Patient Safety Ten Years After the IOM Report on Medical Errors: Unmistakable Progress and Troubling Gaps

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Disclosures: Dr. Wachter is on the board of the American Board of Internal Medicine, has a contract from AHRQ to edit two patient safety websites, and is or has been compensated to serve on the healthcare advisory boards of Google, Epocrates, and PatientSafe Solutions. No products will be discussed.

“The IOM Report” December, 1999

The BBC’s “Wrong Guy”

Guy Goma
Guy Kewney

Anchor: “Guy Kewney is the editor of the technology website ‘Music Online’… were you surprised by today’s verdict?”

The Wrong Guy: “I was very surprised…”

http://news.bbc.co.uk/1/hi/entertainment/4774429.stm
What Were the Problems?

- Wrong mental model: all about individual fault
- No expertise: how to analyze errors and fix systems, how other industries do safety
- No infrastructure: IT, national standards, transparency, robust local org chart
- Little research: evidence-based practices that work, implementation science
- Absolutely no business case to invest in/focus on patient safety

What Has Worked?

- Regulations
- Reporting Systems
- Clinical IT
- Balancing “No Blame” and Accountability

Regulations: B+ *(down from A- in 2004**)

- Why regulation/accreditation?
  - Sign your site: “X” marks the spot
- The Joint Commission gets real
- But beginning to run out of gas
  - One size fits all
  - Hard to regulate culture (leadership standards, disruptive behavior)
  - Limited knowledge base (med rec)


Reporting Systems: B+ *(up from C)

- Flawed notion that reporting has any intrinsic value by itself
- Huge opportunity to waste time, money, and squander caregiver good will
  - Admonition to “report everything” was silly and naïve (and a mis-analogy from aviation)
**Public Reporting**

- Biggest surprise of quality revolution
  - Simple reporting leads to major improvements
  - Mechanism is shame/pride, not public scrutiny

- Problem viz medical errors: measuring safety
  - Medicare public measures all quality, not safety
    - Processes (beta blockers, aspirin, flu shots), outcome (risk-adjusted mortality)
  - At this point, measuring safety mostly depends on self reports
    - Except for certain healthcare-associated infections

**How Would You Interpret These Hospital Incident Report Data?**

**And How About These?**

**Why Reporting Systems Are Gaining Mojo**

- Key was to develop a manageable list of topics (NQF “never events”)
- 27 states now require reports of NQF list
- Key is internal change, not outside analysis
  - CA’s required reporting of “never events” has transformed UCSF’s RCA process
- New: efforts by CMS to use “never events” to create “non-pay for non-performance” pressure
Healthcare IT: C+ (down from B-)

- Not worse than it was, but juxtaposition with IT in the rest of our lives is even more jarring
- Early glowing studies were not generalizable to vendor-built systems
- Expect unforeseen consequences
  - Emerging literature re: problems

But $19B says we’ve now passed the tipping point

Balancing “No Blame” and Accountability: C+ (up from D+)

- The “No Blame,” “It’s the System Stupid” approach has been crucial
  - Most errors are “slips” – expected behavior by humans, particularly when engaged in “automatic behaviors”
  - Can only be fixed by improving systems (checklists, double-checks, standardization, IT, other new technology…)

Is IT The Path To Improvement? What I Learned At Residents’ Report

Why We Needed a Systems Approach
Two Disconnected Conversations

No Blame

Accountability

At the Junction, the Message Gets a Little Garbled...

NOBL

ACCO

BLAN

TABI

METY

In Summary, We Struggle With Two Competing Epiphanies

- Most errors are committed by caring, competent people who are trying hard to get it right
- Therefore, finger-pointing, shaming and suing them doesn’t help, it stifles open discussions and learning
- The system produces low quality, unsafe, unreliable care partly because there’s been no incentive to do otherwise
- Therefore, the last 10 years have seen a variety of initiatives to create accountability, which generates action, focus, and resource flow

Jack Rowe’s Desk

Accountability at individual and organizational level

Define errors, measure errors, reporting systems, IT, new accreditation standards, change education, provide resources…

Too Hard!
What Does Accountability Look Like?

- Reasonable performance expectations
  - Applied fairly, expectations similar for all
  - Appropriate carrots and sticks used to drive system toward excellence
- “No blame” is the dominant front-line culture
  - For innocent slips and mistakes
- Clear demarcation of blameworthy acts
  - E.g., Gross incompetence, disruptive behavior, and now, failure to heed reasonable safety/quality rules

Individual Accountability: The Hand Washing Story

- Typical hand hygiene rates circa 1999: 10-30%
- Over last decade, tremendous push to improve (via transparency, social pressures, and more)
- Many organizations now at 40-70%, and stuck
- “It’s a Systems Problem”: Education, dispensers every 3 feet
- A systems problem? Really?

Who Decided that a 60% Hand Washing Rate is a “Systems Problem”?

- The practice is important and works
- The systems have been fixed
- Unintended consequences have been addressed
- Providers understand the practice, its value, the auditing strategy, and the penalties
- A single transgression has led to a warning

At that point…
Weakness is provocative

The Bottom Line: Leaders and organizations will be held accountable

“‘No blame’ is not a moral imperative (even if it seems so to providers, it most definitely does not to patients). Rather, it’s a tactic to achieve ends for which providers and healthcare organizations will be held accountable.”

Wachter, Pronovost, NEJM, 2009

Overall Grade: Patient Safety
10 Years After the IOM Report

B-

Where Are We A Decade Into the Quality and Safety Revolutions?

This is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning.