Commentary: Small Things Are Big

by Kathleen Dwyer, MS

Kathy Dwyer is a Loss Prevention Specialist for Risk Management Foundation of the Harvard Medical Institutions.

By most measures, surgery is risky work: inherent uncertainty, complexity, rapidly changing priorities, and dependence on teamwork. Preventable complications happen even in the best of hands, but, most often, they are not a sign of negligence or substandard care, merely a reflection of human limitations.

Given the work of James Reason and others, patient harm can, almost always, be traced back to an alignment of human error and systems shortcomings.[1-3] Tragic events are, almost always, the result of many small errors that only in hindsight reveal themselves to be part of a larger, cascading problem. At some point, too many failures line up and harm occurs. In the vast majority of CRICO's surgery-related cases—as in all malpractice cases—everyone involved has the right intention, but those intentions are blocked or sidetracked by human factors, poor system design, and individual shortcomings. Unless changes are made, little stands in the way to prevent another similar event.

With an eye toward identifying high-risk situations and behaviors that pose a threat to surgery patients, Risk Management Foundation has been studying these alignments of human and systems problems. Analysis of CRICO surgery-related claims filed from 1998-2002 *(see page 5)* suggests several patterns and situations that contribute to the accusation of malpractice:

- lack of communication among physicians resulting in misunderstandings,
- inexperience and cultural barriers to asking for help,
- lack of effective transfer of meaningful and accurate information to clinicians during handoffs,
- lack of actively engaging patients in the decision-making process, and
- lack of active follow-up by surgeons (e.g., abnormal test results; post discharge treatment).

Not only do small errors often converge to cause big problems, but small errors by individuals reflect bigger systemic issues.

1. A majority of the complications that prompted surgery patients to sue their doctors are well-recognized complications. And, while a surgical injury alone may not be grounds for an accusation of negligence, failure to timely recognize and treat complications can be. This suggests that communication—both pre- and post-operatively—plays a critical role in strengthening the surgeon-patient relationship, perhaps more so than many clinicians realize.
2. In all of the malpractice case files reviewed, patients and families indicated anger directed at individual practitioners. Among the recurring reasons:
   - the indications for surgery were not clear,
   - their surgeon repeatedly failed to provide clear answers to their questions,
   - residents who were allowed by their surgeon to call the shots failed to recognize that the patient was not recovering as expected,
   - no one of the many caregivers seemed to be in charge, and
   - unfortunate outcomes were exacerbated by communication breakdowns (often silence).

One thing is perfectly clear: surgical care in a complex environment requires better systems of communication and responsibility. This *Forum* sets forth pieces of a framework: to learn from honest mistakes, to highlight some dangers that have predisposed surgeons and patients to errors, and to provide a broad outline for a changing mindset through which surgeons and institutions might effectively minimize the impact of human fallibility and strengthen the patient-physician relationship. ■

References

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