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EDITOR'S CHOICE

First do no harm: the impossible oath

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Discussions about patient safety describe healthcare as an industry. If that's the case then what is healthcare's business? What does it manufacture? Health and wellbeing? Possibly. But we know for certain that healthcare manufactures harm. Look at the data from our new research paper on the prevalence, severity, and nature of preventable harm (doi:10.1136/bmj.l4185). Maria Panagioti and colleagues find that the prevalence of overall harm, preventable and non-preventable, is 12% across medical care settings. Around half of this is preventable.

These data make something of a mockery of our principal professional oath to first do no harm. Working in clinical practice, we do harm that we cannot prevent or avoid, such as by appropriately prescribing a drug that causes an adverse drug reaction. As our experience, evidence, and knowledge improve, what isn't preventable today may well be preventable in the future.

The argument, then, isn't over whether healthcare causes harm but about the exact estimates of harm and how much of it is preventable. The answer that Panagioti and colleagues deliver from their systematic review of the available evidence is the best we have at the moment, though it isn't perfect. The definitions of preventable harm differ. Existing studies are heterogeneous and focused more on overall rather than preventable harm. The standard method is the retrospective case record review. The need, say the authors, is for better research in all fields and more research on preventable harms in primary care, psychiatry, and developing countries, and among children and older adults.

While these are important holes in the data, more research is unlikely to deliver more reassuring answers. Editorialists Irene Papanicolas and Jose Figueroa agree that this new study raises serious questions about the safety of health systems (doi:10.1136/bmj.l4611). They prioritise standardisation of terminology and better measurement as important steps in meeting the challenge. A cultural transformation is needed that systematically captures near misses, identifies harm across multiple care settings and countries, and empowers patients to help seek out and avoid causes of preventable harm.

If ascertaining the level of preventable harm is difficult, then estimating the contribution of medical error, a subset of preventable harm, is more complex still. An analysis article we published in 2016 includes estimates of death from medical error that are hotly disputed (doi:10.1136/bmj.i2139). We plan a series of commentaries to critique and reflect on that controversial article and help advance the debate on medical error and preventable harm. The precise estimates themselves are contestable, but the message that everybody must agree on is that we can do much more to understand the causes of preventable harm and make it less common. First do no harm, it seems, is an ancient oath true in spirit but impossible to practise in the messy business of modern healthcare.

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