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How to Approach Medical Errors

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Context Matters

No one comes to work intending to make a mistake. The **Local Rationality Principle** states that people do things that make sense to them, based on their goals, knowledge, and understanding of the situation, and focus of attention at a particular point in time.

Biases Impact Our Analysis

When looking back at an error, we have subconscious biases that prevent us from being objective.

Outcome Bias: We assume that a bad outcome must be the result of a proportionally bad decision.

Hindsight Bias: Once we know the outcome, the probability of that outcome seems more likely than it would prospectively.

Healthcare Systems are Error-Prone

Goal Conflicts (e.g., Do it better, faster, cheaper!) force us to make difficult choices to manage these conflicts. Rule violations are rarely malicious. They are frequently a well-meaning action intended to get the job done. Errors are often the result of pursuing success in a resource-limited environment.

Drift is the accrual of small-scale changes in response to goal conflicts. When changes that make work more efficient have no obvious consequences, the workaround is normalized. The deviations keep becoming the new normal until a tipping point is reached.

Error is Normal

Error is not a choice, even when it seems like one in retrospect. Expecting perfection implies that it is achievable. Instead, we should expect error and build resiliency into our systems. Blame only serves to stigmatize errors and prevents learning.

Culture is Everything

A **Punitive Culture** asks, "who failed?" and sees the person committing an error as a problem to be fixed.

A **Just Culture** asks, "what failed?" and focuses on fixing the system that failed the person while addressing the needs of the injured.

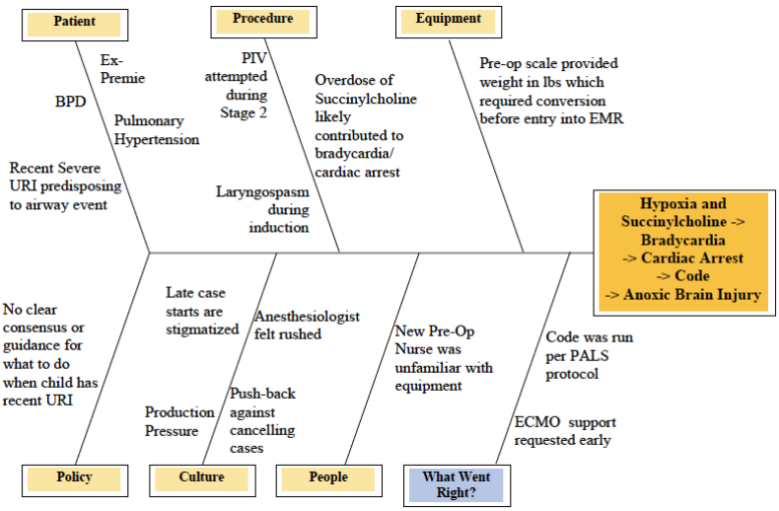
Near Miss and **Error Reporting** should be encouraged and seen as an opportunity for system improvement.

Learning from Errors

After an error, a Formal **Debrief** should occur.

1. Identify and support ***Second Victims*.**
2. Reconstruct the event in context and identify all contributing factors. An Ishikawa or "Fishbone" diagram (Figure 1) may help visualize.
3. Generate **SMART** recommendations
    a. **S**pecific- Fix A by doing B.
    b. **M**easurable- Have defined criteria for success.
    c. **A**greeable- Be in line with organizational goals.
    d. **R**ealistic- Be doable for those responsible.
    e. **T**ime-Bound- Have an implementation deadline.

Figure 1: Sample Fishbone diagram



References and Further Reading:

1. Conklin, T. (2019). The 5 principles of human performance: A contemporary update of the building blocks of human performance for the new view of safety. Santa Fe, NM: Pre-Accident Investigation Media.
2. Dekker, S. (2016). Drift into Failure from Hunting Broken Components to Understanding Complex Systems. Taylor & Francis Ltd: CRC Press.
3. Dekker, S. (2016). The field guide to understanding 'human error'. Ashgate Publishing Company: Ashgate Publishing.
4. Dekker, S. (2017). Just culture: Restoring trust and accountability in your organization. Boca Raton; London; New York: CRC Press, Taylor et Francis Group.