The culture of blame must change

A pilot spoke recently on the radio following the death of his wife after what should have been a routine operation. Alongside his grief and anger, what disturbed him most about the NHS was the culture of blame. He explained, in aviation when there is an accident, the process is to find out why, in order to prevent it happening again. It is not centred on looking for a scapegoat. A culture of blame has become the core of our profession. It is often the focus in online training, which is how many of us now are updated. The programmes focus on legal jargon; acts and legalities. While recognising the modules are trying to ensure we can be safe and accountable for our actions, the legal emphasis within the training seems counter- productive to helping us cope with the 'grey areas' we all come across daily.

Recently, I had concerns regarding a child; I had no firm evidence of abuse, but wanted to 'share the scenario' in case there had been past incidents noted.

I contacted my child protection lead who explained it was helpful to log this and thanked me for sharing the incident. Shortly after contacting the child protection lead, I did an online child protection up-date. This was terrifying, it focused on legal acts brought into action following mistakes. There was little encouragement to talk over a case with a colleague. I doubt I would have contacted the child protection lead with my vague concern if it had occurred after the online training. The risk of legal involvement would have been too prohibitive. In the aftermath of mistakes, particularly when looking at child abuse or vulnerable adults it has been highlighted again and again how short-fallings are often due to poor communication. I suspect this may be due to concerns to discussing grey areas without fear of being sucked into black and white legalities.

Another example of legality prohibiting action involves incompetent colleagues. No one likes a tell-tale or whistle blower, it is easier to put your head down and look the other way. Some years ago, I was working with a locum who I suspected to be under the influence of alcohol.

I considered action, but the locum would be gone in two weeks and although his consultations were very sparse, they were not obviously negligent. I waited to see if someone else took action; I did want to be the one getting him in trouble. Years later, this particular locum came up in conversation. It came to light he had died of alcohol abuse.

I wonder if we had discussed the locum openly would it have led to him getting help?

Nurses and doctors are human. They make mistakes, they have personal problems, they may have mental health issues. When someone makes a serious error they are suspended at a time often when they are most vulnerable. Suicides after suspension or reprimands occur annually. Where is the support and caring counsel instead of admonishment when most needed? Very few mistakes are made maliciously; but as the pilot noted the NHS response is to blame, not to rectify or support those making mistakes. How can we call it a caring profession when we can't care for our own?