A cultural shift in the approach to medical errors: How much have we progressed?

Errors continue being very common in medical practice and even when their consequences seem to be mild, they frequently lead to serious adverse events, including death. Data from several developed countries show that 7-12% of hospitalized patients have an adverse event as a consequence of an error. It is very likely that a similar or even worse situation occurs in countries like Argentina, with fewer resources and not so efficient health systems. It has been shown that deaths occurring each year from mistakes in patients' care are higher than those caused by any other human situation, including traffic accidents, cancer, and high-risk activities.

Thanks to the publication of the studies conducted by Dr. Leape, et al. from Harvard University (*N Engl J Med* 1991;324:370-6 and 377-84), the world has become aware of the magnitude and serious consequences of errors occurring in relation to the care provided to patients hospitalized in the United States. These studies led to the birth of a new era in medicine, and a new paradigm was developing, which was destined to change the history of approaching error by replacing the traditional approach by another one completely different. The typical approach to errors made in patients' care is mainly based on hiding the error, punishing those who make a mistake, and focusing exclusively on the individual. With the implementation of strategies targeted at preventing errors or at reducing their number and severity, a different and honest culture focused on facing the problem has slowly emerged, resulting in a significant improvement.

However, there is a widespread agreement among all countries that the expectations brought forth at the end of the 1990s and at the beginning of this century these expectations have only been partially met and that there is still much more to be done. There is also an agreement that the main hurdle to greater advances is the resistance to changing the traditional disgraceful culture that has caused so much damage. The persistent reluctance to disclose medical errors and the little critical attitude, especially among medical doctors, are two of the main reasons for the high prevalence of errors since the fact that we only learn from errors is being overlooked. Karl Popper wisely pointed out: "They may teach him (the individual man) how to learn from his mistakes, and how to search for them. These standards may help him to discover how little he knows (...) and to adopt a more critical attitude." (McIntyre N, Popper K. The critical attitude in medicine: the need for a new ethics. *BMJ* 1983;287:1919-23).

In schools of medicine and in residency or fellowship training, there is a tendency to avoid treating errors in an honest manner; on the contrary, it is assumed that skillful doctors make no mistakes by placing a significant emphasis on perfection. There is no doubt that the "aura" of infallibility in medical practice is false because, as all human beings, we will inevitably make mistakes no matter what our skills are.

The concept of "The Culture of Safety" arose from several other disciplines much earlier than in medicine, being aviation the most remarkable one, with a marked reduction in the accident rate in the last 40 years. Commercial aviation is very safe, with approximately 15,000,000 take-offs and landings per year and an annual average of four serious accidents.

Organizations that have succeeded in establishing a strong culture of safety are known as "high reliability organizations" and they are constantly reducing adverse events in spite of carrying out extremely complex and dangerous activities. Such organizations are committed to safety at all levels, from first-line providers to managers, executives and directors. Unfortunately, this concept is not yet applied as frequently as it should in public and private healthcare facilities. In order to achieve a culture of safety in medical care, at least the following conditions should take place: to be aware of the high risk entailed in the activities performed, to establish safe and consistent strategies, to work in a guilt-free environment where individuals are capable of reporting errors or quasi-errors without the fear of being punished or reprimanded, to foster collaboration between members by setting up groups aimed at finding solutions in error prevention and reduction, to involve the institution and the State so that they provide the necessary resources to face safety issues.

The underlying reasons that prevent or hinder a change in the culture of healthcare are complex, and the lack of a guilt-free environment, scarce team work with adequate communication, and a null or insufficient commitment from leaders and directors with the implementation of a safety cul-

ture prevail. The sustained improvement in the provision of a safe patient care requires a sound and unavoidable commitment of the entire organization towards the culture of safety (Reason J. Human error: Models and Management. *BMJ* 2000;320:768-770)

The person-based approach to medical error is still prevalent and the most widespread "tradition." It is assumed that errors are exclusively the product of one person and when something goes wrong, it is considered obvious that an individual has made a mistake and therefore is the one to be blamed. The message being conveyed is important because, for most people, having someone to put the blame on would be emotionally preferable than feeling that we work in an unsafe environment where everyone is exposed to making mistakes ("out of sight, out of mind"). In addition, firing the healthcare professional who made the mistake from the healthcare facility is undoubtedly the main objective of any manager because it is assumed that it is the best approach from a legal standpoint.

Such humiliating model is the one that, to a greater or lesser degree, is the predominating culture of most health care organizations, at least in Argentina. It is regrettable that the currently available evidence is ignored; most errors are the result of inadequate or non-existent systems and consequently, the approach to error should mainly be based on the system instead of the person. In essence, human nature cannot be changed, so why not change human working conditions instead, and build systems with defensive barriers and prevent errors from reaching patients. When an error occurs, instead of looking for someone to blame, we should find out how and why these defensive barriers have failed.

At present, in an attempt to change the punishment model and reconcile individual needs of "no guilt", a "just and fair culture" model is currently being developed, focusing on identifying and approaching system weaknesses that lead individuals to making mistakes, but also on claiming for individual responsibility with a zero tolerance policy with respect to careless or irresponsible behavior. In such culture, the response to an error is based on the behavior of the person who made the mistake, not on the seriousness of the event. There is neither punishment nor guilt; however, a warning is given as soon as the inappropriate action is identified, and if it occurred again, this could lead to taking more serious measures.

Finally, I would like to point out a new strategy that entails a remarkable cultural change and that is partnering with patients in order to improve their safety. This initiative (Partnership for Patients) has recently been launched in USA and it requires, as I pointed out in relation to the other conditions necessary for a cultural change to take place, to bring together all stakeholders, such as hospital leaders, healthcare professionals and staff, as well as National and Provincial governments. Patients should be encouraged to take responsibility for their own care and adequate information should be provided to prevent errors and consequently improve healthcare safety. This will translate into major benefits, both for patients and doctors and nurses, who will modify the habit of acting on their own and having an inadequate communication with patients. If patients are considered "partners", communication will remarkably improve.

Little progress has been made in relation to the change of culture when dealing with a medical error; but we, physicians, can do a lot to change the course of events by understanding that we have to reduce our patients' risks learning from our mistakes and preventing them from occurring again. If this were not the case, we would then be part of the group so well defined by Cicero over 2000 years ago: *"Any man can make mistakes, but only fools persists in his error."*

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