BMJ 2018;362:k2923 doi: 10.1136/bmj.k2923 (Published 5 July 2018)

EDITOR'S CHOICE

Lessons from Gosport

Fiona Godlee *editor in chief*

The BMJ

The report of the inquiry into deaths at Gosport War Memorial Hospital is hard but essential reading (gosportpanel.independent.gov.uk). In cool clear prose it records the personal tragedies of patients, admitted for respite care and not in pain, for whom "keep patient comfortable" proved a death sentence. It describes the courage and persistence of the families, and the devastating roll call of professional and institutional failings.

As Nigel Hawkes explains (doi:10.1136/bmj.k2901), key players at every level have been found wanting: the hospital managers who effectively silenced the nurses on Dryad Ward; the pharmacists and consultants who failed to spot the routine overprescribing of opioids, despite the fact that this continued in plain sight for 12 years; the GMC, which failed to strike off GP Jane Barton despite finding her guilty of serious professional misconduct; the Hampshire police force, which, despite three investigations begun between 1998 and 2002, failed to properly examine reports by families and whistleblowers. The file is now being handed to another police force, and we must hope for the sake of the families and their supporters that it succeeds in persuading the CPS to look at the case again in the light of the Jones report once the force has finished its work.

Although the actions of a single doctor have attracted most attention, this was a monumental collective failure, symptomatic of the prevailing culture. Gosport War Memorial Hospital was unusual, as the report makes clear: isolated geographically and professionally, an old style community hospital in a traditional military setting. But how much else from this saga can we still recognise in today's health system? There is the uncritical deference shown to doctors, the fear of repercussions among staff raising the alarm, the unwillingness of patients and their families to question the medical and nursing teams, the lack of routine audit that could have spotted suspicious patterns, the 10 year delay in publishing the Baker report, the accumulating evidence that the General Medical Council is no longer fit for purpose. Dido Harding, chair of NHS Improvement, which regulates trusts in England, says she has been shocked by the lack of basic people management skills in the NHS (doi:10.1136/bmj.k2657). She wants to see a "fully fledged approach" to managing senior people in the NHS. "It's much easier to teach doctors and nurses to be great managers than it is to teach me to be a doctor or nurse," she says.

Much has changed for the better in the past 20 years, but if Gosport tells us anything it is that the voices of patients, families, and whistleblowers must be heard.

fgodlee@bmj.com Follow Fiona on Twitter @fgodlee