Epidemiol. Infect. (2001), **126**, 157. Printed in the United Kingdom

Book Review

To Err Is Human. Eds. L. T. Kohn, J. M. Corrigan and M. S. Donaldson. National Academy Press Washington, D.C. 2000. Pp. 287. $34.95

Are the horrific cases of medical error that make up headlines just one-off events or the tip of the iceberg? Probably the latter. In the USA errors in health care are now recognized as a leading cause of death and injury and it is estimated that more Americans die each year as a result of medical errors than from motor accidents, breast cancer or AIDS. Errors or 'preventable adverse effects' are costly not only in terms of financial costs but also in terms of loss of patient trust, unnecessary pain and discomfort, loss of staff morale, and frustration of not to be able to provide the best possible care. This report, which was produced by the Committee on Quality of Health Care in America, aims to break the silence that surrounds the issue and emphasises the need for a comprehensive approach to patient safety. Both errors of planning and errors of execution can occur at all stages of the health care process from prevention to diagnosis and treatment. Not all errors have a fatal outcome and many events may even remain unrecognized. The authors argue that all adverse events resulting in serious harm should be evaluated to assess what changes to the health care delivery system can be made to prevent similar events occurring in the future. Lessons of how to devise a systematic safety strategy can be learned from aviation and other high-risk industries, that are far more advanced in their attention to basic safety than the health sector. Throughout the report, the authors advocate a shift from blaming individuals for past errors to a systematic approach that builds safety into the health system. Patient safety is seen as a part of a comprehensive quality assurance process that should involve all levels of the health care system. This implies a change in organizational culture that encourages identifying and reporting errors as well as drawing lessons to implement safe practices. The book has much to offer any manager, clinician or policy-maker who is interested in a systematic approach to improving patient safety. The report reviews current regulatory and market initiatives and analyses a range of novel approaches to safety management. It gives detailed recommendations relating to leadership and knowledge, identifying and learning from errors, systematic data collection, improvement of performance standards and implementation of safety practices. The Annex contains a comprehensive literature overview of studies on patient safety and useful information on the characteristics of adverse event reporting systems that have been implemented in the US.

R. GRUEN
London School of Hygiene & Tropical Medicine

https://doi.org/10.1017/S095026880100509X Published online by Cambridge University Press