

Mistakes

Last year the newspapers reported that doctors in Florida had amputated the wrong leg of a patient with diabetes and that technicians in the same community hospital had removed the wrong patient from ventilator support. Missed diagnoses are claimed to be found in 40% of autopsies; 5-10% of hospital admissions are said to result in iatrogenic injury; and 10-20% of these have been classified as serious, a statistic extrapolated to 150 000 Americans dying each year - a "hidden epidemic," comparable with a jumbo jet aeroplane crashing every few days.

That errors may occur in medicine has long been taken for granted, given the complexity and uncertainties inherent in medical practice and the multitude of interventions that patients are being subjected to. But the public has always taken a dim view of people who make trains crash or bridges collapse, or for that matter of doctors who make mistakes. Prosecutors, juries, and hospital officials also tend to deal harshly with those who have made mistakes. Nurses have been dismissed for giving the wrong drug, house officers have been severely disciplined for making mistakes, and hospitals have had their accreditation revoked in the aftermath of serious errors or accidents.

When a few years ago a New York doctor mistakenly ordered enteral feedings to be administered through a peritoneal dialysis catheter and then delayed transferring the patient from a nursing home to the hospital for 10 hours, he was convicted of manslaughter by an apparently enraged jury and sentenced to spend 52 weekends in prison. He failed to have the case reversed until after four years of legal entanglements the governor of the state of New York commuted his sentence.

A more constructive and less punitive suggested approach has been to reduce the frequency of mistakes by studying them and learning from them. This would necessitate inducing doctors to report their errors themselves, a requirement already embodied in codes of medical ethics but difficult to implement in practice without fundamental changes in the legal system and in the public's expectations. But already the Joint Commission on Accreditation of Hospitals has revised its procedures to allow hospitals to investigate in house serious mistakes that were reported voluntarily and promptly, and to develop corrective action. Other people have suggested that more mistakes could be avoided by adopting systems already used in industry; making information more readily available by means of modern technology; entering orders directly on to computers to reduce prescribing and dispensing errors; standardizing, simplifying, and structuring tasks so that mistakes cannot be made; and designing self correcting systems.

Diagnostic mistakes could further be avoided by recognizing the underlying factors that distract attention, such as boredom, frustration, anger, work overload, or environmental factors, such as noise or heat. Errors may be due to poor skills, faulty judgment, flawed data, or doctor bias, to haste, to not seeing the patient as a whole, to not looking rather than not knowing. Unwanted outcomes may also result from leaving major decisions in the hands of inexperienced junior staff; these often also represent system failures and should be corrected by better deployment of medical personnel.