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EDITORIAL

An arrow pointing somewhere

Qualitative study of the Helsinki declaration on patient safety and its role in European anaesthesiology

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The Helsinki Declaration on Patient Safety in Anaesthesiology (hereafter 'the Declaration') was launched in 2010 by the European Board of Anaesthesiologists and the European Union of Medical Specialists in close co-operation with the European Society of Anaesthesiology (ESA).[1] The ESA initiated a project designed to assess and improve the adoption of the Declaration's requirements, as there were few data about its uptake.[2] The first phase, an online survey of ESA members, was recently published.[3] The second phase of this investigation, reported here, aimed to ask national leaders in anaesthesiology in a number of European countries about patient safety and the role played by the Declaration, and its benefits, limitations and barriers in daily practice. We used a semistructured interview guide with open-ended questions. The interview transcripts were analysed by standard qualitative methods,[4,5] through a broadly ethnographic approach, drawing on the theoretical framework known as 'Safety II', which aims to understand why things go right in healthcare safety most of the time, complementing the 'Safety I' approach which seeks to learn from error.[6,7] Between August 2018 and May 2019, we conducted seventeen interviews with senior national leaders in European anaesthesiology, lasting a median [range] of 56 [34 to 100] min.

Respondents mentioned a number of activities, structures and processes that they believed exert a positive influence on patient safety. These commonly included: education; guidelines and protocols (whether at European, national or departmental level); monitoring; preoperative assessment; and training (especially around the use of new technology).[8] The risk from medication errors was also frequently discussed. Table 1 summarises respondents' perceptions of the influence on safety in European anaesthesiology. We categorised interviewees' responses into six main themes, presented below. Further methodological detail, data analysis with illustrative quotations, and discussion can be found on the journal's website (Supplemental Digital Content, http://links.lww.com/EJA/A246).

'Like a juggler, with a lot of balls in the air': clinical changes in anaesthesiology since 2010

There were three commonly cited areas of change: an intensifying workload; more challenging patients; and suboptimal pre-operative preparation. Within this there was common agreement that day case surgery has become more widespread; however, this brings pressure to administer anaesthesia to older and multiply comorbid patients without the desired pre-operative investigations. A sense of frustration and stress was apparent as a result. In addition, high workload intensity has led to a perceived erosion of professional identity and patient safety. Similarly, there was an explicit appreciation, too, of the role of the anaesthesiologist in maintaining vigilance for the rest of the healthcare team, almost like a 'goalkeeper'. Workload pressure extends into the intra-operative period, with senior anaesthesiologists being less able to provide adequate supervision. The fact that safety problems seem to be uncommon (and may not be fully captured by quantitative audits or official governance systems) does not make compromises in safety standards acceptable. Respondents mentioned the temptation to 'cut corners' to get the work done.

'Fighting not to fall down': external influences on patient safety

Respondents focused predominantly on resource constraints, as well as relationships between hospitals, governmental bodies and national anaesthesiology societies. Although some mentioned the perceived benefits of

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Table 1 Summary of respondents' perceptions of influences on patient safety in European anaesthesiology

Positive	Negative
Guidelines and protocols	Financial austerity
Monitoring	Medical workforce migration
Vigilance	Older, sicker patients
Equipment and drugs	Production pressure
Pre-operative assessment	Lack of time to talk about safety and quality
Education on safety culture	Lack of trust to enable sharing of incidents
Keeping up to date	
Colleagues who have worked overseas	
Good relationships with government	
Regional networks	

improved pan-European professional relationships, there were a number of challenges such as anaesthesiology workforce migration, hospital finances, salaries, working conditions and staffing. We discerned within the responses two discrete types of relationship between hospital anaesthesiology departments and the broader healthcare system. In some countries it was clear that departments and their parent hospitals work within a national policy framework, within standards set by national anaesthesiology societies and national governmental bodies, informed by the results of large-scale, organised safety and quality data reporting. In other countries, Ministries of Health and national societies are regarded as out of touch or ineffectual, with clinical practice working on a more 'decentralised' model. Within this, the departmental 'chief' was repeatedly cited as the source of departmental policy and the reference point for reporting of problems or arbitration.

'An arrow pointing somewhere': what the Helsinki Declaration means in practice

The Declaration is perceived as a force for good, a standardisation framework and a catalyst for change. It benefits from being succinctly laid out, yet broad in scope. This has led to its acceptance and utilisation, though implementation requires tailoring from country to country. The general themes of the Declaration were better known than more specific details. Respondents from a number of countries, typically from northern Europe, commented that their national safety standards and discourse are already more advanced than the contents of the Declaration might advocate. However, Europe is a diverse continent and the Declaration's standards have been useful elsewhere in enabling change and improvement. The Declaration also seems to link into anaesthesiology education. Despite knowledge of the Declaration itself being variable, the themes and overall aims of the Declaration were commonly reported to be present within anaesthesiology training curricula, albeit without referring to the document explicitly.

'Attitude education': culture, training and human factors

The vast majority of respondents highlighted the critical nature of safety culture, human factors and training systems in maintaining patient safety. Culture plays a key role in the adoption of safety tools and practices. For instance, the uptake of the WHO Surgical Safety Checklist is dictated by the context in which it is introduced. A respondent from one country suggested that their compatriots were unlikely to accept attempts to shape their behaviour, commenting that people in that country have a cultural tendency to resist following rules. Similarly, a workplace where staff feel familiar with each other does not necessarily create a perceived need to undertake introductions and talk through proposed operations. Several countries were in the process of publishing a new training curriculum, or else had recently done so, with an agreement that simulation, patient safety and human factors were a much more prominent feature; 'attitudes' to safety being as important as technical prowess.

'A good anaesthesiologist can explain his work well': the patient perspective in anaesthesiology

Common themes included public understanding of anaesthesia, patient feedback, and trust in healthcare systems. Respondents in many countries suggested that patients typically focus on risks posed by surgery itself, rather than the wider peri-operative period or anaesthesia specifically. The role of the anaesthesiologist is often underappreciated, as is the influence of patient comorbidities on peri-operative safety.

Nevertheless, empowerment and education were seen as vital, with the pre-operative clinic and broader public health campaigns providing part of a solution. The role of patients' views and observations was also highlighted, though many hospitals and countries lack a co-ordinated means of harnessing such safety 'intelligence'. Attitudes and practices towards disclosure of problems and patient involvement vary, with some respondents describing a situation of public mistrust in medical professionals, with a reciprocal medicolegal 'paranoia' from clinicians.

'We tried it, it didn't work. Nobody said anything': critical incident reporting

There is a lack of uniformity in incident reporting compliance and system availability. Standardised reporting systems were often found for specific incidents such as difficult airways, allergic reactions and drug events. However, national level data co-ordination, analysis and reporting are poorly developed or nonexistent in some countries. In keeping with the previously described 'decentralised' healthcare systems, many respondents felt that incident reports went no further than departmental 'chiefs', and did not feel any further sharing took place. Indeed, these individuals were often frustrated

that mandatory incident reporting did not lead to any regional or national reporting; thus they are unable to ascertain common themes, trends or potential solutions. Incidents may not be shared with the patient concerned, nor reported to departmental or higher-level systems. Factors influencing this include perceived severity, patient outcome, time pressures and attitudes towards the reporting system.

Discussion

To be effective in practice, quality and safety improvement tools and initiatives must take account of the complexities of healthcare practice and 'make sense' to practitioners within the context of their practice. This argues for a sociologically based approach which constructs an account of patient safety in anaesthesiology reflecting participants' perceptions of, and meanings attributed to, patient safety within the social context of anaesthesiology practice.[9] Practitioners' own views of the work they do is often somewhat different from how it is envisaged by policymakers and politicians (referred to, respectively, as 'work as done' and 'work as imagined' in recent safety scientific literature).[6,7] Safety initiatives need to resonate with the professional identity of the clinicians concerned.[10] In addition to the previously noted roles which anaesthesiologists play,[11] we see references to other, hitherto unrecognised roles. These include: 'goalkeeper' (acting as the 'last stop' to prevent potential hazards from becoming real); 'firefighter' (purely responding to events rather than feeling able to influence safety pro-actively); and 'individualist' (acting according to personal preferences rather than formal protocol). Finally, this 'social' approach argues for an expanded view of 'human factors', one which moves beyond psychology and engineering to encompass how people relate to each other.[7,12]

Two particular themes deserve further comment. Pre-operative assessment, for instance, of the patient's airway,[13] and optimisation through modification of intercurrent disease[14] and lifestyle factors, is widely regarded as essential to high-quality anaesthesia care. The suggestion that resource constraints are preventing this is concerning. Second, critical incident reporting structures and practice vary widely and, while systems must be properly resourced, social cultural factors amongst anaesthesiologists seem to play a significant role in determining whether anaesthesiologists actually make use of the systems that exist.[15]

The Helsinki Declaration would benefit from revitalisation, possibly by inviting signatories to confirm their continuing commitment on the Declaration's 10-year anniversary in 2020, and a publicity campaign. A revision would also afford an opportunity to tailor this valued, succinct document such that it reflects the changes in anaesthesiology since 2010 and the current concerns of practicing anaesthesiologists, patients and policymakers. Our suggestions for this, based on our findings, are set out in Table 2. Key issues for future consideration and research are those the anaesthesiologist's resilience and fatigue, an increase in workload and the delivery of safe care throughout the whole peri-operative period, increasingly on a day case basis, to an ageing and multiply comorbid population. Ultimately, these measures require investment from, and collaboration with, political stakeholders as well as anaesthesiologists.

Table 2 Suggestions for further implementation and development of the Helsinki Declaration on Patient Safety in Anaesthesiology

Create and maintain structures for safety education both in training curricula and for established specialist anaesthesiologists
Promote a 'no blame' culture to encourage the reporting and open discussion of threats to patient safety
Greater involvement of patients in the promotion of safe practice
Make the scientific, clinical, humanitarian and economic case for thorough pre-operative assessment
Establish and maintain regional networks within Europe to share practice and solutions appropriate to available resources

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