

To err is human: learning from mistakes

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The public is increasingly restive and anxious about the almost daily reports of medical disasters. Our traditional defence that these reports are grossly exaggerated is undermined by the frequency (and glee) with which they are reported, and the even more sober analyses which point to the large numbers of errors in treatment, most of which, by good fortune, result in little or no harm. The usual reaction to near misses or minor error is relief and little else, while defensiveness, internalisation and even denial are common initial responses to more obviously damaging errors. Fear of litigation, disciplinary action and lowered esteem in the eyes of colleagues do little to encourage a spirit of openness. The result is that we learn little from our mistakes, which continue to be repeated. How are we to change this pervasive defensive culture so that we may reduce the potential to repeat the errors of our ways?

An expert group was set up by the Chief Medical Officer to examine the extent to which the NHS has the capacity to learn from adverse ‘incidents’ and to recommend steps to avoid them¹. The report is strong on analysis of the problems and although it inevitably falls short on solutions, it is a welcome step in the right direction. A number of important, if self-evident, points are made. Severe events are fortunately rare and not the tips of icebergs that they are often portrayed as, but less severe incidents are very common. Errors are most often the result of a combination of human and organisational failures, and while it may be human to err, organisations could do something to ensure that the opportunities for error are minimised. In a report from the United States entitled *To err is human*² the point is made that it is more important to examine the circumstances in which an incident occurred rather than who committed the error. Inattention, forgetfulness, carelessness, distraction and fatigue are commonly cited contributory factors. These, combined with the pace and pressure of clinical practice, much of which involves procedures and treatments which are far from risk free, in patients who are of poor risk, all point to the need for a system of ‘error management’ and compensatory mechanisms to be set up within organisations.

While preventing repetition of serious accidents is clearly important, lowering the incidence of less serious but much more frequent events is at least equally important. The authors accept that errors

can never be entirely eliminated. For example, they calculate that, in an imaginary 600 bed hospital with a 99.9% error free drug ordering, dispensing and administration system 4,000 drug errors would occur per annum. Nevertheless, it is suggested that 70% of adverse events are preventable, so that the dividends to be gained in terms of relief of human suffering and costs to the NHS are potentially enormous.

Despite the attention given to risk management and avoidance of adverse incidents in other fields of endeavour, and despite the enormous literature on the subject, the NHS has clearly lagged behind. Reporting of adverse events has been haphazard and there is no reliable, systematic way of identifying lapses, analysing them and learning from them. Competition, which was so much part of the internal market, drove reporting even further underground.

How then to introduce the necessary cultural change? Heavy emphasis is laid on organisational systems. Clinical governance locally, working within national guidance provided through national service frameworks, NICE, performance assessment, professional standards and guidelines prepared by colleges and specialist societies should provide the necessary framework. The accent, it is suggested, should be on a continuous process of monitoring, rather than short-term responses to specific events. This is to be applauded of course, but requires a considerable cultural change across the whole organisation.

The changes required are critically dependent on full, open reporting of adverse events and ‘near misses’. While reaction to such incidents continues to include ‘naming and shaming’ coupled to punitive disciplinary action, little will be achieved in the prevention of similar events in the future. Indeed it is likely to drive out the prospect of future reporting, and hence the possibility of prevention. Those seeking revenge may find this approach managerially and legally attractive, but it will not help future patients and will not raise standards.

Heinous crimes will no doubt be detected in the end and punishment meted out where necessary, but the much larger numbers of daily human errors will remain hidden and therefore repeated. The trick will be to persuade clinicians that they will be helped and supported if they report adverse events, whether they are at fault or not. However, this will be no easy task in this litigation prone age. ‘Whistle blowing’,