departments with non-urgent complaints, claiming that they cannot find a general practitioner. But the figures cannot tell us whether the care used could be better or should be different. At least there are a lot of data on the efficiency with which patients are dealt with by their doctors in surgeries and hospitals. Those who have made such operational analyses find that many clinicians are hard to convince and continue their old ways even when they have been shown to be inefficient.

In the end, it is the individual who decides when he is a patient. Granted that the decision is forced upon him by any obvious disaster such as a stroke or an acute abdomen. But the sociologists are right in saying that there is a wide spectrum of human distress that may or may not prompt the person to seek a doctor. The individual's decision is an amalgam of his own concepts of disease, of the availability of medical aid and of his anticipation of relief. Given that muddle of feelings, it is difficult to lay down criteria for a necessary visit to a doctor. It cannot be the presence of a disease entity, a formal diagnosis used as a badge of respectability. Every general practitioner spends his time with unsorted psychosomatic problems. The skills needed to handle these are as hard to acquire as any technical manoeuvre. In a sense, each decision to see a doctor is self-justifying. The climate of public opinion may well play a large part in such decisions, so there is an obvious role for health education to inform people what medicine can do and where it is inappropriate and that the Health Service is not obliged to provide instant contentment for all.

**Mistakes in Medicine**

My thesis is that most mistakes in medicine are due not to ignorance but to failure of communication or carelessness.

In the past couple of decades there has been an immense upsurge in postgraduate medical education. Most hospital centres in this country now have their postgraduate centres and tutors and all the regions have their postgraduate Deans, men who have achieved real distinction in their clinical fields before they turn, usually part time, to teaching. There are innumerable courses, meetings and conferences, many of them financed by drug companies, but none the worse for that.

There can be only one reason for this activity, the same as for all medical education, the improvement of medical practice—the improvement in results and the reduction of fault and failure. Is this happening?

It is partly to answer this question that the Medical Services Study Group was created. The Group is concerned with results, with outcome rather than process. How do avoidable errors occur, what is their cause and how can they be prevented? This has been the philosophy of the highly successful Confidential Enquiry into Maternal Deaths. I am not trying to anticipate the findings of the MSSG which, in any case, deals with only a fraction of the problem. I merely speak from observation of medical failings in my own and other departments. From that observation I am in no doubt why most errors happen—they are due to failure of communication and carelessness, rarely to ignorance. Every doctor must have committed errors and seen others do the same. The incomplete, because hurriedly taken, history with the too-quickly reached conclusion whose refutation has been brushed aside, the corners cut in the physical examination—the rectal examination not done, the fundi and eardrums not examined and the urine not tested—these are common events. They spring from necessity; it is only novice medical students and perhaps some American university physicians who have time for a two-hour history taking and physical examination. The rest of us are always in a hurry and we never work under ideal conditions. But, if errors are understandable, that does not excuse them nor reassure their victims. It is still a cardinal error not to test the urine of a patient complaining of thirst. Yet in 12 of 15 consecutive admissions in ketoacidosis to King's College Hospital of previously undiagnosed diabetics the urine had not previously been tested, although the patients had consulted their doctors on 41 occasions. All had complained of thirst yet the simplest of tests had not once been done. The fault here is carelessness, disastrous carelessness, not ignorance.

Ignorance is seldom disastrous. If you come across a finding you do not understand—a rash, a lump, a murmur—you consult someone who does. But to find these signs you must first look, feel and listen.

Failure of communication, by which I mean simply the transfer of information from one mind to another, is even harder to eradicate than carelessness. The sheer circulation of paper, each piece (presumably) bearing information of importance, is now so great, especially in hospital, that it is perhaps hardly surprising that some are wrongly labelled or filed, or lost, or not read—but the error may be fatal. A young colleague recently had a chest X-ray which showed pulmonary tuberculosis. But his name on the form was wrongly written, the occupational health service could not trace him and he remained undiagnosed until, three months later and now with symptoms, he took himself along for another X-ray. In the last year I have seen four patients, who had recently been in-patients for other reasons, in whom an SMA 12 had shown a high blood glucose but, being unexpected and therefore unlooked for, the result had not been noticed.

Sheer ignorance, except in the increasingly important field of drug treatment, is seldom a cause of medical error but carelessness and communication failure frequently are. They can be prevented or diminished only by constant professional self-scrutiny.

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