The Francis Inquiry report was completed in 2013 after an investigation over the preceding two years, focusing on presumed excess deaths at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. It was reported that between 400–1200 excess deaths occurred, mainly involving people over the age of 70 years.

Following this finding, it was discovered that a further 10 NHS hospitals had similar rates of excess deaths among similar age groups, although the subsequent Keogh Review cast doubts on the validity of the methodology used. Nevertheless, NHS England decided to halt the use of the Liverpool Care Pathway (LCP) to assist the deaths of older patients in hospital, since a significant proportion of people who died at Mid Staffordshire Hospital were on this pathway.

All this occurred against the background of an NHS England target, backed up by extra payment, of getting a higher proportion of patients dying in hospital on the LCP. Furthermore, all the hospitals named as having excess deaths had ongoing financial deficits. These facts were not particularly highlighted by Francis, who chose to concentrate on ‘ineffectual’ leadership and a ‘bullying’ culture where whistleblowers were persecuted by management.

The Francis Inquiry has resulted in the dismissal of some managers and senior nurses who were working at Mid Staffordshire. Despite 43 referrals of medical staff being made to the General Medical Council (GMC), none of the doctors have undergone formal investigation of practice. The statement from the GMC confirmed that this was on the basis of legal advice.

Unanswered questions
There has been no systematic investigation of the medical and nursing notes of the patients placed on the LCP in Mid Staffordshire or in the other hospitals named by NHS England. In particular, the crucial issue of potential discrepancies between the diagnoses described during the final inpatient stay and the causes of death in death certificates have not been investigated. Research into this issue is urgently awaited.

From my standpoint as an Old Age Psychiatrist, the concern is whether incapacitous older people, suffering from delirium, dementia and depression, were inappropriately and precipitously placed on the LCP by the treating multidisciplinary teams (MDTs). This would have resulted in fluids, food and active rehabilitation being withheld. These psychiatric conditions are, of course, treatable in the short term and do not necessarily lead to death. It is questionable if the LCP should have been applied under these conditions in the first place, as it was designed for terminal cancer patients, where timing of death is much more predictable. However, withholding fluid is more predictable in causing death – through acute kidney injury and chest infections.

Biases pertinent to multidisciplinary teams
There are three common biases that can influence an MDT. These have been described in a number of settings including health, banking and engineering. These are affective bias (‘heart ruling the head’), groupthink (‘we are the greatest’) and escalation of commitment (‘throwing good money after bad’). It is my opinion that these biases could have played a role in the teams concerned in the following ways.

Firstly, with regard to affective bias, it is possible that the direction by NHS England of placing more people on the LCP (backed up by financial inducement) could provide sufficient motivation to actively seek out patients who could potentially die in hospital. There was an urgent need in these hospitals to balance budgets, which would have devolved to individual departments and wards. Furthermore, ‘clinical excellence awards’ are increasingly associated with ‘performance targets’ defined by Trust management, which could provide motivation to make certain decisions.

Considering groupthink, a ‘bullying’ culture within an MDT can lead to pressure to suppress dissent on overt or covert team objectives. Typically there is a ‘mind guard’ within teams to keep dissent at bay. Individuals within the team (for rea-
sions of fear, or for potential personal gain) can decide not to express a contrary opinion, thereby confirming the correctness of the MDT approach. In MDTs where group-think is present, behaviours either to avoid or dismiss external criticism will be employed to maintain group confidence and cohesion. This might, for example, include criticisms from patient’s relatives.

Finally, regarding escalation of commitment,7 some MDTs will find it extremely difficult to accept that the current approach towards a patient is leading to costly and potentially catastrophic consequences. The explanation is that much cost (and reputation) has been invested already, making it difficult to change direction. If the approach taken with one patient is reversed, it leads to questions about much larger numbers of patients, which would cause major reputational damage and potentially trigger an external review.

It is often difficult to verify bias occurring in teams, although e-mail exchanges have been invaluable in ascertaining this within the financial industry. It is more helpful to be aware of biases that could affect MDTs and to reflect as teams on the role they play in day to day practice. Most clinicians in hospitals would suggest they do not have the time to meet as a MDT to discuss these issues. However, reflective practice is now a core component of appraisals leading to relicensing, so doctors do have the motivation to carry out this work either individually or as a team. Application of the LCP does involve medical consent; the ultimate decision, in my experience, is made by medical staff.

Lessons from recent history
Excess deaths in hospitals and similar institutions, either through neglect or design, is not unknown overseas. In Germany, during the Weimar republic (1919-1933), financial constraints resulted in the well established community care programme being curtailed and vulnerable individuals – mainly older people with mental health issues – being returned to institutions (the equivalent of our community hospitals). Coincidentally, there were discussions involving lawyers, doctors and politicians about the economic costs to the state of maintaining these vulnerable individuals, resulting in the phrase ‘a life not worth living’.8,9 Initially, this notion resulted in incremental neglect in institutions, involving reduced rations and medical treatment, ultimately leading to ‘mercy killings’ of people using lethal injections. Medical staff led this process, and following the end of World War II, most of these doctors returned to their posts.

Clearly, this is not a path that doctors in the UK would conceivably follow, considering due diligence provided by the GMC and the judiciary. The actions at Mid Staffordshire are more likely to be misconceptions and errors of omission, rather than errors of commission. However, as studies by Milgram and colleagues have shown,10 apparently empathic individuals, given enough direction by authority figures, can resort to cruelty.

Ways forward
Clearly, there are major methodological problems in identifying samples of excess and avoidable deaths, although patients in hospitals placed on the LCP would be a good starting point, comparing people with and without cancer as the principal diagnosis. Nursing notes would indicate the degree of involvement of the various disciplines in deciding placement of older people on the LCP, and also give an indication of other problems, including the existence of delirium, dementia and depression. Examination of primary care records might help to ascertain any psychiatric or other co-morbidity prior to the final admissions. It would also be worthwhile determining the extent of involvement of relatives and other carers in the case of avoidable deaths.

From a broader perspective, all professionals working in MDTs need to actively use reflective practice, and document the lessons learnt in their appraisal documents. The influence of biases described above is regularly discussed in non-health settings, including in the financial industry post-2008, and I see no reason why medicine should not follow suit. Surely, evidence of reflection as part of a MDT should be a core component of the evidence for medical practitioners applying for relicensing.

I hope this article will generate further thinking, helping to ensure safer and fairer management of vulnerable individuals with multimorbidity – increasingly the norm in modern hospital care.

Declaration of interests
None declared.

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References