

The blame game

“You’re a fire fighter. You arrive at a burning house and hear screaming. There are ten people inside. You run in and save nine lives, but despite your best efforts, one person perishes. So, should you be cited for heroism or indicted for homicide?”

(Dr. Richard De May, American pathologist)

The Bristol enquiry has called for more openness in medicine. However, it is not likely to happen without a significant change in the current ill-informed blame culture which characterises political and media responses to medical ‘scandals’. And if that sounds like special pleading from doctors unwilling to change their secretive ways, let’s illustrate the point by looking at the national screening programmes for breast and cervical cancer, because ‘blunders’ by screening staff provide one of the richest sources of media outrage. The breast and cervical cancer screening services are rapidly approaching a state of crisis, largely as a result of political, media and public ignorance of the principles which underpin them. These programmes are among the best in the world; the results are there to prove it, and yet with monotonous regularity we read scare stories about women who develop cancer of the breast or cervix despite undergoing screening and being given the all clear. Allegations of incompetence soon follow; assertions that abnormalities were there to see in the past but were either missed or misinterpreted as benign. Litigation is set in motion, an enquiry established, thousands of similar cases reviewed, apologies read out and promises made that it will never happen again. But regrettably it *will* happen again. Despite the exhortations of the politicians and lawyers, many of these so-called mistakes are an inevitable part of the screening process. Whilst we work hard to reduce them to a minimum, any attempt to eliminate them completely would not only be futile, it would make screening so expensive as to be unaffordable. Then there would be many *more* deaths.

The misunderstanding surrounding screening centres on the tests we use: mammography (x-ray of the breast) for breast cancer, and the smear test for cancer of the cervix. The expectation of patients is that a clinical investigation, be it an X-ray, scan, blood test or

cervical smear, will either be positive (they *have* got the disease in question) or negative (they haven't). But life isn't like that, and it is this widespread misunderstanding of the principles of clinical testing which underlies much of the political and media comment concerning screening 'scandals'. The uncomfortable fact is that most test results lie on a spectrum. At one end, the patient almost certainly has the disease, at the other, they don't. In between is a grey area. So, someone has to decide where to position the cut-off between normal and abnormal. Making the test too sensitive by calling even the slightest abnormality a cancer will make sure you don't miss any tumours, but will generate lots of false positives (patients with a 'positive' test but no cancer), and each of these will need further investigation and perhaps even surgery. This causes lots of unnecessary worry for patients who have no disease, and makes the cost of the programme prohibitive. What's more, patients would soon stop coming for screening if they knew there was a good chance their lives would be disrupted for no reason. Move the burden of proof too far the other way (only diagnosing cancer when the signs are obvious) and you reduce the number of false positives, but start to miss lots of patients who *do* have early signs of cancer. Take the criminal justice system as an analogy: convict everyone who is tried by a jury and fewer criminals will walk the streets. On the other hand, some innocent people will get locked up. Move too far the other way and there will be fewer wrongful convictions but some guilty people will get away with it. This doesn't make the lawyers, the judges or the juries incompetent or negligent, it's an inevitable part of any system that requires fallible human beings to make a judgement on the basis of the best available evidence, and the same is true in screening for disease. In other words, a small number false negative results are the price society pays in return for a screening service which is economically and logistically viable but still picks up the majority of tumours. Every effort is directed at keeping that number of false negatives as small as possible.

Ignorance of the principles underpinning clinical testing reaches the highest levels of the health service. Frank Dobson, before he heard the call of Bow Bells, said it was a disgrace that some women developed breast cancer despite attending for mammographic screening as part of the national programme. The cancers had clearly been 'missed', and this was intolerable. Frank is presumably a good man, and no doubt his outrage was

genuine, but he just doesn't understand. We know that in the best centres, with the best equipment and with radiologists who have undergone special training in mammographic interpretation and whose performance is subjected to regular audit, 10-15% of breast cancers will not be detected by mammography. Some were there, but not visible; some will have been seen, but judged to be non-cancerous; a few will be genuine 'misses' which, with the benefit of hindsight, could have been picked up. The same is true of cervical screening. A lot of bad publicity was recently generated by an audit of the cervical smears of women in Leicester. Over a 10-year period a few women developed cervical cancer despite having had regular smears, and in some of these, with the benefit of hindsight, it was thought the abnormalities were missed first time around. The tabloids raised their customary indignant cry of 'scandal' and 'blunders'. As a percentage of the tens of thousands of smears screened in this period the number of serious misses was very small, probably close to the irreducible minimum of false negatives found in screening programmes of this type anywhere in the world. And in the meantime, how many women had their lives saved by this screening programme? We don't know, but they undoubtedly greatly outnumber those whose smear abnormalities were not recognised for what they were. We're not saying that the current screening programmes are perfect, but they *are* subject to more scrutiny, audit and continuous improvement than almost any other aspect of healthcare, and stand comparison with similar schemes anywhere in the world.

Does all this matter? If we were just asking everyone to be nicer to doctors, then perhaps it wouldn't, but we now find ourselves in a situation in which public expectations of the health service, based on the sort of misunderstanding outlined above and fuelled by unrealistic government targets and promises, exceed our capacity to deliver. Sadly, it's about to get worse, and this is where we begin to see why the openness demanded by the Bristol enquiry may not be as easy to deliver as everyone imagines. In the aftermath of the Leicester cervical smear shock/horror, Julietta Patnick, National Co-ordinator for Cancer Screening Programmes, decreed that every woman who develops an interval breast cancer (a tumour arising after one normal screening mammogram, and before the next is due) must be given the results of the internal audit of her old x-rays. Although

such an audit is always carried out as part of the continuous learning and quality assurance process, the results are currently only made available to patients on request. As we have seen, this audit will frequently reveal that an abnormality was seen on the previous mammogram, but was thought at the time to be non-malignant. In very few of these instances will there have been any negligence on the part of screening personnel, but the unfortunate patient or her relatives have only two options; to accept the explanation given, or to sue. It is therefore likely that a radiologist working in the screening programme, despite providing a high quality service and meeting all his or her performance targets, will be taken to court every one or two years for 'missing' cancers which were actually not missed at all.

We sympathise with the Bristol enquiry's demand that we should be open and honest with patients, and none of us can object to being taken to task for genuine negligence. However, if the outcome of such honesty is the undeserved villification of workers whose performance has been beyond reproach, the movement for more transparency in medicine is likely to be stillborn. The government, which has recently extended the breast screening programme to the over 65s despite warnings that there are too few staff to deliver the current level of service, must stop raising public expectations by promising the impossible. They must also take the lead in establishing a no-blame culture for the discussion of perceived medical errors. Failure to act now will result in medical practice becoming increasingly defensive, which will engender more, not less, secrecy. If the demand for perfection in medical services continues, the result may eventually be no service at all, and in the case of breast and cervical screening, it is already becoming difficult or impossible to find radiologists and cytologists willing to put their heads above the parapet and get involved in this demanding and thankless work. As a result, collapse of the current excellent programmes is becoming a very real possibility.

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