CAUTION OR CANDOUR?

When things go wrong we must not let fear of the blame get the upper hand on honest reflection

Three things happened recently that are unconnected but triggered a train of thought. I took a foggy flight to Belfast and on the approach it was announced we would be following the fog safety procedure, obviously a tried and tested protocol based on previous experience and formulation of best practice. It was odd, but reassuring, to feel the sudden thud of rubber on tarmac while thinking I was still up in the clouds.

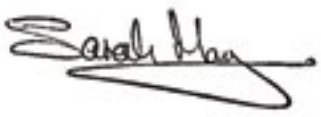
The next day *The Guardian* published a piece about "safety blunders exposing lab staff to potentially lethal diseases in the UK" and cited a number of recent Health and Safety Executive (HSE) investigations.

Finally, there was the story of the junior doctor who was convicted of manslaughter, suspended from the General Medical Council register for a year and then subsequently struck off.

What do these events have in common? They all involve the process of reflective practice and learning. 2017 was the safest year in the history of commercial airlines, a record achieved through the process of learning from mistakes in order to avoid them happening again. Laboratories also use safety breaches or failures to reflect and learn. Given the vast number of samples processed each year, the relatively small number of reported cases indicates the high level of safety in diagnostic laboratories. It is also important to understand that as a part of their health and safety protocols laboratories themselves are the originators of most reports made to the HSE. It would be far more alarming if the article found that laboratory infections were not reported to the HSE and investigated accordingly.

The story of the doctor is worrying because part of our healthcare culture is to reflect and learn from our experiences and then to apply that to future practice. While not directly used as evidence against her in the trial, the personal reflections of the events that led to the doctor being convicted and struck off were referenced. This has sent shock waves through the medical professions.

It is dangerous when fear of our blame culture allows our actions to become a means of self-preservation. Life is complex, particularly in situations that require snap decisions amid conflicting priorities. To let caution curb honest reflection is a sure-fire way to repeat errors. We should applaud candour, otherwise the recommendations of the 2013 Francis report on the Mid Staffordshire NHS Foundation Trust may have been in vain and foggy plane landings may be a little less safe.



Sarah May
Deputy Chief Executive

IBMS

Institute of Biomedical Science is the professional body for the biomedical science profession.

INSTITUTE OF BIOMEDICAL SCIENCE
12 Coldbath Square
London, EC1R 5HL
United Kingdom
+44 (0)20 7713 0214
+44 (0)20 7837 9658
Email: mail@ibms.org
Web: www.ibms.org

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EDUCATION AND TRAINING
education@ibms.org

EXAMINATIONS
examinations@ibms.org

MEMBERSHIP
mc@ibms.org

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