

Beyond Bristol

Beyond Bristol: taking responsibility

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Important lessons must be learned from the Bristol inquiry

I was disturbed when I first read the following in an October 1998 issue of the *Medical Journal of Australia*.

In June 1998, the Professional Conduct Committee of the General Medical Council of the United Kingdom concluded the longest running case it has considered [this] century. Three medical practitioners were accused of serious professional misconduct relating to 29 deaths (and four survivors with brain damage) in 53 paediatric cardiac operations undertaken at the Bristol Royal Infirmary between 1988 and 1995. All three denied the charges but, after 65 days of evidence over eight months (costing £2.2 million), all three were found guilty.

The doctors concerned are Mr James Wisheart, a paediatric and adult cardiac surgeon and the former Medical Director of the United Bristol Healthcare Trust; Mr Janardan Dhasmana, paediatric and adult cardiac surgeon; and Dr John Roylance, a former radiologist, and Chief Executive of the Trust.

The central allegations were that the Chief Executive and the Medical Director allowed to be carried out, and the two paediatric cardiac surgeons carried out, operations on children knowing that the mortality rates for these operations, in the hands of these surgeons, were high. Furthermore, the surgeons were accused of not communicating to the parents the correct risk of death for these operations in their hands.¹

Mr Wisheart and Dr Roylance were subsequently struck off the medical register. Mr Dhasmana was disqualified from practising paediatric cardiac surgery for three years. The doctors required police protection as they left the General Medical Council hearing as furious parents shouted “murderer” and “bastard”.²

Why did this occur?

Dr Stephen Bolsin has presented a disturbing version of events, which I have summarised here from his moving article.¹

Bolsin came to Bristol in 1988 from the Brompton Hospital in London as a cardiac anaesthetist. He formed the view that Mr Wisheart’s operations were up to three times as long as those at the Brompton Hospital and were associated with more complications. He expressed his concerns but this had little effect. By 1993, he had completed a formal audit with Dr Andy Black, a senior lecturer in anaesthetics in Bristol. This showed that while the national average mortality rate for repair of tetralogy of Fallot was 7%, Mr Wisheart’s was 33% and Mr Dhasmana’s was 25%. The audit also showed that while the national average mortality rate for atrioventricular canal surgery was 10%, Mr Wisheart’s was 60% and Mr Dhasmana’s was 17%. By the time he retired in 1995, seven of the last eight children Mr Wisheart had operated on had died. This data was presented to Dr Roylance.

During this time, Mr Dhasmana began performing arterial switch procedures on neonates. He stopped these in 1994, after nine of the 13 patients had died, and one had sustained serious brain damage. At Birmingham, only one death had occurred in 200 patients. Mr Dhasmana’s results in older children were also disturbing, with a mortality of 30%, compared to 1% in the best hands.

In 1993, Dr Bolsin contacted the Department of Health. In June 1994, he and five other anaesthetists called for a review of the switch procedures, one of the more complex cardiac surgical procedures. This did not occur for another seven months. Two children died in the meantime. An agreement was said to have been made not to perform any more of

these procedures until a new cardiac surgeon began work in 1995. In January 1995, however, Mr Dhasmana performed one last switch procedure on Joshua Loveday, despite the objections of Bolsin and the professor of cardiac surgery. The child died on the table.

Mr Wisheart continued to operate on children for closed cardiac conditions. On May 1 1995 he undertook his last operation—repair of coarctation. The child died several weeks later.

On that day, Mr Ashe Pawade from the Royal Children’s Hospital in Melbourne began work as paediatric cardiac surgeon. Since then mortality rates have fallen dramatically.

The mortality rates at Bristol were clearly higher than at other centres in England, but were they too high? What should the mortality rates have been? Not every doctor can be the best and patients cannot all receive the best care. But what is a reasonable standard? How do we ensure that doctors achieve and maintain the reasonable standard of care?

The Bristol Royal Infirmary Inquiry chaired by Professor Sir Ian Kennedy concluded that a “substantial and statistically significant number of excess deaths, between 30 and 35, occurred in children under one undergoing PCS (paediatric cardiac surgery) in Bristol between 1991 and 1995. . . . The mortality rate over the period 1991–1995 was probably double the rate in England at the time for children under one, and even higher for children under 30 days.”³

Central to the Bristol affair are the moral concepts of personal moral responsibility and blameworthiness.

Moral responsibility is a function of the degree of foreseeability of harm and the avoidability of that harm. Here is an example. I am registered to practise medicine in Australia. But I have not practised for about eight years now. I am still licensed to drain a pleural effusion. Though I have done about 30 in my life, I can’t remember crucial details. Imagine that I undertook locum practice in a hospital and agreed to drain an effusion without supervision. The patient develops a serious pneumothorax and arrests.

Moral responsibility and blame (from Justin Oakley)

Moral responsibility = foreseeability of harm x avoidability
Blameworthiness = moral responsibility x magnitude of harm

In this case, the complication is foreseeable and I know that I am at an unacceptably high chance of having one. If there had been no one else who could have drained the effusion and it needed to be done urgently, I am less responsible. But generally, I would be morally responsible for the harm which occurred.

Complications and adverse events will always occur in medicine. The challenge is to distinguish between those adverse events for which we are morally responsible and those for which we are not, which are a result of the probabilistic nature of medicine. And we need to take responsibility for ensuring that our adverse event rate is reasonable. Not zero (it can't be), but reasonable.

Moral responsibility and blameworthiness exist not only at a personal level, but at a professional, social, and political level. The events at Bristol made us acutely aware of the need to set and maintain a reasonable standard of care. The medical profession is now responsible for ensuring Bristol never happens again.

Since Bristol, the public has witnessed the Alder Hey retained organs scandal and the monstrous behaviour of Harold Shipman. The medical profession has never been in a darker shadow.

The final Bristol report identified many failings at personal, professional, and political levels. It set out 198 recommendations covering areas such as leadership within the health service; respect and honesty; competency of health professionals; safety and standards of care; public involvement, and care of children, especially those with cardiac conditions.

Have these recommendations been implemented? How? These are the questions to be addressed in a one day conference entitled *Beyond Bristol* (for full details please see the inside front cover of the journal). The conference will begin with Professor Sir Ian Kennedy's perspective on Bristol and events since. Professor Sir Cyril Chantler will address developments in education. Moira Stuart will consider strategies to promote patient centredness. Professor Tony Hope will summarise developments in ethics and communication skills and Professor James Reason will address the issue of safety. Importantly, there will be small group work to discuss progress and strategies relevant to recommendations of the Bristol report.

The Bristol report found "a substantial and statistically significant number of excess deaths, between 30 and 35 . . ." at the Bristol Royal Infirmary. Statistical

deaths are real deaths. We just cannot identify who the children are who died. Thirty children dying when they did not have to is a tragedy. Knowledge creates responsibility. The Bristol report has helped us to understand why children died unnecessarily. One of the shortcomings in Bristol was a failure to take responsibility and inaction. We all now have a responsibility to ensure that things have changed after Bristol, and changed for the better.

J Med Ethics 2002;28:281–282

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- 3 *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995.* Available at <http://www.bristol-inquiry.org.uk/index.htm>