Other journals in brief

A selection of abstracts of clinically relevant papers from other journals.
The abstracts on this page have been chosen and edited by **Paul Hellyer.**

Who is 'in' and who is 'out'?

Jesudason E. Ethical problems with kindness in healthcare. *J Med Ethics* 2022; DOI: 10.1136/medethics-2022-108357. Online ahead of print.

Kindness is optional, not obligatory.
Kindness – related etymologically to kin and our kind – is generally thought to be a virtue. Related to empathy (putting oneself in another's shoes) and compassion (sharing distress, a sense of solidarity and possibly a call to action), kindness may be considered more discretionary than either. Doing someone a kindness, for instance, has an element of doing a favour and hence tends to favouritism.

If kindness, therefore, can be considered discretionary and not an obligation to be provided to all, then ethical issues become apparent. With regards to justice, as an example, the hosting of Ukrainian refugees has been a good example of kindness and mitigates harm to the majority and is difficult to argue against in general. At a deeper individual level, however, African students fleeing Ukraine have been sent to the back of queues in favour of white refugees and kindness can be seen as discretionary. Jesudason argues that promotion within the NHS may also be an example of not dissimilar unjust discretionary kindness.

Healthcare regulation is also impacted by kindness and non-maleficence. Harms may be caused by the discretionary kindness of deciding who and who is not referred to the various regulatory bodies. Hospital directors may be reluctant to press charges against longstanding colleagues and friends. The Bristol Children's Hospital enquiry for instance used the term club culture to define the in-group of doctors who protected each other with 'in-kind benefits, at the expense of the children and families.'

The conflict of kindness and autonomy is illustrated by the issue of overseas aid. It is kind to give to those worse off than oneself, but if aid organisations are paternalistic in their distribution of the assistance, then the autonomy of the recipients is infringed.

'Healthcare professionals are perhaps vulnerable to the seductive belief in their own kindness,' Jesudason writes. 'Practitioners may view themselves as particularly virtuous – when in fact they may sometimes be seen as quite self-serving.' A belief in their own sense of virtue may lead to an expectation of perks and favours but without recognising that these go un(der)offered to others.

Discretionary kindness may therefore lead to the formation of in-groups and out-groups. Future research on policy development should include outgroups to ensure that discretionary kindness is distributed fairly and that harms are mitigated. Greater inclusion of ingroups would remove the repeated focus on minoritised groups and help to determine how kindness (or perhaps kin-ness) is distributed in healthcare.

https://doi.org/10.1038/s41415-022-5207-5

The blame game – individuals vs organisations

Taylor D J, Goodwin D. Organisational failure: rethinking whistleblowing for tomorrow's doctors. *J Med Ethics* 2022; DOI: 10.1136/medethics-2022-108328. Online ahead of print.

The 'Normalisation of Deviance' explained.
Good practice should avoid a culture of blame in the workplace and ensure systems are in place to protect patient safety. However, organisational, social and cultural failures may lead to less than ideal patient care. Ethics teaching for medical professionals though focusses on the personal responsibility of the individual to recognise transgressions from good practice and to duly report it – to be a whistle-blower. This mismatch between individual practitioner and the 'organisational underpinning of healthcare failures' fuels the perception that threats to patients' safety only result from practitioner incompetence rather than system failings.

Drawing on the experience of the other safety-critical industries, the concept of the 'Normalisation of Deviance' is applied to systemic failures in the healthcare industry. Normalisation of deviance springs from the investigation into the Challenger spacecraft disaster and is characterised by a five-stage pattern in decision-making:

1. Signals of potential danger
2. Official acts acknowledging the escalated risk
3. Reviewing the evidence
4. Official decisions accepting the risk (the normalisation of deviance)
5. Continued operation as previously.

The 'official acts' endorse that the level of risk of current practice is acceptable, signalling that workers should continue to work as normal. Within the healthcare environment, the authors state that 'the focus tends to be on the individual within the culture … (who) gradually become accustomed to seeing breaches in safety standards to the point where they themselves adopt them.' Organisational influences are not given the same attention and tend to fall out of view as the focus shifts to the individual.

Using the example of the report into the Morecombe Bay Investigation, where one voice 'of considerable expertise and standing' tried to expose problems, the weakness of the individual whistle-blower to expose systemic failures is highlighted. Creating an environment where staff feel safe to speak up, however, is insufficient to change managerial unwillingness to hear and take action.

Placing the concept of normalisation of deviance at the centre of analysis takes the emphasis away from the individual. Clinical education therefore needs to place more emphasis on an understanding of the culture and organisation of healthcare provision and potential failures. Despite continuing efforts to remove the blame culture within the NHS, other recent cases, such as that of Dr Bawa-Garba, suggest that 'ideas about individual error or incompetence (still) underlie perceptions of organisational failure.'

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