

Ending the blame game key to overcoming medical error

Whose fault was this? That's usually the first question asked when a medical error occurs, but international experts who gathered in Halifax in August say physicians must start asking better ones if they want to get useful answers. They say finger-pointing leads to secrecy and cover-ups, not to the solutions that could prevent future errors.

Instead of trying to apportion blame, they advocate a "culture of openness" in which errors are reported and then dissected to reveal underlying causes so that future mistakes can be prevented. This approach has worked in the aviation industry, where error reporting has reduced crash rates.

So why doesn't medicine take the same step? A major reason is the potential for litigation. Dr. William Beilby, director of research and education at the Canadian Medical Protective Association, told the 140 people attending the symposium that people reveal medical errors at their legal peril because "there is no privilege (exemption from legal action) following disclosure.

But Dr. Philip Hébert, director of clinical ethics at Toronto's Sunnybrook Health Science Centre, said physicians have an ethical responsibility to disclose errors so that everyone can learn from them: "We need new [legal] ways of handling this." (The CMA does not address the disclosure-of-error issue in its Code of Ethics.)

While Canadians debate the issue,

Australia and the United Kingdom are both instituting programs that allow privileged disclosure of incidents.

Australia recently passed legislation allowing physicians to make privileged disclosures. Through the Australian Incident Monitoring Study (AIMS) (www.apsf.net.au/products.html), health care workers in many states are voluntarily and anonymously reporting incidents and accidents. This "culture of safety" is essential to allay staff fears of reprisals, says Dr. John Vinen of the Australian Patient Safety Foundation. New Zealand is also trying out AIMS.

In the UK, meanwhile, a mandatory no-name, no-blame national system for reporting "failures, mistakes and near misses" (www.doh.gov.uk/buildsafeness/) should be implemented by the newly formed National Patient Safety Agency by the end of 2002. It aims to reduce the number of serious prescribing errors by 40% by 2005.

In the US, the Joint Commission on Accreditation of Health Care Organizations, which monitors 5000 US hospitals, told members that mistakes that cause harm must be disclosed to patients or they risk losing their accreditation.

In Canada, the extent of error will be measured for the first time in a study now being commissioned by the Canadian Institute for Health Information and the Canadian Institutes of Health Research. Symposium organizer Dr. Pat Croskerry says Canada desperately



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Dr. John Vinen: culture of safety needed to allay fear of reprisal

needs research in this field, but it also needs to "galvanize" governments and professional organizations to act together. Croskerry, Halifax's regional head of emergency medicine, is forming a Canadian patient-safety foundation.

Today, the study of medical error is evolving rapidly, because of the complexity and stress of medicine. "Harm to patients is often a result of a long series of events," said Dr. Charles Vincent, a professor of psychology in the UK who edited *Clinical Risk Management: Enhancing Patient Safety* (see review in *CMAJ* 2001;164(11):1727-30), "and individual error may play only a small part."

He identified 7 factors involved in any analysis of risk and safety in medicine: the patient, task, team, work environment, organization, management and institutional context.

He advocates a systemic approach that acknowledges that human beings are fallible and that errors are to be expected, and then looks at a range of interventions. "Eliminating harm is the objective," he says, "not eliminating error."

According to Hébert, "the biggest moral error is [failing] to learn from an error. If we can learn, we can at least right some of the wrong." — *Barbara Sibbald, CMAJ*

US agencies policing Internet for health care fraud

Suspicious about a health claim you've seen on the Internet? The US Federal Trade Commission (FTC) and the Food and Drug Administration (FDA) want to hear about it. The FDA has already checked more than 3000 tips submitted by consumers since January 2000; the complaint form is available at www.ftc.gov.

In complaints made so far, respondents say they were told to cancel their surgery or chemotherapy in favour of expensive herbal "cures." In another case, potential customers were told that a device that delivered a mild electric current would kill "the parasites that cause diseases such as cancer and Alzheimer's."

The campaign is part of a broader effort to fight Internet-related health care fraud and misinformation; it is led by the FTC, FDA and Health Canada (see *CMAJ* 2001;165[4]:465). They say that with roughly 100 million Americans and Canadians using the Internet to find health information, the need for enforcement is becoming greater because of the medium's "broad reach, relative anonymity and ease of creating new Web sites or removing old ones." — *Patrick Sullivan, CMAJ*