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Book Review

Patient Safety, Charles Vincent (Smith and Nephew Foundation Professor of Clinical Safety Research, Imperial College London, Department of Surgical Oncology and Technology, St Mary's Hospital, London, UK), Paperback, 268 pp., 10 illustrations, Churchill Livingstone, November 2005, ISBN 0443101205

Charles Vincent is eminently qualified to write this book and his wisdom is beautifully condensed into less than 250 pages. This is one of the most accessible books on the topic I have had the pleasure to read. As they say of thrillers, 'I could not put it down'. I believe that beginners and 'experts' alike will find the book valuable because of its broad coverage, relevant illustrations and references. The publishers should also be congratulated on the quality and clarity of the layout and print face.

The author starts by giving us the history and evolution of medical error science. He illustrates by examples from within and outside medicine. The latter is an important aspect of the book, since it is clear to me, coming from a background that involves both drug and chemical safety, that other disciplines have important lessons for medicine. This is not to say, as the author warns, that lessons can be directly applied to medical care which is complex and involves much more individual decision-making than, for example, flying a plane.

The move from a predominant view that personal factors and negligence was the main cause of medical errors to a more broad and blame free examination of systems and team issues that influence outcomes is traced historically, and illustrated with key events and reports which have changed attitudes.

The book moves us from evolution to an examination of the size and nature of the problem, including how medical error may be studied. The 'hindsight bias' is discussed and other methodological points. The effects of methodologies are important to whether the results are believed. There are many approaches to the various aspects and consequences of patient safety issues, and we get the broad view of the scope linked with methods as diverse as individual case examination through to cost and quality of care analysis. The strengths and weaknesses of the approaches are explored.

There is a logical move to the next chapter on reporting and learning. All the usual issues, such as confidentiality issues and barriers to reporting, are discussed. Many examples are given, though with a UK bias which goes throughout the book. This is not a major criticism, since there is a coherence of experience, and an obvious intimacy with the UK system which gives great credibility to the writing. I suppose I was somewhat disappointed that the WHO's International Programme for Drug Monitoring, was not mentioned in relation to this section since it was the first global reporting system.

The next chapters deal with human error and systems thinking; understanding how things go wrong. The author expands on the comparison between healthcare and other industries, and the main meat of the book is in these two chapters. The interaction between humans, systems and machinery is the essence of error investigation, and this is well illustrated with many examples from the medical arena. In this section, and throughout the book, the boxed sections give useful bullet points, sometimes taken from the literature. These boxed sections also give illustrative case reports. They are all very useful for quick reference, and for presentations!

How to investigate is the next chapter. Models of how errors may complex are reviewed. The much quoted Swiss cheese metaphor is presented together with Reason's organisational accident model. This latter model shifts one through high level factors in management and organisation as latent factors, through error and violation producing environmental factors, to the active failures and then breakdown or deficiencies of defences against errors. Whilst there are different approaches to investigation, all must have a way of getting at the totality of relevant factors. The very many methods and their acronyms are only briefly described, and it is not possible to gain a real picture of their strengths and weaknesses. This is beyond the scope of this book, though some may find this frustrating.

Prof. Vincent's humanity is palpable throughout the book, but it is best seen in the chapter on what happens and should be done about those injured by medical errors. As the General Medical Council has advocated for decades, openness over what has happened is an essential, as is some apology and offer of support. This is indeed a difficult area, but the strong advice comes over that one needs to meet injured patients and their relatives willingly, regardless of the difficulties of compensation issues and litigation for negligence. It is an ethical matter, and also may be practical in that directly, or indirectly, injured people who initially only want an admission and explanation of what went wrong, can move towards embitterment and litigation for compensation the more they are frustrated.

Staff, too, are damaged by errors for which they feel responsible. They need understanding and support if they are not to feel guilty as well as alienated by their colleagues. This is really a part of the culture of safety, which must be inculcated by senior staff and managers. Recognition of how errors are likely in all human endeavour, and in the technology supporting it, is essential. The reporting and learning from weaknesses can only operate when all understand and feel that an organisation has avoidance of error as a priority activity, and that scapegoats are out of season.

The last three chapters are devoted to the ways in which healthcare can be made safer, dealing with processes, IT support systems and returning to people, and their roles. Again, I liked Prof. Vincent's approach, which strongly argues against any idea of an easy overall solution. Medical care is very complex, and an awareness of the multitude of interactions that occur between people and supporting technology is infinitely variable and ever changing. He gives us overviews of how we might approach the complexity top-down, as well as examples of successes in practice.

Patient safety is a 'buzzword' today. It is easy to feel that safety is someone else's problem. This short, accessible, book reminds all involved in any aspect of healthcare how the use of vigilance, imagination, humility to admit mistakes and determination to find solutions, can lead to better outcomes for patients.

Whatever your particular state of knowledge on patient safety issues, I think you will like this book. The writer's style is lovely. If you are an expert you will appreciate this as the work of an equal, if a beginner you will get the overview of an expert. Both of you will be frustrated that there is not more!

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