Perspectives

'We must accept that health care is a risky business'

One of the thorniest issues in the relationship between doctors and patients has been how to deal with a dispute. The rhetoric of the past few governments, both Conservative and Labour, has emphasised the need to treat patients as consumers of services provided by the NHS. Patients need to be "at the centre" of all arrangements for planning, delivery, and accountability. At the same time, the private healthcare system in Britain has grown by aggressively marketing its service as modern and responsive to patients' needs as "customers," and patients are becoming used to making choices both about who provides their services and the nature of the treatment they are to have.

The growth in consumerism has been accompanied by an explosion in information systems, most notably the internet, which have made patients more knowledgeable customers when it comes to disease, treatments, and patients' rights. Recently, information on the performance of hospitals has become available through private initiatives such as the *Good Hospital Guide*,[1] and the Department of Health plans to publish more detailed information on the performance of individual consultants.

Where we are now

When there is a dispute, however, the relationship between doctors and patients can still seem rather paternalistic. Feedback from community health councils, which support people with complaints, suggests that many patients still get removed from general practitioners' lists for no other reason than having dared to complain about their doctor's service or attitude. This is in spite of guidance from the Royal College of General Practitioners that all attempts to resolve disputes should be exhausted before declaring the doctor-patient relationship and trust irretrievably damaged.[2] In acute care, too, there have been examples of disagreements between clinician and patient leading to the services of the clinician being denied to that patient. Although there will be occasions when relationships are damaged to the extent that attempts to retrieve them are useless if not counterproductive, doctors unilaterally terminating relationships simply because there is a dispute should be totally unacceptable, especially in the public sector. In the private sector, few doctors would be so confident of ongoing business to be able to treat their customers in this way.

Even when it comes to issues of patient safety, there is still a tendency to treat the doctor-patient relationship rather oddly. The development of the National Patient Safety Agency, a new statutory body that collects information about adverse events and disseminates the lessons, is something that AVMA welcomed with open arms. It is just the sort of development that the charity has campaigned for for years, and the Bristol debacle made its creation even more necessary. Ironically, however, the agency's ways of working mean that, in itself, it would probably not be able to prevent tragedies such as Bristol. In order to encourage healthcare professionals to report adverse events, so the logic goes, these professionals must be guaranteed anonymity. Thus the National Patient Safety Agency will collect only statistical information and identify trends; it will not intervene in individual cases that are reported to it. So, even if someone blows the whistle to the agency on a Bristol-like situation, no action might be taken until the number crunching catches up.

Similarly, the proponents of so called no fault compensation schemes argue that protection from litigation is a prime factor in promoting the kind of "learning from mistakes" culture that most aspire to. However, I believe most doctors would be appalled at the suggestion that they need special protection in order to protect patients. In any case, in the NHS, doctors are not sued but rather the NHS itself. There is little evidence to suggest that it is fear of litigation rather than concern for patients' safety that lies behind what some people describe as defensive medicine.

Future directions

An Organisation with a Memory (the report of an expert group on learning from adverse events in the NHS) and Sir Ian Kennedy's report on Bristol extolled a move away from a blame culture.[3,4] Few patients' organisations, and certainly not mine, would argue with that sentiment if, by "blame culture," we mean the vilification of individuals for honest mistakes and systemic failures that has become such a preoccupation of our media, and which we understand is a major factor in discouraging doctors from continuing to practise or even becoming a doctor in the first place. We need a culture that accepts that health care is a risky business, and one that helps individuals and organisations to own up to and learn from mistakes. However, "blame" should not be confused with "fault." Mistakes must be investigated to identify where fault lies, even if it is with an individual, if the problem is to be put right and recurrence made less likely. The move away from a blame culture should not and need not be a move to a culture dominated by anonymity and unaccountability. The safety of patients must remain the paramount concern, notwithstanding the sympathy many of us have with those practising at the hard edge of a risky, high profile, and stressful profession.

Britain is already ahead of many parts of the world in getting the balance right. The culture among the medical profession here is improving, judging by many doctors' enthusiastic response to AVMA's "charter of understanding between doctors and patients concerning clinical disputes" (being launched at the "Safety First" conference, 16 June 2003, Royal Society of Medicine) and its doctors' group. The vicarious liability of the NHS for mistakes made in its service, the development of clinical governance, and creation of bodies such as the Commission for Health Audit and Inspection and National Patient Safety Agency are a good start.

Being the eternal optimist, I believe that the chief medical officer's long awaited report on clinical negligence (which was expected in early 2003) and the reform of the NHS complaints procedure (which only went out for consultation in March 2003) will underpin that start and greatly improve the current situation. I believe we will avoid the misnamed and rather unhelpful approach called no fault compensation for medical mistakes, perhaps more because of the realisation that it would cost far more than the state can afford rather than as a matter of principle. (That is not to say that resolving disputes by means other than litigation is not welcome—ex-gratia payments for minor injuries awarded after the complaints process, for example). There has been much scaremongering about the spiralling costs of litigation for the NHS. The latest figure for the cost of clinical negligence is £446m for 2001-2; though a sizeable sum, this is still relatively small in terms of overall expenditure. Rather than short changing the most needy people affected by negligence or restricting access to justice, our efforts over the coming years should be focused on preventing mistakes happening in the first place.

Over the next 10 years, if we are successful in moving a way from a blame culture, we may also develop a culture of openness and honesty that places patient safety and justice for people affected by medical mistakes (including doctors accused of being at fault) at the top of the agenda. What might oil the wheels for this transition is making it a requirement for trusts, other health organisations, and health professionals to be proactive in advising patients of mistakes that have been made, and calling to account chief executives or medical directors who allow obfuscation to take place in the course of any investigation.

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1 Dr Foster. Good hospital guide. www.drfoster.co.uk/hospital_guide/main/choosehospital.asp (accessed 30 Apr 2003).
2 Royal College of General Practitioners. *Removal of patients from GPs' lists–guidance for members*. London: RCGP, 1997.
3 Department of Health. *An organisation with a memory–the report of an expert group on learning from adverse events in the NHS*. London: Stationery Office, 2000.
4 Bristol Royal Infirmary Inquiry. *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*. London: Stationery Office, 2001. www.bristol-inquiry.org.uk (accessed 31 May 2003).

Doctors' notes

Patients may manage to see their medical records, but do they understand the abbreviations? Here is a guide to some of the most commonly used ones.

A&W—alive and well
BID—brought in dead
bid—twice a day
BO—bowels obstruction
CO—castor oil, or carbon monoxide
CVA—cerebrovascular incident (stroke)
D—diagnosis
Dx—diagnosis
DOA—dead on arrival
FBC—full blood count
Hco—history of present complaint
ISQ—in status quo (no change)
MA—mental age
mane—in the morning
MI—myocardial infarction (heart attack)
N&V—nausea and vomiting
NAD—nothing abnormal detected
NBM—nil by mouth
P—pulse rate
PCO—patient complains of
PO—per or (by mouth)
PR—per rectum
PV—per vagina
S/B—seen by
SCAN—suspected child abuse or neglect
SOB—shortness of breath
TATT—tired all the time
3/52—in three weeks' time
TOP—termination of pregnancy
TTA—to take away