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When things go wrong

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Medical error is rarely caused by individual carelessness. Punishing health workers will do more harm than good. To minimise the risk we should build a culture for learning, not for punishment.

Photo: Sturlason

To err is human – to blame others is politics. This recently became obvious when Åshild Bruun-Gundersen, health policy spokesperson for the Progress Party, stated: 'I would now like to see that those who are involved in this come to assume a greater personal accountability for the choices they themselves have made' (1). This move came after a patient died in the emergency reception at Haukeland University Hospital after having been left there for too long without being attended to. Beforehand, however, the nurses in the department had warned the management of staff shortages on more than one hundred occasions (1). Bruun-Gundersen admits that there were too few health personnel on duty that day. On the other hand, the calls for cost-cutting and efficiency improvement are voiced exactly from the political level. To wit, the hospital director had heeded these calls and earned praise from the board chair for his 'outstanding financial management' (1).

In a study of 8 000 British doctors, more than one-half feared that they would be blamed for errors caused by work pressure and system failure (2). A Danish survey found that over the preceding year, five per cent of all doctors reported that deaths had occurred because the department had been too busy (3). A number of European studies have shown that a high occupancy rate in hospitals is associated with significantly higher mortality rates (4, 5).

Insufficient training, lack of good routines and procedures, constant interruptions and time constraints that leave too little time to adequately study the case history may cause errors to be made. Fatigue and exhaustion caused by long shifts on night duty also raise the risk (6). An emergency situation is often challenging and complex. When a patient's life is at stake, there is no time for lengthy assessment. Quick action is required, even though the basis for decisions may be uncertain. Later, when the situation can be reviewed more closely in peace and quiet, it is easy to be wise after the fact and critical of the decisions that were made.

In cases of wilful misdemeanour or gross negligence, the Health Personnel Act makes provision for penal sanctions against individuals. Such events are extremely rare, however (7). Criminalisation of health personnel is therefore not the right approach to reducing the incidence of errors. We know that hospital staff are often reluctant to report adverse events precisely because of the fear of sanctions. It is therefore important to promote greater openness by supporting employees in reporting errors without reproach, and thereby help the organisation avoid repeating the same errors. A positive workplace climate and an improved culture for patient safety are associated with fewer patient injuries and lower hospital mortality (8). A culture of fear that may lead to paralysis of action and give rise to defensive medical practices will not serve us well. The fact that doctors report an increasing fear of committing errors is therefore a source of concern (9, 10).

«To err is human – to blame others is politics»

Bruun-Gundersen appears to think that those who have committed errors are let off the hook too easily. She may not understand that those involved are harshly punished by feelings of guilt and self-reproach. Doctors and nurses have reported how they have experienced personal crises after such incidents. They feel alone and abandoned in the grip of guilt and shame. In addition to the grief over the death of the patient and compassion for the bereaved, further burdens are added by the police interrogation and inquiry by the Board of Health Supervision (10). 'It feels like being accused of murder' one nurse stated after having gone through complaint proceedings. Some experience mental problems (11). Living with the awareness of having committed a serious error and fearing to end up in court and on the front pages, something that would also affect one's own family, may become unbearable. A study of American surgeons found a threefold increase in the risk of suicidal thoughts among those who believed they had made a serious error (12), and doctors constitute the occupational group with the highest suicide rate (13).

Those who are affected when something goes wrong want those involved to be held accountable. Unfortunately, the gravest errors are sometimes made afterwards, in attempts to cover up what has happened. Lack of openness and information is the cause of many complaints in the health services. Good communication with the patient and their next of kin is crucial after adverse events. Not least, an apology may mean a lot to those affected as well as those expressing it. We will all benefit from being better able to admit our own

mistakes, because as Abraham Lincoln is reported to have said: 'A man should never be ashamed to own that he has been in the wrong, which is but saying in other words that he is wiser today than he was yesterday'.

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