To Err Is Human Ten Years On

In 2000 The Institute of Medicine (IOM) published To Err is Human. This report on patient safety in the United States received both internal and worldwide attention. The headline findings were that 98,000 patients were dying unnecessarily in US hospitals each year. Many countries extrapolated the statistics to determine the likely number of mishaps in their health services. This issue was debated widely in the Irish media at the time. Livingston states that it would have been expected that the medical and nursing professions and hospital administrators would have immediately sat about making the delivery of care safer. It was anticipated that a rigorous culture of safety would be adopted. While there have been some notable improvements progress overall has been slow. It hasn’t happened. Medical errors remain common but in retrospect it may have been unrealistic to have expected rapid change.

It is important to consider why safety progress has been disappointing. The report To Err is Human was not universally well received. In some quarters it was met with derision. Others felt that the Institute Of Medicine had exaggerated the size of the problem and the number of avoidable deaths. Many doctors feared that the outcome of the Report would lead to tougher recommendations and more sanctions. These sentiments have to be viewed in the context of the existing rigorous accountability facing doctors with peer review, board evaluation and high litigation frequency. Reliable reporting systems for medical error and near-misses continued throughout the 2000s decade to be overshadowed by the fear of reprisals. There were tensions between the medical profession and government agencies whose motives and approach to promoting safety was viewed with suspicion. One concern was that the safety umbrella was being manipulated to impose further clinical control over doctors. Lowering investment in medical care and increased bureaucracy may have led doctors to feel that there wasn’t sufficient time to put more rigorous safety measures in place. Also there was that well recognised human tendency to resist change.

It has recently been stated that most errors are committed by good, hard working people trying to do the right thing. A worrying problem is where an error affects multiple patients. Livingston comments on a number of examples from US hospitals. Cedars Sinai Hospital, Los Angeles had two adverse events. In the first, several infants were administered excessive anticoagulant doses. In the second, radiation dosing for cranial CT scanning in 206 patients was eightfold above the recommended dose leading to hair loss. In a single Rhode Island hospital there were 5 wrong-site surgeries. Iniped hospital there were 5 wrong-site surgeries.

Wrong site surgery has always been accepted as an example of clear medical error and system failure. There are 4000 wrong-side procedures in the US each year. It is increasingly being recognised that it also occurs outside the operating theatre and has been reported in Radiology, thoracentesis and dental procedures. Ophthalmology and Orthopaedics are experiencing higher adverse rates not only because of wrong side surgery but also due to incorrect device implantation.

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