Creating a no-blame culture through medical education: a UK perspective

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Dear editor

We read with great interest, and agree with the points made, in the Commentary by Leotsakos et al[1] regarding the need to integrate patient safety into the core curricula for higher education in health care. The World Health Organisation (WHO) patient safety curriculum guide: multi-professional edition (Geneva: Switzerland 2011) appears to be an effective aid to achieve this aim, promoting the culture of patient safety internationally. In the UK, where patient safety is a defining part of quality of care,[2] attempts have been made to introduce the concept of a "no-blame culture". The no-blame culture was introduced as a method to improve the quality of care by learning from mistakes, putting safeguards in place to ensure they do not occur again.

The aviation and automobile industries currently make use of real-time error reporting in order to document and analyze errors, with the objective to prevent similar occurrences in the future. In order for this to be possible in the health care setting, a no-blame culture is necessary. Yet, as demonstrated by Walton,[3] the extent of professional responsibility for mistakes is still not fully understood. More than one "never-event" still occurs every day in the UK National Health Service (NHS), indicating that the system is allowing for them to happen. This poses the question: why has the aviation industry achieved "Ultra Safe" status, while health care trails behind in the rate of fatal adverse events?[4]

We identify two reasons why the no-blame culture is not yet present in the NHS:

Leotsakos et al[5] emphasize the importance of a comfortable and safe professional environment in which patient safety can be improved. Yet in the NHS, the hierarchical style of management tends to deter staff from reporting mistakes, often for fear of possible repercussions.

Walton discusses the "need to clarify where and how professional responsibility fits into the no-blame culture".[3] Sources of medical mistakes are various and can be classified as human error, at risk behavior, and reckless behavior. It is commonly understood that health care practitioners should be held fully accountable for reckless behavior and adequate disciplinary action should ensue. However, for the other two, transparency through open reporting should be encouraged. As in the case of Wayne Jowett – who wrongly received a fatal spinal injection of vincristine – root cause analysis almost always identifies a system failure as the cause of these rather than one individual mistake.[6] Therefore, despite the unfortunate outcomes of such

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events, they should be seen as crucial iterative processes in medical education.

Continuous error reporting is currently used throughout industry (with techniques such as the Toyota Production System and SixSigma) and has successfully been implemented in the health care setting. For example, at Virginia Mason Medical Centre in Seattle, Washington, a flattened hierarchy has been developed and a multidisciplinary approach taken to identify the root cause of any reported mistake. This has permitted it to become one the safest hospitals in the United States[7] and their adapted use of industrial production techniques is used as a common example in patient safety management courses.

We therefore argue that to achieve the intended outcomes of the WHO Curriculum Guide in the UK, a broader culture and system change is required. Quality Improvement Projects, currently in place to improve patient safety locally are often viewed as tick-box exercises to add to a portfolio.[8]

Currently, medical students have the option to undertake courses such as intercalated management degrees and foundation doctors can apply to management and leadership programs. This teaching equips these future practitioners with the tools to understand and implement patient safety improvements. We would go further than Leotsakos et al[1] and argue that all future medical practitioners should receive obligatory training in the management principles mentioned above. Educating the future generation of medical practitioners will allow for the much needed culture change – where reporting of mistakes should be common practice and where patient safety is central to the delivery of health care.

Disclosure

The authors report no conflicts of interest in this communication.

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