To Err is Human: Bringing Humanity into Medical Error Prevention.

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Medical errors are a frequent cause of harm, both to patients and practitioners. Medical error has been defined as "A preventable adverse effect of medical care, whether or not it is evident or harmful to the patient" (Hofer et al 2000). Medical errors are estimated to be the third leading cause of death the in United States, second only to heart disease and cancer. The issue is not as well studied in veterinary medicine, however the limited information we do have should cause concern. In a large survey of veterinarians administered through VIN, 73.8% had been involved in an veterinary error at some point in their careers (Kogan et al 2019). A smaller survey of recent graduates in the UK found 78% had been involved in a medical error (Mellanby et al 2014). In a study looking at medical error reports in multiple environments (Small and Large animal teaching hospitals and a small animal specialty private practice hospital) found an error rate of 5 per 1,000 cases across all environments, and 8.3 per 1,000 cases in the small animal specialty private practice hospital.

The nature of veterinary medical care delivery is that of a complex, tightly coupled system, meaning that there are multiple interdependent variables. This type of system is at risk for error. Because of the complexity in veterinary practice, much relies on human participants in care delivery. Humans provide rapid adaptability to changing circumstances, however we are in the end… Human. Knowing that veterinary healthcare delivery relies on fallible individuals working together, we must adapt the systems that support us to help prevent error, and accommodate for when the inevitable error occurs.

Taking a systems approach to preventing medical errors means limiting the opportunity for errors to occur, and when they do occur, preventing them from reaching the patient. In order to develop these defenses, we rely on learning from past errors. Just Culture is an approach that fosters disclosure of medical errors and encourages critical evaluation of errors to uncover the systemic flaws that allow errors to occur. Individuals involved in errors are not judged by the consequence of the error, but rather by their own culpability. When intent was good (as it almost always is), and gross negligence or maliciousness is absent, the individuals involved in the error are supported while the system is carefully evaluated for failure. This approach prevents the short-circuiting that can occur with medical errors, where the error is assigned to an individual who is then labelled as problematic and discarded, but the faulty system carries on, exposing additional individuals to the risk of committing a similar error.

A successful approach to Just Culture requires a committed organization, with support from leadership, yet participation across disciplines. How an organization responds to medical errors will either build trust and reinforce a safe culture, or degrade trust and lead to shame, fear and lack of disclosure. Organizations should be consistent and transparent in how medical errors are investigated. Changes to improve safety in the organization should prioritize high leverage interventions that make it impossible or difficult to make an error rather than training and reminders of individual staff.