A bottom line in medical ethics?

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In the mid 1980s, in a Memoir extracted from me by Stephen Lock, I ventured the opinion that, 'The most unethical thing that a practising doctor can do is to let his competence fall away'. Setting aside deliberately criminal behaviour, which is rare, I still think so. At the time I justified it by suggesting that 'in other aspects of his practice he will sooner or later be pulled up by the law or by the judgment of his peers, but his ability to practise competently is primarily a charge on his own conscience'.

Can we be content with present methods of assisting doctors to retain competence, or of detecting unethical practice, of which clinical incompetence is an important, but certainly not the only cause? There is certainly no lack of concern on both these matters; and in the media vigilant reportage has at times spilt over into exaggeration of both the frequency and the gravity of lapses from acceptable standards.

Clinical incompetence

It has not been my good fortune to meet any doctor who is fully competent across the whole range of medicine; and even within our own field, through tiredness, through inattention, through gaps in knowledge, we are all liable to lapses in competence, or to failures in discussion with our patients. Fortunately for our patients, these are for the most part minor, recoverable, or corrected by natural healing, especially in the young. I hope I am being realistic, not pessimistic, in my belief that the 'control of incompetence', important as it is, can at best be partial. It should include both prevention to the extent possible, and also limitation of damage when it does occur.

The most effective preventive measure is a sound training, refreshed by further study and experience while clinical responsibility remains. Appropriate experience, and discussion with informed colleagues of all levels of seniority, are as important as formal courses. The lust for learning has to be life-long, and generally is so. (When legalists on appointments committees have taxed good candidates with being a few months short of the allotted time of training, I have been moved to suggest that the ability to learn is not annulled by appointment to a consultant post, and may even be enhanced by wider experience and also greater responsibility, as is seen at a more junior level when a jaded final year student becomes an eager and competent houseman.)

On matters of relative detail, technology assessment should include scrutiny of design features which will make it impossible to commit lethal errors in using the apparatus. Specialist training has to embrace frequent use of relevant apparatus and procedures, with attention to major variations, less frequent in medicine perhaps than in, say, hip surgery. In audit meetings, attention may be fostered by the reflection that learning from the mistakes of others is less painful – though no less desirable – than learning from one's own. The ladder of lowliness is not private to young ambition; we all need it in our walk through life. Guidelines developed with the aid of what John Swales called 'numerical medicine' can be helpful both in training and in practice, given that they are competently drawn and regularly revised; but for the clinician, responsible contact with patients and talking with colleagues, should take precedence over scrutiny of VDUs, though that too may be valuable.

It would be churlish not to recognise that over the past several decades a great deal has been done, by universities and colleges, by the pharmaceutical industry, and by the Health Departments, to strengthen training and continuing professional education. Provision and need are coming closer; but more is needed; and their potential meeting is reserved for infinity, as medicine never stands still.

Detecting error

Even at present, there is no lack of mechanisms for detecting and pursuing inadequate performance, whether this arises from misdemeanour or from clinical incompetence; and no enquiry seems complete unless it advocates yet another supervisory body, raising the spectre of a canine menagerie of watch-dogs. However, some of the existing mechanisms are intrinsically flawed, by failure to appreciate that it is in the nature of an average that individual cases are about as likely to fall below it as to rise above it, and by erroneous reporting or interpretation of complex indices. The whole league table approach is a monolith of statistical naivety, providing wasteful employment and little else. And even when error is blatant, and steps are taken, the 'later' in 'sooner or later' can well be very late indeed,

both with internal NHS mechanisms of suspension, and with recourse to the GMC or the courts of law. Delay is not only injurious to the individual, but in aggregate it damages the service by depriving it of substantial numbers of trained people.

Rather than piecemeal '*ad-hocerie*' in response to particular incidents, there should be a review of the complaints procedure and its sequelae, with a view to establishing an open, unified system for dealing with errors, which sadly will be always with us. Such a system should at all costs be dispassionate, and alert to the bias inherent in pressure groups. There are welcome signs of governmental appreciation that a 'culture of complaint' is not the best way to cement that trust between patients and health professionals, which some of us remember from the earlier decades of the NHS. This cloud, as yet no bigger than a man's hand, is hopefully a sign that the Secretary of State is learning that part of his duty is to support the people who provide the service for which he is responsible.

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