"Mistakes are a fact of life. It's the response to the error that counts".

– Nikki Giovanni (American poet, 1943)

Alexander Pope's famous words, “To err is human, to forgive divine”, apt in most situations do not seem quite appropriate while dealing with medical errors. Forgiveness suggests that there has been the committing of sin, and this is inextricably linked to fault and blame.[1]

Patient safety traverses all medical specialties and affects every health-care professional. The attention to medical errors and adverse events and the resultant literature have grown exponentially over the past decade. A number of practicing physicians, however, remain unaware of the extent of the problem, the impact on patients, and the burden on the health-care system. Many are unfamiliar with strategies to reduce the risk of harm.[2]

When patients suffer harm, most providers of healthcare are ill prepared to respond. Abandonment of care providers and patients is common.[3] The tendency to “shame and blame” often perpetuates the “wall of silence”[4] between providers and patients.[5]

It was in response to this unsatisfactory situation that the “Patient Safety Movement” was founded, guided by the nonjudgmental recognition of the ubiquity of human and system errors. By understanding that error—particularly human error—is inevitable but still largely preventable, patient safety efforts focus on improving systems, creating fail-safe mechanisms that intercept error before it reaches the bedside, and on implementing measures that mitigate harm when an error involves the patient.[1]

EXPLANATORY MODELS OF HUMAN ERROR

There are two explanatory models of causation of human error: the person approach and the system approach. The person approach focuses on the errors of individuals, and is apt to accuse them of forgetfulness, inattention or moral failure. Followers of these approaches tend to treat errors as moral issues, assuming that bad things happen to bad people—what psychologists have called the “just-world hypothesis”.[6]

The basic premise in the system approach is that humans are fallible, and errors are to be expected, even in the best organizations. Errors are seen as consequences rather than causes. These include recurrent error traps in the workplace and the organizational processes that give rise to them. The system approach identifies the conditions and systems under which individuals work, as the source of the error, with the aim of both understanding the origins of error and building defenses to avert errors or to mitigate their effects.[6]

The system approach acknowledges that the majority of clinical errors do not result from individual recklessness or the actions of a particular group.[7] The most common systems deficiencies identified as underlying clinical errors are failures in dissemination of drug knowledge or its updating, and inadequate availability of patient information such as test results necessary for safe treatment.[8]

DETECTION OF MEDICAL ERRORS AND ADVERSE EVENTS

Difficulty in identifying medical errors and adverse events creates a significant barrier to assessing risk reduction strategies. In the absence of an accurate, reliable methodology to measure errors and events, the ability to assess the impact of patient safety initiatives remains challenging.

Historically, identification of medical errors and adverse
events relied on incident reports, a methodology that has many pitfalls. If an error or adverse event is identified, staff may assume, mistakenly, that someone else will report it. Personnel who do report events often receive no feedback, which serves as a disincentive for reporting subsequent events. Staff may have valid apprehensions about reporting errors and adverse events. There is a natural hesitancy to point out one’s own mistakes for fear of being labeled incompetent and a reluctance to point out others’ mistakes for fear of being labeled a whistleblower, a sensationalist or an adversarial professional.

Trust is a key element of a reporting culture, and this, in turn, requires the existence of a just culture—one possessing a collective understanding of where the line should be drawn between blameless and blameworthy actions. There is a need to carefully distinguish between human error (e.g., slips), at-risk behavior (e.g., taking shortcuts), and reckless behavior (e.g., ignoring required safety steps). Engineering a just culture is an essential early step in creating a safe culture. However, staff may still worry about disciplinary actions by their institutions or licensing organizations. Fear of litigation also remains a major deterrent.

DISCLOSURE

Patients and families often know when they have experienced an adverse event. They may observe worsening of clinical status, the need to perform additional testing, or adjustments made to treatments. They may perceive a change in the behavior of the physician or other staff. They may overhear conversations between staff members. Patients and families want to be told when an error has occurred. They want to know what happened, why it happened, how it will affect their health and the measures being taken to minimize the impact, and what is being done to prevent such an error from recurring.

Informing patients and families when medical errors cause harm is the right thing to do, but despite physicians’ best intentions, full disclosure of such events is uncommon. Practitioners often fear that such disclosure may result in litigation, loss of trust by the patient and family, or the tarnishing of their professional reputation.

Full disclosure is a process, not an event. Communicating the details of a patient safety incident involves a series of meetings. In most cases, the responsible care provider leads the disclosure and delivers the apology if an apology is indicated. The process of apology may be guided by Gallagher and Quinn’s “balance beam”, which considers the facts of the case and may ultimately involve an apology, admission of unreasonable care and accountability. This approach guides the timing and content of the disclosure discussions and “balances” the benefit of early disclosure against the risk of prematurely disclosing information and conclusions that may later turn out to be incorrect.

Health-care professionals must overcome the instinct to ignore, to hide, to deny, to “choose words carefully” or present a positive “spin” when an adverse event occurs. Hospitals, insurers, and lawyers frequently advise physicians against using trigger words, such as “error”, “harm”, “negligence”, “fault”, or “mistake”. The result can be an impersonal demeanor which leads patients to view physicians as uncaring. Disclosure relieves the anxiety of not knowing and reaffirms an open, honest physician–patient–family relationship. Such transparency has been demonstrated to decrease litigation as well as the average settlement amount for claims that are filed.

Patients and families also want an apology. An apology historically has been viewed as an admission of guilt, and for this reason, practitioners are often reluctant to say “I’m sorry”. However, this omission is perceived as cold, heartless, and impersonal by patients and families. They correctly feel angry and distanced, which is toxic to the physician–patient–family relationship and actually may increase the likelihood of litigation. The importance of an apology and the unwillingness by physicians to provide one due to fear of litigation has resulted in legislative changes. In the United States, some states have enacted statutes that prevent an apology from being used against a physician in a lawsuit. However, the impact, effectiveness, and protection afforded by these recent statutes have yet to be established.

Patients and families have their own fears: fear of retribution and/or of future poor treatment. On account of the power dynamics between physicians and patients, questioning the expertise or skill of an authority figure is particularly fraught with apprehensions for the least empowered. More strikingly, some patients and family members are afraid that confronting medical personnel might lead to further injury. Given the nature of the emotions provoked by medical error, feelings of isolation can be particularly harmful. Family members of injured patients told us, “What we needed was for someone to reach out and connect with us in human terms. The sense that somebody could empathize and know what I was feeling. That was almost totally lacking.”

THE SECOND VICTIM

Although patients are the primary and most visible victims of medical errors and adverse events, it is important to remember the “second victims”: the clinicians. The emotional impact of medical errors on health-care personnel, especially those errors that cause harm to patients, should not be underestimated. In many cases, more than one clinician is involved and may feel responsible. Resultant feelings of guilt, anxiety, ineptitude or lowered confidence...
can be devastating, leading to inappropriate behaviors such as lashing out at patients, families, and colleagues and to unhealthy behaviors such as substance abuse. Distress escalates in the face of a malpractice suit. Clinicians who feel guilty after a medical error may have parallel feelings of fear—fear for their reputation, their job, their license, and their own future as well as that of their patient.

Medical errors are too often a taboo subject. They haunt the conscience of those involved and medical personnel naturally find them difficult to discuss.\textsuperscript{[13,14]} Health-care professionals must be supportive and nonjudgmental of their colleagues when medical errors occur. Disclosing one’s own experience of mistakes can reduce the colleague’s sense of isolation. It is helpful to ask about and acknowledge the emotional impact of the mistake and ask how the colleague is coping.\textsuperscript{[12]} Debriefing sessions can provide a therapeutic venue to discuss not only the medical aspects of the event, but also the emotional issues as they relate to the clinicians involved.\textsuperscript{[12]}

Strangely, there is no place for mistakes in modern medicine. Society has entrusted physicians with the burden of understanding and dealing with illness.\textsuperscript{[15]} Although it is often said that “doctors are only human”, technological wonders, the apparent precision of laboratory tests, and innovations that present tangible images of illness have in fact created an expectation of perfection. Patients, who have an understandable need to consider their doctors infallible, have colluded with doctors to deny the existence of error.\textsuperscript{[12]}

Hospitals react to every error as an anomaly, for which the solution is to ferret out and blame an individual, with a promise that “it will never happen again”.\textsuperscript{[12]} Paradoxically, this approach has diverted attention from the kind of systematic improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. Also, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.\textsuperscript{[13]}

RESPONSE TO ERROR

The ideal response is to think of error as a systems failure rather than an individual failing.\textsuperscript{[8]} This could be the starting point for redesigning the system and reducing error.

The tactics with which this can be done are:\textsuperscript{[15]} (i) reduce complexity, (ii) optimize information processing, i.e., checklists, reminders, protocols, (iii) automate wisely and (iv) mitigate the unwanted side effects of change.

The building of a safe health-care system rests on the belief that safety is everyone’s business. The top management (in the case of a hospital) or the individual practitioner needs to accept setbacks and anticipate errors, review past events and implement changes and concentrate on fixing the system rather than the individual in case of an error.\textsuperscript{[15]} There is a need to be proactive and seek out error traps, eliminate error producing factors and brainstorm new scenarios of failure.\textsuperscript{[6]}

This can occur if safety related information is easily accessible to all levels of the staff, all clinic and hospital staff meet regularly on safety issues, messengers are rewarded, and there is a just and reporting culture, with qualified indemnity and confidentiality and disciplinary systems agree between acceptable and unacceptable behaviors.\textsuperscript{[15]}

The existence of protocols written by those doing the job, which are intelligible and workable, coupled with training in recognition and recovery of errors, and most importantly, feedback on recurrent error patterns help mitigate errors.

When mishaps occur, the decency to acknowledge responsibility, apologize, and convince patients and victims that lessons learned will reduce chance of recurrence is of essence.\textsuperscript{[15]}

Once we accept the premise “To err is human…”, we also concede that “zero error” and “zero tolerance” to error are both unattainable goals. What can certainly be done, however, is to minimize the disastrous consequences by regular clinical audits, and a shift of emphasis from blame to learning, from individuals to system and from fault finding to fact finding. Above all, an environment and culture must be created where it is safe to admit ‘I made an “honest error”, let me learn if I can prevent it from happening again’, and for the organization to revamp the system which led to the error, without the specter of blame and shame looming large.\textsuperscript{[16]} Finally, it is time we remembered that the patience of the public we serve is already wearing thin. They are asking us to promise something reasonable, but more than we have ever promised before: that they will not be harmed by the care that is supposed to help them. We owe them nothing less, and that debt is now due.\textsuperscript{[17]}

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