VIEWS & REVIEWS

NO HOLDS BARRED

Margaret McCartney: Don't blame us

Margaret McCartney *general practitioner, Glasgow*

We keep hearing diktats that we need a no-blame culture in the NHS. Don Berwick, the US healthcare quality supremo, has claimed that such a culture is safer for patients and leads to better care, but there doesn't seem to be much evidence of one.¹

We need an amnesty on mistakes, errors, screw-ups, and near disasters. The truth is that mistakes are normal; perfect care is not. Every normal day is full of near misses, many of the dangerously slow-burn kind.

Technology could help more. Prescribing a drug requires clicking and dismissing so many alerts that it might distract us from a real potential problem (no, I don't want to make this a repeat prescription; yes, I do realise that the patient is already taking a different antihypertensive). If I've typed in the notes that a referral is needed but haven't arranged it, the system should be able to detect this. And hospital systems should respond when a patient leaving a clinic needs to make a future appointment but for whatever reason doesn't do so.

Despite repeated deaths caused by the inadvertent intrathecal delivery of vincristine from 1968,² the same mistake is still technically possible—and now with more drugs.^{3,4} Our systems should be devised to expect the worst, from miniature mishaps to gross calamities, and to help us prevent them from happening.

Custodial sentences for individuals can't guarantee that the same error won't recur,⁵ whether or not a patient's relatives think such sentences are justified.⁶ Such action seeks to fix only the end result of a bad system. Prison may be appropriate for doctors found guilty of causing deliberate harm, but it is not appropriate for those who have made honest mistakes. Does the threat of prison make us safer doctors? Rather, it surely makes us more likely to cover up—and our mistakes more likely to be repeated.

Much in medicine is grey; other kinds of "error" are not clear wrongdoing. For example, no system can predict which children are definitely at risk of abuse or neglect. To try to identify them is sometimes to get it wrong. Similarly, the worthy campaign (which I support) to reduce the inappropriate use of antibiotics will inevitably mean that some people sustain a complication that might have been prevented by taking them immediately.

Medicine inhabits an inexact territory with terrifying hazards, and the best way to avoid them is to demand honesty from everyone. The first truth that we must accept is that human beings are not perfect. We should be able to welcome inspectors into our practices, confident that they will support us in working better and more safely, but first we must lose the fear that we'll be blamed if they find fault.

Competing interests: I have read and understood the BMJ policy on declaration of interests and declare the following interests: I'm an NHS GP partner, with income partly dependent on Quality and Outcomes Framework (QOF) points. I'm a part time undergraduate tutor at the University of Glasgow. I've written a book and earned from broadcast and written freelance journalism. I'm an unpaid patron of Healthwatch. I make a monthly donation to Keep Our NHS Public. I'm a member of Medact. I'm occasionally paid for time, travel, and accommodation to give talks or have locum fees paid to allow me to give talks but never for any drug or public relations company. I was elected to the national council of the Royal College of General Practitioners in 2013.

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