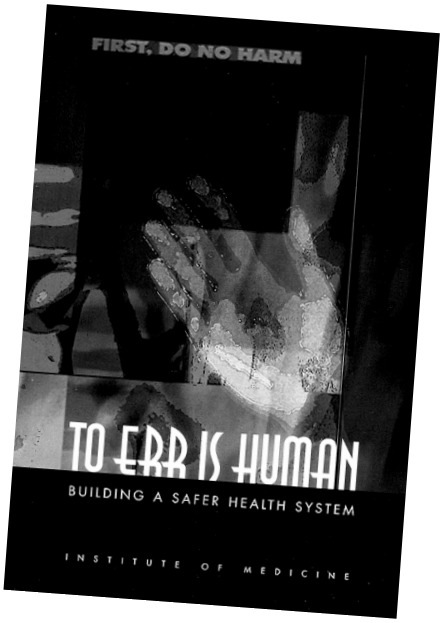
# To Err is Human

*By Prof Chee Yam Cheng*




**Identifying errors is important for learning. Preventing errors means designing the health care system at all levels to make it safer. Building safety into processes of care is a more effective way to reduce error than blaming individuals.**

To Err is Human is a 287 page book authored by the Institute of Medicine (IOM) and published by the National Academy Press in year 2000. The IOM operates under a charter granted by the US Congress. The book is a report from the Quality of Health Care in America project committee investigating why some 98,000 people die in any given year from hospital medical errors which is more deaths than from motor vehicle accidents, breast cancer or AIDS. Caring health care professionals do make honest mistakes but the book sets out to recommend ways to reduce medical errors and improve patient safety through the design of a safer health system. To err is human but make it difficult to err. The problem is not bad people in health care. It is that good people are working in systems that need to be made safer.

Patient safety is a critical component of quality care. Safety is defined as freedom from accidental injury. Error is defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors depend on two kinds of failures – error of execution or error of planning. Errors can happen in all stages in the process of care, from diagnosis, to treatment, to preventive care. Not all errors result in harm. Errors resulting in injury are called preventable adverse events. An adverse event is an injury resulting from a medical intervention. In other words, it is not due to the underlying condition of the patient.

While all adverse events result from medical management, not all are preventable (i.e. not all are attributable to errors). For example post-operative pneumonia is an adverse event. But it is nobody's fault unless it is proved that the surgeon had poor hand washing technique or the instruments used were not properly sterilised.

Identifying errors is important for learning. Preventing errors means designing the health care system at all levels to make it safer. Building safety into processes of care is a more effective way to reduce error than blaming individuals. The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system.

This is what the whole book is about and there are many recommendations directed at Congress, e.g. to set up a Centre for Patient Safety, to pass legislation to extend peer review protection to data related to patient safety and quality improvement. The individual is not spared either. Individuals cannot be careless. They must still be vigilant and responsible for their actions. Health professional licensing bodies should implement periodic re-examination and re-licensing of doctors, nurses and other key providers based on competence and knowledge of safety practices and to work with certifying and credentialling organisations to develop more effective methods to identify unsafe providers and take action.

What the book is not about are the following three issues. It is not about how to improve the intrinsic motivation of health care providers even though this is recognised as a major force for improving patient safety. Second, it is not about workers safety although a safe environment will improve both patient and worker safety. Procedures for avoiding needle sticks or limiting long work hours aimed at protecting workers can also protect patients. Third it is not about access to care. Safe care is an important part of quality care. When someone needs medical care, the worst quality is no care at all.

The book is divided into 8 chapters. It makes easy reading. Each chapter has specific recommendations in bold print and numbered for easy reference and each chapter has good references to medical literature. Granted, the target is the American readers who are federal, state and local health policy makers and regulators, (which is different from Singapore), but when the target also includes health professional licensing authorities, hospital administrators, medical educators and students, health care givers, health journalists and patients advocates, as well as patients themselves, we are all included.

First do no harm but to err is human. So how do we resolve these two apparently contradictory cliches? I suggest you read the book. ■

*Editorial Note: This book can be purchased online at http://www.nap.edu at US$29.60.*