Patient Safety in 2005: The End of the Beginning

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What's New This Week 05/25/05

Legislation/Regulations


Prohibition of Excessive Overtime for Nurses Act.

Books/Reports

Health Information Technology Leadership Panel: Final Report.
Falls Church, VA: The Lewin Group, Inc.; 2005.

Journal Articles

High rates of adverse drug events in a highly computerized hospital.

Surgical skill is predicted by the ability to detect errors.

Adherence to simple and effective measures reduces the incidence of ventilator-associated pneumonia: [L'observation de mesures simples et efficaces reduit l'incidence de pneumonie associée a la ventilation mecanique].

The investigation and analysis of critical incidents and adverse events in healthcare.

Building a framework for trust: critical event analysis of deaths in surgical care.

Browse the Collection

Browse by Resource Type
Journal articles, Books and reports, Tools and toolkits, Upcoming meetings, More...

Browse by Subject

Safety Target
Medication errors, Diagnostic errors, Nosocomial infections, Post-operative surgical complications, More...

Approach to Improving Safety
Human factors engineering, Error reporting, Teamwork training, Culture of safety, Nurse staffing ratios, Regulation, More...

Error Types
Cognitive errors ("mistakes"), Non-cognitive errors ("slips & lapses"), Latent errors, More...

Clinical Area
Anesthesiology, Emergency medicine, Critical care nursing, Community pharmacy, More...

Target Audience
Physicians, Nurses, Risk managers, Educators, Policymakers, More...

Setting of Care
Intensive care units, Operating room, Children's hospitals, Ambulatory clinic or office, Residential facilities, More...

Patient Safety CLASSICS
The most influential, frequently cited articles, books, and resources in patient safety. View CLASSICS
“The IOM Report”
December, 1999
This report says medical errors such as indecipherable prescriptions cause the deaths of 98 patients a year, or is that 98,000? It's hard to read this. In any case, we're supposed to report them, or is that repeat them?
How Did Health Care Become So Unsafe?
Medical Progress Over Half a Century
Problem Goes Beyond Complexity

- A flawed mental model
- The bizarre organizational dichotomy of American medicine
- The absence of an incentive system
  - Business, academic, marketing... anything

Predictors of robust safety commitment:
- MDs and organization are unified (VA, KP) or
- You’ve made it to 60 Minutes or the NY Times (Hopkins, Duke, Dana Farber)
...our cases are less horror stories of malfeasance or incompetence than cautionary tales about misguided priorities, mixed signals, and mass denial. From Congressional decisions about what kinds of research to fund, to choices by hospitals about where to focus their attention and dollars, to judgments by medical and nursing schools about how to train the healers of tomorrow--safety has always been an afterthought. It is the problem you tackled after all the high-tech, profitable and sexy stuff was taken care of (which, of course, it never was)…
… We all know that [we] maim and kill the patients we aim to heal with shocking regularity, but our profession has reacted to this knowledge mostly with a collective shrug of its shoulders. We have become inured to and paralyzed by it, coming to think of medical errors as the unavoidable collateral damage of a heroic, high-tech war we otherwise seem to be winning. It’s as if we spent the last 30 years building a really souped-up sports car, but barely a dime or a moment making sure it has bumpers, seat belts, and airbags.
What Has Worked?

- Regulations
- Reporting Systems
- Teamwork Training and Simulation
- Clinical Information Technology
- Malpractice and Other Venues for Accountability
- Workforce Issues
Regulations: A-

- Why regulation?
  - “Let me read your order back to you…”
  - Sign your site: “X” marks the spot
  - The pilots in the OR

- JCAHO gets real

- But will probably run out of gas
  - Awfully hard to regulate culture
  - Regulation often oversteps
Reporting Systems: C

- Flawed notion that reporting has any intrinsic value
  - Create stories
  - Generate action
  - A feedback loop

- Huge opportunity to waste time, money, and promote wrong paradigm
  - “We could stop reporting tomorrow…”

- Some successes
WebMM.ahrq.gov

Cases & Commentaries: MAY 2005

**Emergency Medicine**

**Mistaken Impressions**

**SPOTLIGHT CASE**
Using past WebM&M cases, the authors discuss the challenges inherent in classifying diagnostic mistakes as medical errors.

**Medicine**

**Discharge AMA**
A man admitted with alcoholic dementia and a broken upper arm refuses surgery and decides to leave the hospital in the middle of the night.

**Ob/Gyn**

**Pregnant with Danger**
A woman who was 38 weeks pregnant came to the emergency department (ED) complaining of left leg pain. Ruled out for DVT, she was sent home, only to die the following morning.

Commentary by
Robert McNutt, MD; Richard Abrams, MD; Scott Hasler, MD
CME/CEU available

Commentary by
Stephen W. Hwang, MD, MPH

Commentary by
Mark D. Pearlman, MD; Jeffrey S. Desmond, MD

Perspectives on Safety

- **Organizational Change in the Face of Highly Public Errors—I. The Dana-Farber Cancer Institute Experience**
  by James B. Conway; Saul N. Weingart, MD, PhD
- **Organizational Change in the Face of Highly Public Errors—II. The Duke Experience**
  by Karen Frush, MD

Submit your Perspective

AHRQ PSNet Patient Safety Network

What's New: Proposed legislation would support implementation of Regional Health Information Organizations (RHIOs).
Visit AHRQ PSNet for more patient safety news and information

Did You Know?

Some hospitals asking patients to remove or cover rubber wristbands

As some hospitals have turned to color-coded wristbands to indicate their patients’ resuscitation (DNR) status, patients with yellow wristbands may face a new safety hazard. In the past 2 years, nearly 30 million people have purchased Lance Armstrong “LiveStrong” rubber wristbands to support cancer research. Some
Teamwork Training & Simulation: C+

- Emerging evidence is hopeful
- Lots of targets
  - Improve procedures
  - Standardize communications
  - Dampen down hierarchies
- Where is the money?
Teamwork level felt to be “high”

Sexton, British Medical Journal, 2000
Believe that decisions of the “leader” should *not* be questioned

Sexton, BMJ, 2000
Clinical Information Technology: B-

- Benefits may be overstated, ?generalizable
- Costs far more than anybody budgets
  - Risk that it will consume every safety resource
- Expect “unforeseen” consequences
  - Cedars, BI-Deaconess are only the most prominent examples
  - Emerging literature re: problems

But in 2004 we passed the tipping point
The Malpractice System and Other Venues for Accountability: D

- Malpractice system: overrated impact on patient safety
  - It has plenty of baggage, but not the root cause of our safety problem

- Lack of accountability: a big problem
  - There are some bad doctors and nurses, notwithstanding “no blame” paradigm
  - Now, not just competence, but some ignore sensible safety rules
Three Fundamental Tensions

1. How to promote no blame culture for innocent slips or mistakes while holding persistent rule violators or incompetent providers accountable;
2. How to compensate patients for harm without necessarily invoking the heavy hand of tort law;
3. How to hold institutions accountable for allowing unsafe conditions without hammering them in the newspaper or the courts when they acknowledge their flaws.

I believe we have made essentially no progress grappling with these questions since 1999
Workforce Issues: B+

- New care models: hospitalists, intensivists
  - New roles for a “coordinative generalist”
  - Can primary care docs do this in the outpt. world?
- Nursing: connecting workforce issues with safety (with real data)
  - Need comparable data for physicians
- Graduate education: A new frontier
  - ACGME duty-hours limits important
  - Still not tackling the big issue…
“In fact, considerable attention had been given to a plan to anesthetize or tranquilize the astronauts, not to keep them from panicking but just to make sure they would lie there peacefully with their sensors on and not do something that would ruin the flight.”

Tom Wolfe, *The Right Stuff*
Overall Grade: Patient Safety
Five Years After the IOM Report

C+
The End Of The Beginning: Patient Safety Five Years After ‘To Err Is Human’

Amid signs of progress, there is still a long way to go.

by Robert M. Wachter

ABSTRACT: The Institute of Medicine’s 1999 report on medical errors galvanized public and health professionals. Before then, providers, health care organizations, and the public had little awareness of how often such errors occurred, how serious they were, or how they might be prevented. The report came as the result of an 11-year study that examined medical errors that killed or seriously injured patients. The Institute set out a number of recommendations to help prevent such errors. A key one was that nonpunitive systems for reporting errors be developed. This has not happened. In this Health Affairs, the authors consider whether nonpunitive systems for reporting errors have been established and what has prevented them from doing so.
## A Brief Sampler

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<td>Ratios (e.g. class size)</td>
<td>Aiken, <em>JAMA</em>, 2002</td>
<td>CA legislation, other pressure</td>
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<td>Fatigue (e.g. truck drivers)</td>
<td>Landrigan, <em>NEJM</em>, 2004</td>
<td>ACGME regs, more coming</td>
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<td>EBM (clinical medicine)</td>
<td>AHRQ Evidence Rept 2001, NQF</td>
<td>Some JCAHO regs, 100K Lives</td>
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The Safety Pie

JCAHO, CMS, Fixing last sentinel event

HIT, Leapfrog

e.g., RRTs vs. Teamwork Training

That Ye Must Do
That Ye Sorta Must Do
What's Left
Pre-IOM Era

- Patient safety not in the vocabulary
- Little understanding of nature of problem
- Providers: Kubler-Ross stages I/II
- No business case for change
- No significant IT infrastructure
- Weak regulations and enforcement
- No research to inform decision-making
Patient Safety in 2005

- “Changed the conversation”
- Many “get” systems thinking
- Providers now at acceptance stage (mostly)
- Growing business case
- Early IT adoption, improving systems
- Much more robust regulation
- Impressive research progress
Patient Safety in 2010

- Core value of system
- Virtually everybody “gets it”
- Embedded in curriculum
- Moderately powerful business case
- IT a “must have”
- Regulation marches on
- Research continues to drive change
Lessons of the Post-IOM Era

- Pt. safety is too complicated for it to be “one thing”
  - Diverse research techniques/agenda
  - Diverse set of drivers of change
  - Nothing can work in isolation (e.g. IT and safety culture)
- Watch out for squeezed balloons
- Expect unexpected consequences
  - Workarounds, fudging, IT-induced glitches to be expected
- No point in doing the research unless it drives change
  - In practice, understanding, funding… something real