VIEWS AND REVIEWS

David Oliver: Are comparisons between acute healthcare and the aviation industry invidious?

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Much of the inspiration for establishing the Healthcare Safety Investigation Branch in 2016 came from Jeremy Hunt's wish to learn from the aviation industry. Significantly, Keith Conradi, who had been chief investigator for the Air Accidents Investigation Branch (AAIB), was appointed the new unit's chief investigator.

It's easy to understand the desire for the NHS to learn from airlines. Commercial aviation has a relentless focus on safety: learning from incidents and ensuring safety is central to staff training and values. Most of all, aviation supports an open culture of learning and reporting in which staff who report concerns are protected.

During the investigation into the 2015 Shoreham Air Show incident in which 11 people died, Sussex Police appealed to the High Court for the records of the AAIB's initial inquiry. The police were refused access because such reports have privileged status in statute. This is very different from the way internal reports or personal reflections have fed into recent manslaughter cases brought against doctors.

The differences between the two sectors don't end there.

Modern aviation is an inherently safe activity. The recent death of Jennifer Riordan on a Southwest Airlines flight was the first aircraft related fatality in US domestic aviation for 15 years. Acute healthcare, by comparison, deals with people whose condition is often already unstable, who are unwell, and who have life limiting illnesses. Many people die, deteriorate, or have complications even when no serious failings occur in healthcare: it's often just the natural history of disease. And no number of protocols or checklists can eliminate all common harms and incidents.

Another crucial difference is that, whereas commercial airline companies don't have to schedule flights on routes that they no

longer consider profitable, acute healthcare trusts must deal with everyone who arrives. We must continue to soak up relentless demand, no matter how bad the rota gaps are, how exhausted or demoralised the teams are, how short of beds or community support services we are, and no matter what key parts of logistics may be broken or what infection outbreaks the organisation may have. And there's often nowhere else patients can go that isn't also under severe pressure.

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The aviation industry enforces strict, uniform, international standards about minimum rest periods for crew members. Plane departures are delayed if staff haven't had adequate rest, and passengers are informed when this is the reason. Planes don't take off without a full complement of staff. Yet, in the acute NHS, we frequently do the equivalent of taking off with the co-pilot missing and two of the cabin crew absent.

For a detailed, referenced comparative review of the health and aviation sectors I highly recommend Kapur et al in *JRSM Open*.¹ Meanwhile, I'd say that acute healthcare has a lot more in common with firefighters—including those attending a stricken plane after an emergency landing—than with scheduled flights.

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

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1 Kapur N, Parand A, Soukup T, Reader T, Sevdalis N. Aviation and healthcare: a comparative review with implications for patient safety. *JRSM Open* 2015;7:2054270415616548.26770817

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