

Let's talk about error

Leaders should take responsibility for mistakes [see also p. 390, 393](#)

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In the time it will take you to read this editorial, eight patients will be injured, and one will die, because of preventable medical errors. Medication error—wrong drug, wrong dose, wrong route of administration, wrong patient, or wrong time—is the most common single preventable cause of patient injury. When all sources of error are added up, the likelihood that a mishap will injure a patient in the hospital is at least 3%, and probably much higher.¹⁻⁴ This is a serious public health problem. When one considers that a typical airline handles customers' baggage at a far lower error rate than we handle the administration of drugs to patients, it is also an embarrassment.

Given the prevalence of errors in our work, and given also that one of our first principles is "first do no harm," it is strange that we talk so little in our hospitals and clinics about this problem. Perhaps it is because we tend to view most errors as human errors and attribute them to laziness, inattention, or incompetence on the part of those identified as committing the errors. As a result, when we do talk about errors—whether in morbidity and mortality conferences, doctors' lounges, or courtrooms—we seek to place blame. We blame the physician who failed to remember a patient's drug allergy, the surgeon who misplaced a stitch in a bowel anastomosis, and the nurse who failed to read the concentration of adrenaline (epinephrine) on the vial. These blaming conversations are tinged with everyone's fears—of lawsuits, of humiliation, of job loss. While we talk bravely about someone else's negligence, we privately think, "There, but for the grace of God, go I." And so clinicians prefer to talk about something else—almost anything else—than our errors.

We don't talk much about errors because deep down we believe that individual diligence should prevent errors, and so the very existence of error damages our professional self-image. While professionally heroic, this view of errors is simply wrong. Yes, some errors are due to negligence by a doctor or a nurse. But most are latent errors, or errors "waiting to happen," arising from poorly designed processes and systems of care.⁵ If the doctor who failed to remember the allergy had access to a current medical record, or to a computerized order entry system, might that information have stopped him or her from prescribing the wrong drug? Was the leaky anastomosis done after the surgeon had been working for 28 hours without sleep or in an operating room in which the nursing, anesthesia, and surgical teams were at war? When the nurse reached for the 1:10,000 vial of epinephrine during the emergency, why was the 1:1,000 concentration on the same resuscitation cart?

Overreliance on memory, denial of the overwhelming evidence linking fatigue to poor performance, "fighting in the cockpit," and placing look-alike doses of medications next to one another on a cart are classic failures of process and system design. Although the individual professional is the final pathway by which these errors happen, errors are designed into our systems and are waiting to be made, if not by you, then by the next doctor or nurse. If "attention is the currency of leadership,"⁶ all of us who have leadership roles have a responsibility to direct the attention of our fellow physicians, health care professionals, and communities to this problem and to keep attention on the problem until it is satisfactorily resolved. What would it look like if leaders were to direct attention to the issue of medical error? Health care leaders and managers would feel personally responsible for error. Rather than assigning blame to the unfortunate individuals who find themselves at the sharp end of an error, leaders would take personal responsibility for the safety of the processes and systems in which those individuals work.⁷

Our organizations would declare error reduction to be an explicit organizational goal, and a significant proportion of the board and management agenda would be devoted to achieving this goal. Reported error rates would go up for awhile because we currently underreport errors and near misses by a factor of 10.⁸ We would feel good about this increase in the number of errors because we would finally be uncovering the real extent of the problem. When errors occur, we would learn and prevent, rather than blame and hide. Our grand rounds, morbidity and mortality conferences, medical meetings, and professional journals would prominently feature experts on error reduction, process improvement, and system design. Hospitals and clinics, with our guidance and leadership, would urgently implement the best-known practices in patient safety and error reduction and begin to invent the next level of knowledge. Our patients would be injured less often, and health care costs would go down considerably.^{9,10} Leaders lead by channeling attention—it is time for health care leaders to channel attention toward our error-prone health care systems. Let's talk about it.

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