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VIEWS AND REVIEWS

NO HOLDS BARRED

Margaret McCartney: Clinical errors need a systemic response

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Before I graduated we had a talk about professional responsibility. We were told that we shouldn't need to worry about the General Medical Council (GMC). If you worked hard, weren't lazy or drunk on duty, and didn't have sex with your patients or embezzle funds, you had little to fear. You should just make sure that you paid your fees on time and gave the GMC an up-to-date address.

Back then, the unspoken message was clear: only truly bad doctors would come to the GMC's attention. This seems much less clear since the High Court ruled that Hadiza Bawa-Garba must be struck off the UK medical register after the death of Jack Adcock. And I know that many doctors are wondering what other job they can do, or which countries will welcome them into less stressed, and better funded, health systems.

The judgment on who had responsibility for Jack Adcock's death has caused shockwaves in the medical profession for two reasons. Firstly, doctors in clinical practice have been speaking out for years about their distress at the unmanageability of good and safe practice in the NHS—and many, including me, feel ineffective. Secondly, near misses are recognised by all practising clinical doctors. Errors are common, but admitting to them may not be. A few years ago the ex-president of the GMC admitted to having missed sepsis himself.[1] So, are we all truly bad?

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I fear that the pressures in the NHS have led us to accept poor standards as normal, with waits of six months for some referrals, other referrals being refused, and no beds to which to admit high risk teenagers with anorexia. We roll our eyes and see it as business as usual, rather than being furious that this is the state that we and our patients are in. And all the while we waste time and money on politically motivated initiatives that have no evidence base to support their introduction.

As Peter Wilmshurst has pointed out, the GMC has often taken no action against doctors who are on the sex offenders register or those who have dispensed fraudulent treatments for personal gain.[2] Yet those are of a different nature entirely from clinical errors made by staff who never intended, either by omission or commission, to do harm.

Manslaughter charges against healthcare professionals in the past few years have focused on individual clinical errors, not on the professionals who are in charge of making decisions about how systems are run or funded.[3] Pinning blame on one person allows us to believe that the bad apple has been removed from the barrel and that all is now well. But this is a system issue. It's the barrel that's the problem.

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1 Coombes R. Senior doctors admit mistakes in campaign for more open culture. *BMJ* 2005;331:59510.1136/bmj.331.7517.595-b.
2 Wilmshurst P. BMJ rapid response 5 Dec 2018. www.bmj.com/content/359/bmj.j5534/rr-4.
3 Manslaughter and Healthcare. www.manslaughterandhealthcare.org.uk.

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