



A new approach to medical error and adverse outcomes: a persistent need for a change in the culture in Portugal

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It has been said that to err is human and to forgive, divine. To that we might add that to investigate error is professional. In a recent editorial we explored what it means to be a true professional in family medicine.¹ Part of professionalism involves maintaining a positive attitude to learning from things that do not turn out as planned. In an article published in this journal in 2010, Maria José Ribas outlined the nature of adverse events in primary care and steps needed to promote a culture of safety.² Fragata has described errors and accidents in the surgery and anesthesia in a recent article published locally but the literature he cited is from countries outside Portugal.³ In this editorial, we will explore some changes in the current climate that can lead to a more positive approach to the issues of medical error and adverse outcomes and allow us to make decisions based on local data.

We have come a long way since the publication of the Institute of Medicine report that described heavy costs of errors in medical care in the United States.⁴ Along the way, several good reports on the epidemiology of error have appeared in other countries, with proven strategies for preventing and coping with error.⁵ With the recent publication of the Portuguese Directorate General of Health (DGS) guidelines on the approach to medical error, we may have a local tool that can help us move forward.⁶ However this latest document appears to be more appropriate for the root cause analysis of major adverse events occurring in hospitals. One wonders if teams of five members holding a series of five meetings, as suggested in the document, are really necessary to

analyze and prevent the kinds of errors we see daily in general practice. Perhaps another more practical approach is necessary.

Several facts can help us understand the task at hand. «Do no harm» is a basic principle in medicine along with doing good, respecting patients, and being fair. This principle recognizes the potential for harm in all of medicine. Our task is complex, our tools are powerful, our professional autonomy, though challenged of late, remains a strong force, and the environment we work in is sometimes hostile. This mix can lead to unwanted outcomes as a result of bad decisions, impairment, technical failure, or sometimes, bad luck. We hope to be able to minimize this by learning from our mistakes and putting in appropriate safeguards for patient and professional safety.

We have learned a lot from other sectors such as the airline industry. We have all heard of the pre-flight checklists that pilots use and these have been copied in settings such as operating rooms where long complex procedures involve big teams and many pieces of machinery.

The world of general practice is perhaps less glamorous than transplant surgery but it is prone to as many if not more mistakes in type and number because of the volume and variety of patients seen. Patients with penicillin allergy may still receive penicillin if we fail to ask them about allergies. Patients and drugs with similar names may be mixed up if we fail to follow proper identification procedures. The diagnosis of pregnancy may be missed with dire consequences if we don't consider it.

A brief classification of types of error includes errors of commission (wrong drug, wrong procedure, wrong

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side), errors of omission (forgotten tests or treatments), errors in communication, errors in recording, and physical injury (falls).

An analysis of the causes of these problems uses a simple mnemonic of 5 M's: the man (we make bad choices), the machine (our equipment breaks), the mission (we don't communicate well with our team), the medium (we may be hot, upset and tired after a long day) and management (we don't provide adequate supervision to juniors or follow guidelines from above).

Using this classification of errors and this analysis of causes it is possible to investigate the circumstances when things go wrong. We can ask the following questions: What happened? How did it happen? Why did it happen? What can we do to prevent this from happening again? This can be done at regular staff meetings with minimal preparation and far-reaching potential beneficial outcomes.

An important step forward involves moving from a culture of blame and shame to a culture of learning. For this to happen we need safeguards to prevent the fear of legal or other sanction from interfering with the learning process. Of course, patients who have been hurt are entitled to some form of redress if they are harmed by misapplied measures that might have been prevented. Often our patients simply want an apology or guarantee that this won't happen again.⁷ For many of the bad outcomes we see there was certainly no malicious intent. We need to be able to learn from events and take steps to prevent them from recurring without fear of censure from patients and colleagues. Even the use of the term «adverse outcome» instead of «error» removes the sting of blame or possible legal responsibility from many situations.

Though we have some data on local errors and their prevention in the hospital setting,⁸ we need more empiric data on the types of adverse outcomes and errors seen in general practice in Portugal. We need reports on

the types of effective measures used to investigate and prevent them from happening again. We need to see how these measures can improve patient safety.

New, automated voluntary reporting schemes may aid in this process.⁹ This has been pilot-tested in Portugal in primary care as well as in the hospital setting. We look forward to seeing the first results of this program and hope to publish their findings on these pages. We deserve the culture of patient safety and can all take steps in our daily practice to make it a reality.

CONFLICT OF INTEREST

None

REFERENCES

1. Yaphe J. Good family doctors are made not born: An overview of teaching and learning about professionalism in family medicine [Editorial]. *Rev Port Clin Geral* 2011 Nov-Dec; 27 (6): 497-8.
2. Ribas MJ. Eventos adversos em Cuidados de Saúde Primários: promover uma cultura de segurança. *Rev Port Clin Geral* 2010 Nov-Dec ; 26 (6): 585-9.
3. Fragata JI. Erros e acidentes no bloco operatório: revisão do estado da arte. *Rev Port Saúde Pública* 2010; Vol Temat (10): 17-26.
4. Kohn L, Corrigan JM, Donaldson MS, editors. *To Err is Human: building, a safer health system*. Washington, DC: Institute of Medicine of the National Academy Press; 1999.
5. Weingart SN, Wilson RM, Gibberd RW, Harrison B. Epidemiology of medical error. *BMJ* 2000 Mar 18; 320 (7237): 774-7.
6. Direção-Geral da Saúde. Análise de Incidentes e de Eventos Adversos. Orientação 011/2012. 30/07/2102.
7. Pérez Fernández M. Ética de "las pequeñas cosas" en medicina. <http://www.equipoceca.org/organizacion-de-servicios/etica-de-las-pequenas-cosas-en-medicina/> accessed 13/12/2012.
8. Fragata J, Martins L. *O Erro em medicina: perspectivas do indivíduo, da organização e da sociedade*. Lisboa: Almedina; 2008.
9. Direção-Geral da Saúde, Departamento da Qualidade na Saúde. Sistema Nacional de Notificação de Incidentes e Eventos Adversos. Available from: <http://www.dgs.pt/ms/8/default.aspx?pl=&id=5521&access=0> [accessed on 12/13/2012].

ENDEREÇO PARA CORRESPONDÊNCIA

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CORRECÇÃO

«Enurese em crianças portuguesas – prevalência e relação com hábitos de sono e pesadelos»
Neste artigo de Catarina Azevedo Gomes, Sílvia Henriques, Alexandra Tavares e Clara Fonseca
(*Rev Port Med Geral Fam* 2012; 28:338-42) foi, por lapso, omitido o seguinte texto:

CONFLITOS DE INTERESSE

As autoras declaram não possuir conflitos de interesse.