To Err is Human

By Dr Daniel Fung, Deputy Editor

Christmas is a time for reflecting on the year that has gone by. It is a season when we think about our families and our colleagues. It is a time of giving, not just gifts and presents, but giving thought for the future so that we can make resolutions in the New Year.

I am attending a conference on healthcare improvement here in Orlando Florida. It is the first time I am spending the Christmas season away from home – usually, I take leave and spend time with my family. But how can I refuse the chance to visit Disneyworld during Christmas?

In 1999, the Institute of Medicine here in the United States of America, published a landmark article called "To Err is Human." In it, it describes how doctors, through medical errors, cause death and harm, instead of the old adage of Primum non nocere (First do no harm). The press picked up on this and it was widely reported in the news. In fact, someone remarked to me as I was preparing to go for the conference: "Why learn from the Americans? They have killed millions of patients, and they have the audacity to teach others?"

But, at least the Americans can admit to medical errors. Can we?

The Institute of Healthcare Improvement is led by a charismatic paediatrician, Donald Berwick. In his plenary lecture, he announced a campaign to save 100,000 lives by 2006 through six initiatives to reduce medical error. (See side box.) It was an audacious claim and the cynical (like Salma Khalik) may ask: "You mean you have been killing so many till now?"

But I am impressed by the way the Americans have gone about admitting to errors. Part of their committees' work – looking at quality improvements – invariably involve parents of victims of medical errors. If only our doctors were

WHAT ARE THE 6 INITIATIVES TO REDUCE MEDICAL ERRORS?

- **Deploy Rapid Response Teams** at the first sign of patient decline.
- **Deliver reliable evidence-based care for Acute Myocardial Infarction** to prevent deaths from heart attack.
- **Prevent adverse drug events** by implementing medication reconciliation (meaning that wrong medications are not administered during transition of patients across departments or hospitals, or during discharge).
- Prevention of Central Line Infections by implementing a series of interdependent and scientifically grounded steps (called the central line bundle which has five components: hand hygiene, maximal barrier precautions, chlorhexidine skin antisepsis, appropriate catheter site and administration care and no routine replacement).
- **Prevent surgical site infections** by reliably delivering the correct perioperative antibiotics at the proper time.
- **Prevent ventilator associated pneumonia** by implementing a series of interdependent and scientifically grounded steps (called the ventilator bundle which has five components: elevation of the head of the bed to at least 30 degrees, sedation vacations, daily assessment of readiness to extubate, peptic ulcer disease prophylaxis and deep vein thrombosis prophylaxis).

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About the author:

Dr Daniel Fung is married to Joyce, and sometimes, to his work. Fortunately, Joyce has kept his feet on the ground by sharing with him five wonderful children who are a constant reminder for his work as a child psychiatrist. Being rather absent-minded and full of errors, Daniel relies heavily on a quality management tool called the personal digital assistant.

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willing to admit to this. For surely, it is not possible that we do not make errors. And when we do, how can we learn and improve from them? Our main problem is that despite our tracking errors, we also have a blame culture. We like to point fingers or ask the question whenever something goes wrong: "Who is responsible?" So over time, doctors and their co-workers (nurses and other allied health professionals), learn to keep quiet if nothing goes wrong even when a mistake is done. The concept of near misses becomes one of "near *kenna*". Suppose a nurse were to give a wrong medication or a doctor were to prescribe a wrong dose of medication – if nothing happens, do we go on to find out why the error occurred in the first place? There is always a fear that sharing will result in medico-legal implications. Instead of trying to understand why errors occur and the problem in the system that makes it so, we choose to blame the "perpetrator".

There is no better impetus for change than when you start to experience the potential for error. I was recently struck with a bad backache which had persisted for several weeks. Paracetamol did little to contain the agony and it was hard to get out of bed in the morning. I went to our sick staff clinic to see the doctor. The medical officer on call asked me some questions with patience and diligence – she was obviously concerned (I hope not because I was a consultant) and suggested some investigations. She ordered bloods to be taken and also a urine microscopic examination. She also ordered an X-ray of the lumbar spine. The nurse passed me a bottle for urine collection and I diligently collected it and returned the bottle to her. When I was at the X-ray department, I received a note that asked me for another sample of urine as they had used the wrong bottle. The X-rays were done but when it was being reported, the radiologist could not make any comments as only one view was taken (despite the order being two views). These were minor errors that only resulted in me needing to spend more time with the X-ray and pass out a little more urine, but it also struck me that something that was so routine could have so many loopholes.

I think this Christmas, we should seriously think about how we can focus on our patients and make sure that we prevent medical errors from happening. If we drive a car which breaks down once in 10 days, are we likely to drive it? It is likely we will never buy that car again. Or what about flying an airline which crashes the plane every one hundred flights? Would you dare take it? What is the rate of an a dverse event occurring in Singapore that is related to medical errors? I think when it comes to lives being affected, even one is too many. ■