Editorial - Educational

Mandatory Reporting

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We live and work in a world of sophisticated technology and high expectations. The cutting edge of science constantly advances at a pace unheard of 50 years ago. Stem cell research promises a cure for everything, from cancer to organ failure, and we are assured that we will live, if not forever, then certainly well into our 90s. While great progress in science and medicine is a reality, it is unfortunately linked with the unrealistic expectation that mistakes are not possible or that they are so rare as to be unimportant. If only this were the case! It is estimated that between 5 and 10 incorrect procedures occur in the USA each day and that complications and errors affect between 3% and 22% of all hospital admissions. However, the problem is that even now, we do not have accurate statistics of adverse events!

Medical practice, both in and out of the hospital presents a unique and hazardous environment where the marriage of expectation and human error could result in harm to the patients and damage to the doctors/nurses as well as an institution's reputation. These adverse events have been the subject of intense research and analysis and recognize that the majority of errors occur due to a lack of appropriate communication (not discussing a concern or assuming that someone else has completed the required task). In reality, adverse events in medicine are usually the end result of multiple small errors with a negative end result, the so-called "Domino Theory".

Models of error in practice often draw a comparison from the airline industry concluding that the majority of human error is a consequence of poor communication. If the process of communication is interrupted or corrupted, the end result is distraction and error. It is easy to see how this could occur, but other examples include the "plan–continue–fail" scenario which could explain some errors in clinical practice. The airline industry recognizes the importance of teamwork, but ultimately, the pilot (like the operating surgeon) must make the decision. However, it underscores the need to empower and enable every member of the clinical team to voice a concern. This openness in medicine is often lacking, for cultural or other reasons, and allows the error to go unchecked in full sight of the correct option.

Apart from certain notorious cases, no doctor or nurse willingly causes harm to a patient. Error is a complex phenomenon that usually occurs as result of poor or inadequate communication. It is a force that we as doctors must acknowledge and strive to prevent. Risk avoidance is a vital part of practice, but unfettered, its consequence could become a defensive practice which is wasteful of resources. What has become clear is that clinicians could not depend on traditional barriers to risk as these are easily overcome. It is also apparent that the profession must embrace the reality of risk and actively participate in its prevention. There is little room for complacency or hoping that "it would never happen to me!"

Current risk management strategies, therefore, aim to learn from error and prevent its recurrence. This naturally implies a non-punitive position and assures the clinicians that they will not be punished when an error occurs. This is not a defense of negligence, however, error must be judged against the performance of a reasonable section of a doctor's peers. It assumes that hospital systems are fit for purpose.

We owe much of our current knowledge about risk and its prevention to the work of the Joint Commission International and the World Health Organization: both organizations recognized that there was a lack of awareness of risk in practice and that complex technology does not provide the answer to risk prevention. There is no doubt that error is a human failing and that prevention should be our priority. Like any strategy, a useful starting point should be the awareness of the scale of the problem. Unfortunately, there remains a reluctance to report adverse events. Perhaps wrapped in ego or fear of punishment, this could hinder an institution's response to risk and retard risk prevention. Voluntary reporting generally under-reports events and most hospitals now require a process of mandatory reporting through a trained "Risk" department. The challenge remains in ensuring compliant reporting.

In setting up a risk management practice, KHUH introduced an in-house online reporting system "DATIX" which went live in 2012. This system captures all adverse events from minor to major and reports major or sentinel events to the National Health Regulatory Authority. If we accept that risk is part of practice (show me the man who has never erred and I will show you the man that has done nothing!) and that our efforts are to prevent rather than to punish, then we should learn to put aside our ego and be the first to put our hands up and say, "yes that happened to me too". It is especially important that senior clinicians are seen to do this as they lead by example.

We will never eradicate risk in practice, but openness, complete reporting and leading by example will reduce risk and minimize the severity of patient and institutional consequences.

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