BMJ 2018;361:k969 doi: 10.1136/bmj.k969 (Published 2 May 2018)

VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Learning from deaths in hospital

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The secretary of state for health and social care, Jeremy Hunt, has spoken of "750 avoidable deaths in hospitals in England every month"[1]—the equivalent of a passenger plane falling out of the sky each week. The source of this figure was a methodologically rigorous, peer reviewed study by a respected group, published in *The BMJ* in 2015.[2]

But the researchers who conducted the study had expressed caution about the limitations of their methods and baseline data, saying that their metric was no reliable indicator of the quality of care. They had reviewed 100 random sets of case notes from 34 hospitals, estimating that 3.6% of deaths had at least a 50% chance of being avoidable. The lead author said in an interview that, in many cases, it would require "the judgment of Solomon"[1] to know whether a death had been avoidable.

In seeking to tackle avoidable deaths, Mr Hunt has understandably been influenced by high profile investigations such as those into Morecambe Bay maternity services[3] or Southern Health NHS Foundation Trust and people with learning disability.[4] He's also been influenced by the individual stories of bereaved people whose grief has sometimes been compounded by insensitive treatment, delays, obfuscation, and a lack of confidence that changes have been made to protect future patients. On the other hand, he has publicly committed to the need for an open, learning culture in the wake of the Bawa-Garba case.[5]

> There are deaths where no cause for concern arises—but hospitals still want to learn from them

In December, Mr Hunt officially announced plans for the national mortality review programme.[6] As part of this programme, from this year onwards, each hospital in England will publish a quarterly dashboard summary[7] of what it's doing to review the case notes of patients who have died.

Each hospital will select some notes for deeper structured judgment reviews to identify potentially avoidable deaths and learning themes for improving practice. They will also have to set out plans on how to involve bereaved people more in this process and to share information with them.[8] In the first wave of quarterly dashboards very few "avoidable" deaths have been reported by trusts.

I support this initiative in principle, but I have some concerns. Firstly, the time taken by practising clinicians in reviewing these case notes could take them away from clinical care for the living (although the increasingly widespread appointment of senior, specially trained doctors as "medical examiners"[9] to spend some or all their time scrutinising all certified deaths may ease this burden). Secondly, it's important not to conflate issues across a whole range. NHS organisations have sometimes gravely mistreated bereaved families when care was often woefully substandard. Some families have raised complaints and concerns that have been investigated with varying degrees of speed, openness, and family involvement.

But there are also deaths where no cause for concern arises—yet hospitals still want to learn from them. Those lessons may have nothing to do with avoidable death or harm. They may relate to better organisation of services, better communication or palliative care, or perhaps avoidable admission to hospital of someone clearly near the end of life.

So, considering the political focus on public assurance, demonstrating decisive action, and showing bereaved people that meaningful action is being taken, let's not lose the other potential benefits of this work.

Competing interests: See www.bmj.com/about-bmj/freelance-contributors/david-oliver.

Provenance and peer review: Commissioned; not externally peer reviewed.

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