Radio Ombudsman #29: Dr Bill Kirkup on patient safety and investigating avoidable harms

Since retiring from his role in public health, Dr Bill Kirkup has focused on independent investigations into public service failures, including maternity services at Morecambe Bay and East Kent. In this episode, Bill talks to Rob Behrens about his career, what he's learnt during his investigations and how we can make more progress in improving patient safety.

Rob Behrens: Hello, everybody and welcome to Radio Ombudsman on a sunny day in the heart of London. It's good to have you with us, and we have a very special guest today Doctor Bill Kirkup, distinguished clinician who has made an outstanding contribution to investigations into public health and maternity services in the last 20 years, in the UK.

Bill, it's very good to have you. Thank you for joining us.

Bill Kirkup: Thank you very much. It's great to be here. Thank you for the invitation.

Rob Behrens: Now, most people listening to Radio Ombudsman will know of Bill. He qualified in medicine from Oxford in 1974. He trained in obstetrics and gynaecological oncology, and later in public health. And he held public health and management positions in the North East, before becoming Associate Chief Medical Officer for England.

One of the great things about Bill is that he's been even more prolific since his notional retirement, and he's undertaken critically important, independent investigations, particularly

into maternity services, in Morecambe Bay, East Kent, and elsewhere.

So, Bill, you're also a distinguished member of our expert advisory panel here at the National Ombudsman, so we know each other quite well. But for our guests, for our listeners, would you say just a little bit, to begin with, about your early years and the values that you grew up with?

Bill Kirkup: Yes, gosh, it's a long time ago, as you pointed out, it was 1974 when I actually qualified. I left Newcastle in 1968, which shows you how long it used to take to qualify in those days.

I grew up in a very ordinary part of Newcastle. I was thunderstruck when I arrived at Oxford and found how different the world looked from that particular vantage point. I think what I learned from it, at that stage, was don't get detached from how you started out. And I really, really hope that I haven't got detached from how I started out, as an ordinary lad from Newcastle, all those years ago.

Sometimes not easy, but I was lucky enough to be able to go back to the North East, when was that, 1980 I think, just through chance. Those were the days when you couldn't really pick where you were going to practise, you just had to take the next job that came along. And as it happened, I got one that lasted for three years in Newcastle, and then another one and then another one, and somehow stuck there. So even when I was working in London for five years, I still went back to what I regarded as home, for the weekend. I think it's important to keep roots under those circumstances, and I'd like to think that I have.

Rob Behrens: When did you realise that you wanted to become a doctor?

Bill Kirkup: Quite early, actually. I can remember that my parents belonged to a book club, they used to get a new book every month, most of which sat in the bookcase, and I probably opened them more than anybody did. I can remember seizing avidly on anything that was to do with medicine and being absolutely captivated by the idea that you could do something which just seemed so worthwhile. It seemed such a worthwhile thing to do.

I'm not sure whether I should confess to this, but the sad person that I am, I used to do pretend operations in the back garden with stones buried under the soil. So it was a very, very early stage when I did that. (Laughter)

Rob Behrens: And what was the reaction of your family to this ambition?

Bill Kirkup: Yes, that was a complicated one because my father, who I held no particular brief for, really wanted me to follow him into accountancy. And I really didn't want to do that, to the point where my performance in maths absolutely nosedived over a number of years until, finally, I managed to pick up the courage to say, “I don't want to do that.” And he said, “Well, what do you want to do then?” I said, “Medicine,” very, sort of, diffidently, and he said, “Oh, well that's all right. That's acceptable.” (Laughter) So I felt like I’d kind of got away with that.

The gap was between forming the ambition and being able to admit it, particularly to him. He was a very dominant character, and he was difficult to talk to, so it was quite a moment. And my maths performance exponentially went back up the other way, which was nice.

Rob Behrens: (Laughter) It must've been, at the time, quite unusual for people in your position to have gone to Oxford. So how did that happen? Did you get help from the school? Did you have to go for an interview?

Bill Kirkup: I did. Yes, I did several interviews. I was the first person in my family to go to university, never mind an Oxbridge one. So it was a big step. And it was something that was encouraged by the school. They didn't offer any sort of practical help, other than it was a very good place to learn things like chemistry and biology, which obviously helped a lot. And off I headed, down to do the entrance exams, first of all.

In those days, you had to wait for an extra term after you've done your A Levels, at least most people did, ordinary mortals did anyway, (Laughter) real geniuses used to do it before.

And then went down for a whole series of interviews in different colleges. I went to Worcester College in the end, and I had a second interview at Worcester, because they were considering giving me a scholarship, which I didn't understand at the time. I just knew the second interview was incredibly daunting. There were about 30 people around the room firing questions.

If I've got a moment I'll tell you a story about that, only if I may. One of the questions was, "Do scientific advances happen through individual breakthroughs, or is it more related to teamwork?" And I plumped for teamwork. I knew enough to know that there was no one right answer, so long as you were prepared to defend what you'd say. They said, "Oh, give us an example then." And almost blunderingly, I said the development of penicillin, forgetting the connection that there was there. So they said, "Oh yes?" and I told the story about Fleming not really realising what he'd got and other people, like Florey and Chain having to take his ideas, develop them and make them into something practical.

They said, "Can you remember any of the other names that were associated with that?" I might have managed another one, and a little voice popped up from the back of the room, "Had I heard of Norman Heatley?" And I said, "No, I hadn't, I'm afraid." And he said, "Oh pity, that's me."

Rob Behrens: (Laughter) It shows how good you must have been if you survived that incident.

Bill Kirkup: Despite that, yes, exactly.

Rob Behrens: I don't want to dwell on it but just finally, what was it like going through medical school at that time?

Bill Kirkup: Largely very frustrating, because it was almost four years of pure theory. You never saw a real person. And I found that very frustrating, because I just wanted to get on and do the

bits that I was interested in, which very much involved talking to people, trying to help people, working with people. So the first four years were pretty difficult, from my point of view.

But once we were actually allowed onto a ward, at the ripe old age of 22 and a bit, which is about when people are qualifying now, I think, that improved things a lot.

Rob Behrens: And how long into your medical career was it before you began to orientate towards public health?

Bill Kirkup: That wasn't something that I had ever thought about. It wasn't an ambition.

I always wanted to do something surgical, because - How can I put this? From the very first stages of doing biology at school, people had always said, “Gosh, you've got a knack for doing this.” Dissection, and all of that stuff, and the same through anatomy too. So I'd always wanted to make use of that and do something surgical.

I thought that obstetrics and gynaecology was one of the nicest bits of surgery, partly because an awful lot of the time you have not one happy patient at the end of it, but two. So that seemed like a double bonus to me.

I ended up with a career - How can I describe it? A brick wall. I hit a brick wall because my family circumstances changed very abruptly, and I was suddenly responsible, on my own, for three young children, aged between three and six. And that wasn't compatible with the sort of on call you used to have to do in those days, as a trainee, which was one in three if you

were lucky. So I decided that I had to give it up and go into something else.

I went to see the medical staffing officer, who was a public health physician himself, and he asked what I was planning to do. I said, “I don't really know. I’d have to be able to do something that doesn't involve all of this on call.” He said, “Have you ever thought of doing what I do?” And I said, “No, because I don't know. Tell me.” So he did, and I said, “Wow, that sounds great.” He said, “If you don't sign this contract, I'm going to tie your arms to the chair and not let you leave the room,” which was the nicest thing anybody had said to me in a really difficult week. (Laughter) So I signed.

Rob Behrens: Wow. It's a good lesson for those people who constantly worry about not knowing what they want to do because, in the end, you find out, even if you don't know the route. So that's good. Thank you for that.

Can we move on just a bit? So you became the Associate Chief Medical Officer for England. How long did you do that for?

Bill Kirkup: Five years.

Rob Behrens: And what was your outstanding memory from that time?

Bill Kirkup: Somebody said to me, as I started, “The Department of Health is an amazing place to work, but you'll find that the waters close over your head very rapidly, be alert for that.”

And I wish I'd listened to that, because the first two years were brilliant. The next two years were okay. And the last year was a nightmare because of organisational changes and all the rest of it. I ended up with them saying to me, “Look, we haven't got anything for you to do, you just have to go.” “Go and do what?” “Well, you're 60, so you might as well just retire now, mightn’t you?” which is absolutely not what I wanted to do.

So I was glad to have the opportunity of doing some things after that, but I have to say, the first two or three years were just brilliant. It was great.

Rob Behrens: Okay.

So just tell us a bit about how you got involved in Morecambe Bay? Was that the first big intervention you made after you retired?

Bill Kirkup: It wasn’t, no. The very first one that I did was Oxford paediatric heart surgery, where they had had a run of deaths and they were casting around for somebody who might be able to do a limited external investigation into it. I'm not quite sure how, but my name came up and I did that.

And the next one was almost by accident. I got recruited to the Hillsborough Independent Panel, where I was the lone medic on the panel and I did the work on the post-mortem reports that were instrumental in the first inquest and instrumental in getting that inquest verdict quashed. So that was my first couple of bits of experience.

Morecambe Bay, I think, again, they were looking for somebody between the Department of Health and whatever the regional machinery was called at that point, it might've been the Strategic Health Authority, I think. The reconfigurations have happened so rapidly, it's hard to keep track of them. And they said, "Would I do it?" I said, "Yes," because it seemed to be something that was valuable and something that needed doing. I knew it wasn't going to be easy, but I took it on and I'm glad that I did. I hope that it's been of some use, in the scheme of things.

Rob Behrens: It's quite interesting. You're a person to take on very challenging tasks. I mean, a lot of people wouldn't have gone anywhere near the Hillsborough inquiry. And it must be chastening to reflect the campaigners are still campaigning for a Hillsborough law, as we speak. These things take a very long time to filter through.

Bill Kirkup: Yes, they do. I mean, I've referred to the need for Hillsborough law in the East Kent action points, because this capacity of public bodies to deny and deflect in the name of reputation management continues to horrify me. That was probably my first face on exposure to it, was the behaviour of the police. But the more you look you realise that it wasn't just the police force that were involved in covering up after the Hillsborough disaster. It was the ambulance service, the pathology service... It was much wider than just to limited to the police.

So I do think it's well overdue that we have a duty on public bodies to be honest and open.

Rob Behrens: So one of the things that strikes all of us that read your report into East Kent, was the reflection of how little had been learned in the interim, from perhaps 15 years before. And yet, as you say, as you said at the time, politicians keep saying, “This must never happen again.” And it does, time and time again.

So the Hillsborough law is an intimation that there needs to be legislative change to address some of this, because the duty of candour doesn't work in the way that it should. But we're also talking about something more fundamental, which is a cultural change in public services, and particularly in hospitals, which reverses the idea that reputation is more important than patient safety.

Now, you've experienced this more than anybody else, over a number of years, what are the impediments, do you think in the way of making progress on that?

Bill Kirkup: I think that we have to recognise that there are personal issues that are at stake for doctors, nurses, and midwives. You don't get into the professions easily. You expect that you have high standards. You expect that other people have high standards. And anything that happens that breaches those high standards you find very difficult to deal with, and very few people get trained in how to do this.

I've often said I wish that somebody had sat me down, just before I qualified and said, “You will make mistakes,” because that was true. “And people will be harmed as a result of some of those mistakes,” and that was true too.

“You'll feel absolutely terrible. They'll feel worse, of course, but you'll feel terrible.”

But there are ways to handle it that involve openness, apology and learning that are appropriate. And there are ways to handle it that involve denial, pretending it never happened, and hoping that it'll just go away, which are inappropriate. I mean, the same sorts of mistakes keep recurring over and over. But we don't train people well in that.

I think that there are some places where- and I have to say I mean, it's not everywhere. I don't want to give the impression that I think that all clinicians behave like this, because I know they don't. But there are some places where it becomes acceptable to just deny that anything's gone wrong, find ways to excuse it, not look and move on. And I think we have to find ways to make that unacceptable.

It should not be acceptable to tolerate that kind of behaviour. But to do that, we have to be able to confront it in the first place. We have to be able to be honest about it and say, “Yes, these things do happen.”

One of the things that I do at the moment is go and talk about East Kent, to just about anybody who listened. I think I've turned one invitation down just because of a diary clash. And almost every time people say, “This is an absolutely shocking story. You wouldn't think that things like that could go on. But you've shown us that they do.” The thing is, what do we do now? How do we try and make sure that it doesn't happen again?

Because I agree with you that, “It must never happen again,” is the second most dangerous phrase in the language around

all of this, the most dangerous being, “Don't worry, it'll never happen here.”

Rob Behrens: In relation to that, one of the things that I have learned from you, but also from our own inquiries is- Two things. One is how hierarchical the medical profession is, and how deferential medics are to that hierarchy, which causes them to resist challenging decisions made by more senior people. That's number one.

And the second thing is the tension that exists between professions within the clinical sphere, so midwives, nurses, doctors, surgeons and so on, which takes away a more public benefit view of what should happen and it's quite a lot about protecting your own professional territory. Is that reasonable?

Bill Kirkup: Yes, it is. And I think it shows up most noticeably in the failures of team working. And I think this is one reason that maternity seems to feature quite highly in this because, crucially, maternity involves some very important team working between different groups.

And it isn't just obstetricians and midwives, although they're probably the most obvious two. It also involves neonatologists, it involves anaesthetists, and it involves others too. But I think that the professional relationships can become very challenging in that area, because of all of those tensions that you have named. I think you're absolutely correct about that.

Rob Behrens: The other thing that strikes me, time and time again, and we don't want to get into blame, we're about accountability and learning… But in serious incidents, I see a failure by clinicians to listen to patients and their families about what they think is really happening.

And that is partly created by the pressure that the clinicians are under. But secondly, I guess, as a non-clinician, it must be because clinicians would say that they are the experts in this area, so why would they listen to the patients and the families. And that's sad, given that people live by experience, and they communicate that.

The other problem is that we know all this, but the way in which education is structured in the health service, there are so many stakeholders and regulators that there's no one driving force to be able to say, "You should be doing A, B, C, and D."

I found this with eating disorders, that trying to get the curriculum changed is an immensely complicated area. There are lots of good people trying to do it. But there's no joined-up approach to it. That creates a great problem for ministers, doesn't it?

Bill Kirkup: Yes, the lack of levers that can be pulled from the Department of Health, I think, is pretty striking. And of course, the danger of that is that, in the absence of the right levers, people search for whatever they can pull, which is sometimes not the most appropriate one, and you can get perverse results as a consequence of that.

I think it's absolutely right that clinicians are not great at listening. One of the most striking features in East Kent was

the extent to which patients were dismissed when they said they had ruptured membranes, or they said that their labour had started, or they said that the baby's movements had changed.

All of these are important clinical signs. And when I talk about these things, I'm rather prone to show a slide of a physician from around 1900 or so, called William Osler, who said, “Listen to the patient, they're telling you the diagnosis.” It's an important part of clinical practice.

I do have a concern that it was never as prominent as it should have been since Osler’s day, and it's getting less prominent now. The more recourse we have to very clever investigations, scans, computerised tomography, and so on, that tell us the diagnosis, the less we're prone to listen to the patient. But we miss vital information by doing that.

And I do think we need to look at how we teach people to do that and how we make that stick, because you can teach people to do that when they're at the university stage and then when they get into what they would call the real world and see how practice is carried out, it's often very different. Of course, if you're wanting to be the person who's in charge of the unit one day, then you’ll behave like the person in charge of the unit. You’ll follow their mannerisms, including not listening.

So I do think it requires some fundamental change. I don't know how to do that, by the way. But I want to talk to as many people as I can, who have got ideas about how to do that, which is why we formulated the recommendations following East Kent as action areas. We're not trying to pretend that we have the answers. We just want to pose the questions and seek the answers.

Rob Behrens: I could go on asking you these questions for a long time, but as far as Radio Ombudsman is concerned, are you pessimistic or optimistic about the future and the next 10 years of patient safety?

Bill Kirkup: I should be pessimistic, given the lack of any discernible change in this horrible cycle of incidents cropping up, not even just not getting less frequent, they seem to be increasingly frequent. I'm not. I'm optimistic, because I think that we have some genuine opportunity to change things. I think it's absolutely vital that everybody buys into that, which is one of the reasons why I talk to as many people as I can about this, and I want to make something happen. It's not going to be easy, because these are difficult things to tackle. It's much-

I'll be slightly careful about what I say. It's easy to make the traditional recommendations, as I've done in the past, with Morecambe Bay, "Do this, do that, and it'll all be okay." And it doesn't work. We just keep on coming back to having tragic investigations. My unease starts out with the fact that it's always families who come and tell us that we have a problem that we didn't know about until they pointed it out, and that just feels fundamentally wrong to me.

Rob Behrens: I've done a few investigations recently, where the families have told me, tragically, that their worst mistake was to trust the doctor. And we should not be in that position. But while respecting what clinicians do, we should be talking about the real challenges that clinicians and non-clinicians have in

dealing with this. And so transparency and openness in dealing with them is absolutely vital to any solution, which is going to come forward.

Which brings me on to my last question for you, Bill. We have a lot of young case handlers, fresh out of university, at the National Ombudsman. Brilliant people, great values, non-deferential, don't give up easily. What advice would you give them about being an effective investigator?

Bill Kirkup: That's a great question. I think, don't accept anything at face value; challenge, want to look into it a bit further; I think, don't take what's in the written record as necessarily true, because there's a lot of evidence now that notes don't reflect an objective truth, that they're work as imagined not work as done, and sometimes they're even worse than that, they're work as you wished it had been done but actually really wasn't.

I think I would like to see a difference in the approach that the health service has to handling complaints. I know this is something that you're very much involved with. But I think the biggest problem with the complaints system at the moment, at the local level I'm talking about, not when they come to you, is the fact that it becomes adversarial very rapidly, and clinicians become defensive. I think, without understanding of that, it's hard to interpret how some of these things have played out, up to the point where they get to you.

If I could leave you with one thing. I have a colleague who's based in the North East, who's called Susanna Stanford. She's a patient safety activist who suffered herself as a result of a failed regional analgesic technique. She wrote in a paper,

quite recently, “If a clinician reports that something's gone wrong, it's called an incident. If a patient reports the same thing has gone wrong, it's called a complaint.” And the terminology itself sets people against each other. It makes it adversarial. It makes them defensive.

Nobody should feel that they're a nuisance for making a complaint. I rather wish there was a different way to describe it, so people didn't feel a nuisance, and, even more so, they weren't made to feel a nuisance by the people who received that first complaint.

Rob Behrens: That's chastening, and true. And it emphasises how important it is for all of us, clinicians, families, investigators onwards, to know about mediation, so that you can try and bring people together at any stage of a process, where things are becoming adversarial. So I think that's very important.

Look, Bill, that's been brilliant. Thank you so much. It's really excellent to get your distilled wisdom of the ages and thank you for the brilliant work you do for the public. It's hugely appreciated.

So this is Rob Behrens, signing off from London, on the line to Newcastle, the North East, saying have a good day and enjoy the week. Thank you very much.