

Error is normal

Advancing patient safety is now a high- profile issue in healthcare, with particular focus on reducing error through non-technical skills. *John Duncan* reports from the College's recent patient safety meeting

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The Patient Safety Board of the College organised the conference 'Advancing Patient Safety in Surgery', held on the 15 November 2007. Introducing the conference, the President reminded delegates that the College's Seal of Cause of 500 years ago indicated the need for a surgeon to know the skills of their profession, including knowledge of patient safety. When Lord Lister introduced antisepsis, he introduced a patient safety initiative. However, it is only in recent years that emphasis on human factors in improving surgical results has come to prominence.

Charles Vincent described the development of a culture of safety and how we change that culture from a sense of inevitability to an item for study and improvement. International studies demonstrate that about 10% of patient episodes are associated with some element of error, half of which is preventable.

The need for a change from a culprit-based approach to one based on analysis and improving systems was emphasised, especially as error is ubiquitous in the human condition and none of us are exempt. 'Technical skills enable you to do the job; non-technical skills keep you safe while you are doing it.'

Contributions from the Scottish Audit of Surgical Mortality and the National Clinical Assessment Service set the scene for a moving presentation by Martin Bromiley, whose wife died under anaesthesia from airway difficulties. He analysed the problem in terms he used as an airline pilot to assess the contribution of human factors from aircrew to aviation accidents. He poignantly articulated the human price not only for his family but also for the doctors involved in the incident, and how this affected all their lives.

David Woods, a psychologist from the USA who acted as a consultant for NASA on the Challenger accident, provided an animated description of analysis by other high risk industries and the relevance to a healthcare setting and error prevention. Representatives of the aviation and oil industries emphasised how human factors and non-technical skills have been critical in improving safety and how safety was the prime consideration over efficiency and cost. Recognising risk and empowering personal responsibility are at the heart of these strategies.

Two surgeons, Mr Simon Paterson-Brown and Mr Tony Giddings, talked about the place of human factors research in surgical care with the potential for improving both the safety and the efficiency of operative surgery. One of the most interesting presentations was the James IV lecture by Professor Paul Uhlig, cardiac surgeon from Kansas, who talked about the paradigm shift in healthcare

involving a move from the individual working well on their own, to a true team providing healthcare collectively for the individual patient.

The home team, Simon Paterson-Brown, Nikki Morran, and Steve Yule discussed the surgical human factors research the College is supporting at the University of Aberdeen. Gerry Marr, Chief Operating Officer of NHS Tayside and Dr Harry Burns, Chief Medical Officer, outlined how NHS Scotland is addressing the effort to improve patient safety, emphasising the Scottish Patient Safety Alliance in collaboration with the Health Foundation.

The size and seniority of the audience gave me the strong impression that patient safety has moved to the top of clinicians' and the Government's agenda and that we may truly be seeing the beginning of a change in the way that we manage our patients.

John Duncan, RCSEd Honorary Secretary