not seem to be able to break out of this vicious cycle; one can imagine that the response to deteriorating performance might have been still more difficult and ever more detailed protocolisation.

Striving for “success without victory” in patient safety may seem cynical, or at least uninspiring, but it is realistic and avoids false hopes, inflated expectations, and unjustifiable disappointments. Paradoxically, the “high reliability organisations” that we in health care would like so much to emulate have got where they are by finding ways to sustain such an approach, to foster the continuing expectation of future (unpleasant) surprises; and to keep their celebrations short. Such unwelcome views have been punished in other domains but, more often, like Cassandra, they are just ignored. Keep the celebrations short.

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REFERENCES


It may not be easy for patients to insist on treatment as part of a guideline protocol

A further source of concern for me was the lack of a lay or consumer summary of this very comprehensive guideline. Although I have been involved in health services research for over 20 years, I am not clinically qualified. The specialist terminology and language used in this document render it difficult for me to understand without recourse to a medical dictionary. Furthermore, there is no evidence of consumer involvement in the development of this guideline, with the result that there is scant reflection of the patient’s perspective and experience of the condition and its management. We are told that patient adherence to treatment regimens is frequently poor, often because of unpleasant side effects of topical and oral drugs, but the cited references are in many cases over 20 years old. The NICE guideline development process requires that viewpoints of patients and their carers be taken into account, and all NICE guideline development groups have consumer representatives. A recent report from NICE highlighted the unique and essential nature of these representatives’ contribution to the guideline development process.

Elsewhere in this issue, West and colleagues report on the comparison of patients with pre-eclampsia who were enrolled in a clinical trial, and a control group of non-participants with the same condition who were nonetheless managed according to a strict treatment protocol. It has often been argued that patients opt to participate in trials in the hope that they will receive treatment options unavailable in routine practice, or will at least benefit from higher quality of care because of the rigorous study protocols applied to trial participants. However, West and colleagues found no differences in clinical outcomes and only minor differences with respect to the process of care between the two groups. They conclude that “in routine practice, patients may be well advised to insist on treatment as part of a protocol”. My own experience in trying to find a guideline appropriate to the management of my particular health problem suggests that this may not be as straightforward or as simple a process as these authors imply! Are appropriate guidelines always available and accessible? How well equipped are the majority of patients to find and appraise such guidelines? Will the patient perspective have been adequately captured in the guideline development process? Will clinicians be aware of the guidelines and will they be willing to accede to patient requests for protocol driven treatment? Undoubtedly, as West and colleagues conclude, and as the NICE initiative on protocol based care indicates, guidelines have enormous potential to ensure the quality, safety and effectiveness of health care. Encouraging professionals and patients to realise that potential remains a challenge for all of us.


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REFERENCES


