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correspondence

Root cause analysis

We all look forward to Homicide Inquiries, mandated by the Department of Health Circular HSG(94)27 (Department of Health, 1994) being replaced or modernised as soon as possible, since there seems to be very little evidence that the enormous costs of these inquiries are justified by the benefits. Root cause analysis, as described by Neal *et al* (*Psychiatric Bulletin*, March 2004, **28**, 75–77), may offer useful alternatives. However, reading their article left me with two doubts, both of which relate to the notion of 'logical relationships' between different ideas or issues. It is important that logical decisions are taken in medical practice, since this is one of the legal tests of good-enough medical practice. However, I would raise two concerns; first not everybody would agree on what constitutes a 'logical relationship'. For example Neal *et al* suggest in their first figure that there is a 'logical relationship' between failure to diagnose and treat an emerging psychotic illness and suicide. However, to make such a statement is already to have completed the point of the inquiry without establishing that there is a logical relationship. Furthermore, it could be argued that the whole point of an inquiry is to establish whether there is a relationship or not between two events, and to bear in mind the possibility that there are lots of different types of relationships between events, including the possibility of no relationship.

The other aspect that is sometimes left out of 'logic' is the application and understanding of strong feelings. We sometimes make decisions (which in retrospect seem illogical) because we are moved by powerful feelings, usually negative ones of fear, anxiety and hostility. Post-incident inquiries frequently meet and are moved by similar feelings, and those feelings affect the way that they perceive logical relationships and analyse them. Although it seems that root cause analysis might provide a more systematic way of looking at the evidence that comes before inquiries, I am not convinced from Neal's article that they will deal with these other aspects.

DEPARTMENT OF HEALTH (1994) *Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community*. Health Services Circular HSG(94)27. London: Department of Health.

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Author's reply: I agree with Dr Adshead that root cause analysis (RCA) does not necessarily add anything to the investigation process after an adverse event, in terms of determining causation, other than making it systematic and comprehensive. What is not made clear in our article is that RCA is not a means to an end in itself. The aim of RCA is the development of improved safety systems in patient care, which compensate for human error. The philosophy behind RCA is that human beings make unintentional errors and they will continue to make errors in future. The aim of the investigation phase in RCA is to determine where errors have occurred and their root cause. This information is used to design improved safety systems (e.g. barriers) to prevent any harm caused by similar errors in future. The intention of locating the errors is not in order to blame or discipline individuals.

With this in mind, the strength of the causal relationships, alluded to by Dr Adshead, is probably not of such importance to the individual as it was with the inquiries held under the auspices of HSG(94)27. The worst that can happen, after a flawed RCA, is the design of a redundant patient safety system. Staff who are found to have made an unintentional error may be upset if they feel wrongly criticised, but they can be reassured that they are never going to be the focus of the investigation or the outcome. It is extremely important that healthcare staff are made aware of the blameless nature of these RCA investigations or the cultural shift that is required to bring about the open reporting of errors (as occurs in the aviation industry) will never occur.

Declaration of interest

L.A. Neal is working with the Emergency Care Research Institute (a non-profit

patient safety organisation) collaborating with the Department of Health to introduce root cause analysis into the National Health Service.

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Consultant psychiatrists' working patterns

Mears *et al* (*Psychiatric Bulletin*, July 2004, **28**, 251–253) advocate that consultants should work in 'progressive roles' in order to combat occupational stress. This role includes a low accumulation of patients from other members of the multidisciplinary team, scope for delegation, time to respond to emergencies, taking a low level of direct referrals, and feeling support from and reliance upon other team members. Consultants working in such a role are more positive and less stressed.

However, there is nothing in the methodology to indicate that the numbers of supporting team members were considered in the analysis. Surely, all of the above factors may relate pretty directly to the number and quality of other members of one's team, and without sufficient multidisciplinary colleagues it is rather difficult to envisage consultants surviving in the suggested 'progressive' role. In the absence of such data, and of any consideration of team sizes, the paper's recommendations appear fairly vacuous.

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Author's reply: In his letter Dr John Eagles points out that the assertion in our paper that consultant psychiatrists working in more progressive roles (low accumulation of patients, effective delegation, good team working and support, effective gate keeping and low level of direct referrals, time to deal with emergencies) are likely to suffer less from occupational burdens is flawed, since no consideration is given to the number and/or quality of team members. Dr



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Eagles continues, stating that conclusions and recommendations do not stand up in the absence of these data, since any consultant not in a sufficiently populated, effective team would not survive in a progressive role.

My initial response is to state that we indeed did collect data about the size of the respondent's team. These data weren't included in this paper as submitted to keep the length down to publishable level. In common with many national studies, the original dataset for this project is vast and contains several hundred variables. We are forced to choose not only which to analyse in depth, but must create a subset of those to submit for publication in peer-reviewed journals. I can report, however, that team size was included as a predictor in some of our univariate (the larger the respondent's team, the higher their reported satisfaction level [$P < 0.05$]) and multivariate (the larger the team, the lower the respondent's General Health Questionnaire – version 12 score [$P < 0.05$], and the less they suffer from depersonalisation [$P < 0.01$]) analyses. My second point concerns Dr Eagles' interpretation of the findings more generally. I feel that Dr Eagles has rather missed the point of this paper: the progressive model can only ever work where the consultant has a motivated, effective multidisciplinary team. A progressive role, by reference to its defining characteristics, cannot be achieved without it. Further, the more important point here is that a consultant cannot change in isolation: as we point out in the paper, any change of role is potentially dangerous unless carried out as part of a whole-systems approach to change, a restructure, where due consideration is given to ensure that any reduction in workload is not merely passed onto other team members, rendering them liable to stress and burnout.

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Partners in care. Who cares for the carers?

Mike Shooter, President of the Royal College of Psychiatrists has highlighted an important aspect of psychiatric care in his recent editorial 'Partners in care. Who cares for the carers?' (*Psychiatric Bulletin*, September 2004, **28**, 313–314).

This is very relevant to the developing countries as many clinicians depend heavily on relatives or carers with regard to various aspects of a patient's management, as social services and other supportive systems are poorly developed. For instance in many in-patient units in Sri Lanka, relatives or carers are encouraged to stay with the patients. Sometimes

relatives take turns to stay with the patients to minimise the burden and disturbance. This helps 'overworked staff members' to alleviate the burden at least to some extent. When the patient is discharged from the in-patient unit, administration of medication and rehabilitation programmes are done with the help of the carers. Carers are further distressed prior to the admission of a patient for assessment or treatment. For instance as the existing mental health act does not address the admission policy comprehensively in Sri Lanka, relatives or carers have to play a major role in accommodating the disturbed patient until taken to a hospital for assessment/treatment/admission.

The other important area is the rapidly increasing elderly population in developing countries. At the moment many elderly people are looked after by their family members. For example, in Sri Lanka about 80% of the elderly population are living with their children and the main caregivers are female (National Council for Mental Health, Sahanaya, 2002). We are bound to see more and more people with dementia and other disorders encountered in old age. Services for the elderly are not well developed compared with the West and the families, particularly females, are expected to look after their elderly relatives.

The other important area that needs to be highlighted is the introduction of community care without many resources. Management of mentally ill people in the community without resources will add to the burden on the carers. It is noteworthy that the crisis assessment teams are either poorly developed or non-existent in many developing countries.

We totally agree that the concept of 'caring for the carers' should be further emphasised and the undergraduate and postgraduate medical and nursing curricula must be strengthened with regard to this aspect of care.

NATIONAL COUNCIL FOR MENTAL HEALTH, SAHANAYA (2002) *Community Mental Health Care, Issues and Challenges*. Colombo: National Council for Mental Health, Sahanaya.

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Irish Psychiatric Association survey of psychiatric services in Ireland

The article by O'Keane *et al* (*Psychiatric Bulletin*, October 2004, **28**, 364–367) provides a valuable insight into the deficiencies present in mental health in the Eastern Regional Health Authority (EHRA) in Ireland. Unfortunately the data

presented do not represent 'a national survey'. The consultant sample is only 8.2% of the 281 consultant psychiatrists employed in Ireland (Walsh, 2004) and hence the results of this survey are limited to only the EHRA respondees. The wide variation in the socio-economic and demographic profiles in different regions in Ireland noted by the authors and elsewhere (Central Statistics Office, 2003) alongside the variation in the management style, and political function of the various health boards, and differences in regional infrastructure also make the EHRA results non-generalisable to Ireland as a whole without further data. The paper is a good start at examining the inequities of Irish mental healthcare but data including regions very different from Dublin and the East coast are essential in such a survey.

CENTRAL STATISTICS OFFICE (2003) *Measuring Ireland's Progress. Volume 1, 2003; Indicators Report*. Dublin: Stationery Office (Government of Ireland).

WALSH, D. (2004) *Report of the Inspector of Mental Hospitals for 2003*. Dublin: Stationery Office (Government of Ireland).

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The objective structured clinical examination

The letter by Haeney (*Psychiatric Bulletin*, October 2004, **28**, 383) raises an interesting conundrum.

I have recently been advising a number of my colleagues, who will be undertaking the clinical examination for Part II MRCPsych. A significant number undertook the Part I MRCPsych OSCE exam, so have not had experience of the unobserved long case.

With the introduction last year of the OSCE exam and its widespread use in undergraduate teaching, a large proportion of trainees have no experience of long case examination. As was mentioned in the letter by Haeney, candidates struggle with the uncontrollable variables of patient and examiners. My own feeling about this is that, with experience, candidates can often handle these situations better. During my undergraduate training, I was examined using the traditional long case format, and I believe this exposure to the format gave me greater confidence when dealing with long cases in both Part I, and more recently, in Part II examination.

It would be of interest to get an idea of how candidates who are now undertaking Part II are dealing with the lack of exposure to the long case. This would particularly apply to any proposed change in the Part II examination. Having reviewed previous articles it would appear that