Editorial

Healthcare system error: beyond apology

David P Stevens

When a healthcare professional commits an error that results in an adverse patient outcome, it is increasingly considered appropriate that an apology should be made to the harmed person. Such an apology benefits both the health professional and the patient, and serves to address the considerable emotional burden that accompanies this wrenching aspect of practice (see page 249). The process of apology invariably calls for candid self-reflection and, in the best of circumstances, leads to better and safer care. It emphasises that healthcare is at its heart a social process that contains predictable human emotions that contribute to its value but can also serve to facilitate its improvement.

WHERE DOES APOLOGY FIT IN HEALTHCARE SYSTEMS?

What, then, is appropriate when a system fails a patient? Is an apology due? To whom should it be addressed? Surely most would agree an apology is due the patient, particularly when the error is due to an identifiable mistake, such as a “Never Event,” a term that has been used to identify the most egregious and preventable errors. Typical examples of “Never Events” include wrong-side surgery, or falls in a healthcare facility. Moreover, the list grows as health systems, and those who finance care, find outcomes in their patients with cystic fibrosis were just average when compared with outcomes of similar institutions throughout the US, the leadership in Cincinnati acknowledged this to the parents of these children because they recognised there was knowledge that would enable them to perform better. And arguably more importantly—they linked that apology to an invitation to patients to participate in improvement teams. When the leadership of the University of Missouri-Columbia hospital recognised that system defects could be the underlying cause of mishaps, they redesigned weekly morbidity and mortality conferences to pursue root cause analyses of such mishaps. They progressed from the traditional culture of blame that permeates traditional morbidity and mortality conferences to acknowledgement of the need for system improvement—for the benefit of both patients and health professionals. They formed ad hoc improvement teams that were made up of professional staff including resident trainees that were crafted to improve the system defects.

BEYOND APOLOGY: THE ROLES OF SENSEMAKING AND LEADERSHIP

A health system defect that goes undetected reflects the absence of what Weick has called “sensemaking,” which is essential if corrective action is to be implemented. Fortunately, examples abound of just such “sensing” systems, and these examples point directly to the role of profoundly committed leadership. When Cincinnati Children’s Hospital recognised that outcomes in their patients with cystic fibrosis were just average when compared with outcomes of similar institutions throughout the US, the leadership in Cincinnati acknowledged this to the parents of these children because they recognised there was knowledge that would enable them to perform better. And arguably more importantly—they linked that apology to an invitation to patients to participate in improvement teams. When the leadership of the University of Missouri-Columbia hospital recognised that system defects could be the underlying cause of mishaps, they redesigned weekly morbidity and mortality conferences to pursue root cause analyses of such mishaps. They progressed from the traditional culture of blame that permeates traditional morbidity and mortality conferences to acknowledgement of the need for system improvement—for the benefit of both patients and health professionals. They formed ad hoc improvement teams that

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REFERENCES


Qual Saf Health Care August 2008 Vol 17 No 4
Abstracts

Presentation abstracts from the International Forum on Quality and Safety, April 2008, Paris, France

This issue of QSHC is accompanied by an online Supplement where abstracts are published from the International Forum on Quality and Safety in Health Care that took place in Paris in April 2008. The abstracts that were commissioned for this Supplement were originally selected by reviewers for oral presentations in Paris.

The over 900 abstracts that were submitted for the 2008 Forum reflect an extraordinary commitment to health care quality and patient safety. They represent improvement work from over 20 countries. These currently published abstracts, along with those that were linked to the 376 posters that were presented at the Paris Forum, emerged from a rigorous peer-review process.

The criteria for their selection reflected the consensus of reviewers and included clear aims, attention to explicitly defined methods, and accurate measurement of outcomes. Good improvement work invariably offers new lessons for better, safer care, and insightful analysis of these projects for lessons learnt was an important part of the successful reports. Finally, mindfulness of how the work might be adapted from these specific settings to other contexts of care is a vital part of effectively reporting good work so that it might contribute to wider opportunities for health care improvement and patient safety.

The Editors of QSHC congratulate the authors of these valuable reports, and look forward to the improvement work that will be reported at the International Forum in Berlin in March 2009.

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*Qual Saf Health Care* 2008 17: 234-235
doi: 10.1136/qshc.2008.029595

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