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Medical deaths: should doctors be allowed to learn from mistakes?

Patient safety is an important consideration in the delivery of care. While providers continually seek ways to improve patient safety and overall quality of care, medical mistakes sometimes happen. In the UK, reports say Health Secretary Jeremy Hunt is set to announce new measures aimed at protecting doctors and medical staff when mistakes are made.

These new measures include:

- The investigation of every hospital death by a medical examiner or coroner
- Data on doctors' performance will allow them to see how they compare to others to help them improve
- The regulator - the General Medical Council - will no longer be able to appeal against the findings of doctors' disciplinary hearings

According to Mr. Hunt, improving patient safety means doctors and other staff must be able to reflect openly and freely when they have made ordinary mistakes, instead of being punished for them.

"When something goes tragically wrong in healthcare, the best apology to grieving families is to guarantee that no-one will experience that same heartache again," Mr. Hunt said.

The health secretary said he was deeply concerned about the unintended chilling effect on clinicians' ability to learn from mistakes following recent court rulings.

In particular, concerns were raised following the case of Dr. Hadiza Bawa-Garba, who was struck off after the death of a six-year-old boy. The doctor was found guilty of mistakes in the care of the young boy, Jack Adcock, from Leicestershire, who died of sepsis in 2011.

Dr. Bawa-Garba was originally suspended from the medical register for 12 months by a tribunal, but was then removed from the medical register following a High Court appeal by regulator the General Medical Council. The GMC said the the original decision was "not sufficient to protect the public".

The new measures to be announced by Mr. Hunt are based on findings of a government review ordered by no less than the secretary himself. Professor Norman Williams who conducted the review said that "a clearer understanding" of when manslaughter charges should be brought in healthcare "should lead to fewer criminal investigations". The professor pointed out that criminal investigation should be confined "to just those rare cases where an individual's performance is so 'truly exceptionally bad' that it requires a criminal sanction".

The Department of Health and Social Care said the changes would mean bereaved families would get more information about the circumstances of their loved ones' death and more data would be shared across the NHS to help prevent avoidable deaths in the future.

The British Medical Association's council chair, Dr Chaand Nagpaul, commented: "If we, as doctors, and the wider health service are to learn from these mistakes and to prevent such tragedies occurring, the NHS needs a dramatic shift away from the current culture of blame."

Source: BBC News
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