



Clinical errors and medical negligence

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Modern health care is a complex activity associated with high risks. Previously, the incidence of clinical errors and resultant harm to patients was grossly underestimated and under-reported. However, matters related to patient safety have now become very important in the delivery of health care services across the world.

A major drive for understanding adverse events in the NHS followed the publication of a document titled *An Organisation With a Memory (2000)* by the Department of Health. Subsequently, a new independent body, the national Patient Safety Agency (NPSA), was established within the NHS. The primary aim of the NPSA is to collect and analyse information on adverse events, assimilate other safety related information, learn lessons, and produce solutions to prevent harm to patients.

Although the occurrence of clinical errors and adverse outcomes is inevitable, patient safety can still be promoted through a successful programme of identification and analysis of errors. The focus of risk management programmes has shifted from the individual competence of a clinician to building safer systems where team working and effective communication are valued.

Definitions

Clinical error is defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Contrarily, adverse event involves actual injury to patients due to medical management, and may not always be the result of errors by clinicians.

Epidemiology

Epidemiological studies have shown that adverse events are far more common than actually reported in routine practice. In NHS hospitals, it is estimated that adverse events occur at the rate of 10% of all admissions, giving a figure of 850,000 events a year, and resulting in extra cost of £2 billion to cover the cost of additional stays.

Types and effects of error

Errors are broadly divided into active errors and latent (system) errors. Latent errors focus on factors related to the working environment and differ from active errors in being less critical of the performance of individuals at the 'sharp' end.

The effects of errors and adverse events are far reaching, and involve not only the individual sufferer, but also the health care organisation and society in general. The person who committed the error is likely to suffer from guilt, remorse, and sometimes be subjected to litigations.

Medication errors by far are the commonest clinical errors, and account for 10-20% of all preventable injuries to patients. Antipsychotic medications are commonly implicated in litigation claims.

A condition for medical negligence is met if there is evidence that:

- the doctor owed a duty of care to the claimant
- this duty was breached by a failure to meet required standards causing foreseeable and preventable injury.

Annual NHS clinical negligence expenditure rose from £1 million in 1974-75 to £446 million in 2001-02

Aetiology of error

Two theories have dominated the aetiology of clinical error. The person approach proposes that errors occur due to mistakes committed by individuals, and begets blaming and shaming. On the other hand, the system approach concentrates on working environment ('system') and proposes to design situations to avert or mitigate errors.

Error management

Effective error management strategies follow a threefold approach:

1. Prevention – this involves adding defences at various levels of the system.
2. Early identification – this includes methods to make errors visible quickly to allow correction before harm is caused.
3. Mitigation of adverse effects, analysis and learning from mistakes – this includes root cause analysis and effective error reporting systems.