



# the columns

## correspondence

### Root cause analysis

We all look forward to Homicide Inquiries, mandated by the Department of Health Circular HSG(94)27 (Department of Health, 1994) being replaced or modernised as soon as possible, since there seems to be very little evidence that the enormous costs of these inquiries are justified by the benefits. Root cause analysis, as described by Neal *et al* (*Psychiatric Bulletin*, March 2004, **28**, 75–77), may offer useful alternatives. However, reading their article left me with two doubts, both of which relate to the notion of 'logical relationships' between different ideas or issues. It is important that logical decisions are taken in medical practice, since this is one of the legal tests of good-enough medical practice. However, I would raise two concerns; first not everybody would agree on what constitutes a 'logical relationship'. For example Neal *et al* suggest in their first figure that there is a 'logical relationship' between failure to diagnose and treat an emerging psychotic illness and suicide. However, to make such a statement is already to have completed the point of the inquiry without establishing that there is a logical relationship. Furthermore, it could be argued that the whole point of an inquiry is to establish whether there is a relationship or not between two events, and to bear in mind the possibility that there are lots of different types of relationships between events, including the possibility of no relationship.

The other aspect that is sometimes left out of 'logic' is the application and understanding of strong feelings. We sometimes make decisions (which in retrospect seem illogical) because we are moved by powerful feelings, usually negative ones of fear, anxiety and hostility. Post-incident inquiries frequently meet and are moved by similar feelings, and those feelings affect the way that they perceive logical relationships and analyse them. Although it seems that root cause analysis might provide a more systematic way of looking at the evidence that comes before inquiries, I am not convinced from Neal's article that they will deal with these other aspects.

DEPARTMENT OF HEALTH (1994) *Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community*. Health Services Circular HSG(94)27. London: Department of Health.

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**Author's reply:** I agree with Dr Adshead that root cause analysis (RCA) does not necessarily add anything to the investigation process after an adverse event, in terms of determining causation, other than making it systematic and comprehensive. What is not made clear in our article is that RCA is not a means to an end in itself. The aim of RCA is the development of improved safety systems in patient care, which compensate for human error. The philosophy behind RCA is that human beings make unintentional errors and they will continue to make errors in future. The aim of the investigation phase in RCA is to determine where errors have occurred and their root cause. This information is used to design improved safety systems (e.g. barriers) to prevent any harm caused by similar errors in future. The intention of locating the errors is not in order to blame or discipline individuals.

With this in mind, the strength of the causal relationships, alluded to by Dr Adshead, is probably not of such importance to the individual as it was with the inquiries held under the auspices of HSG(94)27. The worst that can happen, after a flawed RCA, is the design of a redundant patient safety system. Staff who are found to have made an unintentional error may be upset if they feel wrongly criticised, but they can be reassured that they are never going to be the focus of the investigation or the outcome. It is extremely important that healthcare staff are made aware of the blameless nature of these RCA investigations or the cultural shift that is required to bring about the open reporting of errors (as occurs in the aviation industry) will never occur.

#### Declaration of interest

L.A. Neal is working with the Emergency Care Research Institute (a non-profit

patient safety organisation) collaborating with the Department of Health to introduce root cause analysis into the National Health Service.

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### Consultant psychiatrists' working patterns

Mears *et al* (*Psychiatric Bulletin*, July 2004, **28**, 251–253) advocate that consultants should work in 'progressive roles' in order to combat occupational stress. This role includes a low accumulation of patients from other members of the multidisciplinary team, scope for delegation, time to respond to emergencies, taking a low level of direct referrals, and feeling support from and reliance upon other team members. Consultants working in such a role are more positive and less stressed.

However, there is nothing in the methodology to indicate that the numbers of supporting team members were considered in the analysis. Surely, all of the above factors may relate pretty directly to the number and quality of other members of one's team, and without sufficient multidisciplinary colleagues it is rather difficult to envisage consultants surviving in the suggested 'progressive' role. In the absence of such data, and of any consideration of team sizes, the paper's recommendations appear fairly vacuous.

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**Author's reply:** In his letter Dr John Eagles points out that the assertion in our paper that consultant psychiatrists working in more progressive roles (low accumulation of patients, effective delegation, good team working and support, effective gate keeping and low level of direct referrals, time to deal with emergencies) are likely to suffer less from occupational burdens is flawed, since no consideration is given to the number and/or quality of team members. Dr