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Inquiring into inquiries

Before starting an inquiry be sure that it is needed and will be run properly

Education and debate
p 752

Inquiries into crimes and misdemeanours are becoming a way of life in Britain's NHS, but a paper we publish today raises serious doubts about the competence and conclusions of one of them (p 752).[1] The time has come to be clear about what inquiries are for, how they should be run, when they should be started, who should be appointed to them, how their quality should be controlled, and how they should be accountable. Otherwise, the politicians' need to be seen to be doing something when a crisis occurs may aggravate rather than alleviate problems and may squander resources.

Today's paper by Edmund Hey and Iain Chalmers offers a critique on part of the Griffiths inquiry.[1,2] This inquiry was set up by the NHS executive in February 1999 after several parents alleged that their premature babies had been entered into trials of continuous negative extrathoracic pressure (CNEP) without their consent. The inquiry soon expanded its scope to look at, among other things, the use of covert video surveillance to detect Munchausen syndrome by proxy. This surveillance was used by David Southall, the most prominent paediatrician in North Staffordshire, and he attracted considerable hostility from some parents involved in the surveillance.

The team clearly struggled with its immense and emotionally charged task, but the report concluded that much was amiss and that new forms of governance of research were needed throughout the NHS. Rod Griffiths, chairman of the inquiry and regional director of public health in the West Midlands, said at the press conference to launch the inquiry's report: "What was totally unacceptable to [parents] was the apparent lack of adequate explanation, of choice and consequent properly elicited and recorded consent, and of involvement in later decision making."[3] The inquiry team had just two other members: Joyce Struthers, chairwoman of the Association of Community Health Councils of England and Wales, and Terry Stacey, now director of the Central Office for Research Ethics Committees.

Hey and Chalmers' detailed critique, conducted for the Medical Defence Union, which is acting for Southall, was based on an examination of primary documents. It is uncompromising in its conclusions. "We believe that almost every statement made about the design, conduct, and reporting of the CNEP trial in the Griffiths report was ill informed, misguided, or factually wrong."[1] They found a false assertion that the trial's design had not been subjected to external peer review and false statements that some of the consent forms could not be found and that there was no way of checking that consent had been obtained properly. Hey and Chalmers find that the report relied too heavily on evidence from a small group of parents at the expense of evidence from a survey sent to all parents.

The panel members have responded (p 755) but are constrained in what they can say because "much of the matter is still sub judice with the trust and the General Medical Council" and because the report now belongs to the Department of Health. Readers will make up their own minds but are likely to be left with severe doubts about the adequacy of the Griffiths inquiry. I certainly feel uneasy about the editorial I wrote on the inquiry's report, which was based on the assumption that the inquiry was well conducted.[4] (The *BMJ* agrees with the report's main recommendation on the need for better research governance in the NHS, but the work on governance began long before the Griffiths inquiry published its findings. The proposals on research governance were published on the internet last week (p 727).[5,6])

This inquiry is not alone in being criticised. The inquiry into the circumstances that resulted in bovine spongiform encephalopathy being passed to humans was supposed to report in June 1999 but has now had to enter a second stage to deal with "potential criticism, clarification, and conflicts of evidence."[7] The inquiry heard from over 300 witnesses, and many objected to the "draft factual accounts" published on the internet. These accounts were accused of being far from factual, "value laden" and wrong. Pungent criticisms have also been levelled against the second of two inquiries into the running of Ashworth Special Hospital for criminal and dangerous mentally ill patients. John Gunn, professor of forensic psychiatry in London and husband of Pamela Taylor, who was medical director of the Special Hospitals Service Authority, compared the inquiry to a witch hunt.[8] "Witnesses did not know what they were to be accused of," and one professional was criticised for implementing the findings of the previous inquiry.

If inquiries are going to be useful they need to be got right. We await the report of the inquiry into deaths of babies after cardiothoracic surgery in Bristol. And there are several other inquiries, including more than one into organs removed from children and being kept without consent and one into Harold Shipman, the general practitioner who murdered many of his patients.

BMJ 2000;321:715–6

We must be clear about the aims of inquiries. Are they to work out what happened, make recommendations to improve practice, consider the "scandal" in a broader context, or allocate blame? Or are they supposed to be like South Africa's truth and reconciliation commission and try and create harmony from discord? The aims of these inquiries often seems to be confused—and perhaps their real purpose is to divert the heat from politicians. They are not usually about blaming individuals. Nevertheless, those being questioned often feel as if they are being accused and denied the safeguards they would have in a court of law.

The quality of the process is vital in these inquiries, and the Griffiths inquiry seems to have fallen short of best practice. One problem may have been the absence of a lawyer on the inquiry. Much as doctors and others may resent the fact, it is lawyers who know how to conduct inquiries justly, although they may create the intimidating atmosphere of a court when something more agreeable is needed. The process by which people are appointed to inquiries appears wholly opaque, raising the suspicion that politicians appoint people who will give them the result they want. The Bristol inquiry has suffered from these suspicions.[9]

It would be paradoxical to advocate an inquiry into inquiries, but we can begin to see criteria that will make them more likely to succeed. Those who set them up should be clear about their purpose, open about how they appoint members of the inquiry, confident that their processes will be adequate, and sure that they will be value for money. Inquries should publish their materials and methods, check oral allegations against documentary evidence, and send drafts of evidence accusing individuals to those individuals so that errors of fact can be corrected. Inquiries should also surely be held in public—otherwise, there will always be suspicions of bias, corruption, or incompetence. Finally, ministers should think hard before setting up an inquiry. They can easily make things worse rather than better.

Richard Smith *editor, BMJ*

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4 Smith R. Babies and consent: yet another NHS scandal. *BMJ* 2000;320:1285-6.
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Catheter ablation for cardiac arrhythmias

Ablation is the safe and curative treatment of choice

The first diagnostic electrocardiography on a person was carried out by Augustus Waller over a century ago at St Mary's Hospital, London. It was not until the 1980s that therapeutic cardiac electrophysiology emerged; this procedure, carried out while patients are conscious, uses wires passed percutaneously to the heart to ablate the cause of arrhythmias. Cardiac electrophysiology is now an established specialty within cardiology.[1 2] Although the word "cure" is not widely applicable in medicine, it can now justifiably be used for the treatment of cardiac arrhythmias. Catheter ablation is a safe and curative option for most arrhythmias, with 85-98% cure rates among the arrhythmias treated most frequently.[3 4] These results have been borne out by a recent large prospective multicentre study of 1050 patients which provides further evidence of the benefit of catheter ablation; the study found an overall cure rate of 95% and that a second procedure was required in 4% of patients. The rate of important complications related to the procedure was $<3\%$.[3] The only randomised trial comparing catheter ablation with drugs in the treatment of recurrent atrial flutter showed that ablation had a better success rate, a greater impact on improving quality of life, and a lower incidence of atrial fibrillation and rehospitalisation.[5] It would seem, however, that many eligible patients may not be referred for definitive treatment because the principles, techniques, and availability of this procedure are not widely known.

The technique involves the percutaneous introduction of electrode catheters (insulated wires with electrodes at their tip, much like temporary pacing wires) into the heart under fluoroscopic guidance to record electrical signals from relevant parts of the heart.[2–4] Once the mechanism of the arrhythmia is established, one of the electrode catheters is navigated to a critical site at which ablative energy (radiofrequency current, which is predictable, effective, and well tolerated) is delivered to create a localised scar that will disrupt the cause of the arrhythmia.

The mechanism of the arrhythmias is described as either focal or re-entrant. Re-entry is a simple concept, and is the mechanism of most clinically important arrhythmias. It describes the progression of a wave front of electrical activation through cardiac muscle over a pathway that leads back to its point of origin. This completes one cycle of a re-entrant circuit, and providing that certain critical conditions exist, conduction will continue around the circuit again and again to produce a regular arrhythmia. The Wolff-Parkinson-White syndrome is well recognised as causing a tachycardia through a re-entry circuit of conduction from atria to ventricles via the atrioventricular node and then from ventricles to atria via an accessory pathway that is congenitally anomalous.

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