Since the dawn of medicine, harm from treatment has been closely linked to its benefits. The historical human endeavour of improving medical science has subsequently led to major advances in patient care and to expanding healthcare systems, but also to increased aspects of risk. During the last decades, a growing political and public attention has been brought to publications reporting alarming numbers of adverse events in healthcare systems worldwide. The Swedish healthcare system has been highly influenced by a global movement addressing this issue, and acknowledging the use of incident reporting systems for repairing and learning when signs of system weaknesses have been present. With a case-study approach conducted between 2013 and 2017, the author has explored how the incident reporting system in the Swedish healthcare system functions.

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