Editorial
A tribute to a Patient Safety Pioneer
Mr Robert L. Law DCR(R)

It is with mixed emotions that we commence this Editorial. We are delighted to bring to you this Special Issue on Patient Safety, a topic clearly of immense importance to our profession and to the public we serve. However with this Issue we bring news of the passing of an exceptional radiographer and former *Radiography* Editorial Board member who not only took patient safety seriously in his day to day work, but created numerous opportunities throughout his career to ensure that the patient safety message was disseminated, heard and more importantly, acted upon.

Robert L. Law pioneered one of the first radiographer-led barium enema services in the UK, based at Frenchay Hospital in Bristol in the early 1990's. He encouraged and developed a team of radiographers to strive for excellence in fluoroscopy service provision, rigorously auditing the service and disseminating the results at conferences, study days and in peer reviewed journals. This evidence was vital in encouraging and supporting radiographers and radiologists in other centres to introduce role development in fluoroscopy. His experience in radiographer-led services contributed towards the development of the UK radiography career progression framework, and later he was appointed as one of the first Consultant Radiographers in the country.

Rob was keen to pass his knowledge and expertise on to other radiographers, not only in his own hospital, but also through his lengthy collaboration with the Gastro-intestinal Radiographers Special Interest Group (GIRSIG) [1]. He was passionate about radiographers developing their role in fluoroscopy, but never at the expense of patient safety. He advocated the creation of advanced practice protocols within which radiographers could practice safely, and campaigned for radiographers to audit their practice and publish and present their findings. Rob led by example, publishing approximately 17 articles in peer-reviewed journals, including the *British Medical Journal, Clinical Radiology, Radiography and Colorectal Disease,* and delivering over 30 invited UK and international conference presentations since 1996.

His experiences in clinical practice highlighted concerns that trainees (particularly junior doctors) were often taught on a 'see one, do one, teach one' basis [2] and often lacked suitable and affordable resources, so he produced training videos / DVDs for trainees in barium fluoroscopy. He also co-edited a core textbook entitled 'Gastrointestinal Tract Imaging: An evidence based practice guide' [3], which brought together 23 authors from 9 different specialties, including radiologists, radiographers, surgeons, gastroenterologists, speech and language therapists, pathologists and oncologists. The book was published in 2010, and has since been translated into Spanish and Polish.

Patient safety should be under continuous review so that we can make incremental improvements for the benefit of our patients. However occasionally an incident occurs which is so serious that established practice needs to be reviewed as a matter of urgency. These so-called 'never events' can be defined as: '*Specific serious untoward patient safety incidents that should not occur if national guidance is followed*.' [2] They happen rarely but require prompt leadership; Rob had significant impact upon one such adverse event related to the safety of Nasogastric Tube (NGT) insertions. Rob developed an interest in NGT intubation early in his career and assisted doctors with difficult intubations, publishing the framework for this radiographer-led new service [4]. However a never event occurred following an NGT sited incorrectly by inexperienced ward staff, with terrible consequences for the patient. Rob conducted a large audit of chest x-rays, documenting the incidence of misplacement and interpretational errors. With other relevant health care professionals he created guidelines for NG insertion, and introduced a rolling training programme for all junior hospital doctors in interpreting chest radiographs following tube placement. He then spread this learning beyond his centre by creating an accredited NGT e-learning programme. Rob worked tirelessly following the 'never event' to ensure that preventable fatalities do not occur in other hospitals internationally, and was an advisor on the development of a National Patient Safety Alert "nasogastric alert" [5]. The North Bristol Trust where he worked subsequently won a national patient safety award for "changing culture in patient safety".

Rob set a benchmark for radiographers by encouraging participation in detailed clinical decision making and engaging with clinicians from a range of disciplines, putting the patient's interests at the heart of his work. These attributes were recognised in 2008 by the Royal College of Radiologists when he was awarded Honorary Membership of the RCR, and in 2012 when he received the Fellowship of the College of Radiographers.

While we are sad to lose a pioneer of role development and patient safety, we are also grateful to him as an Editorial Board member for personally campaigning for this Patient Safety special issue. He would have been very pleased to see it come to fruition.

References

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