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Recent safety scandals suggest healthcare leaders haven't learned lessons

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Betsy Lehman's death from a chemotherapy overdose prompted the Institute of Medicine's investigation of medical errors.

Safety experts say the recent deadly problems at top hospitals demonstrate holes in the culture of safety, transparency and measurement of errors.

The 1994 death of Boston Globe health reporter Betsy Lehman from a chemotherapy overdose at the Dana-Farber Cancer Institute prompted the Institute of Medicine's investigation of medical errors, catalyzing a national movement to improve patient safety.

But the IOM's To Err is Human report and 20 years of subsequent safety efforts hardly eliminated the problem. News investigations over the past year and a half have found that patients continue to die at prestigious hospitals from preventable errors, even after physicians and staff warned hospital leaders about chronic safety issues.

UNC Health Care System, Baylor St. Luke's Medical Center, Johns Hopkins All Children's Hospital, and University of Texas MD Anderson Cancer Center each have come under fire for medical errors and adverse events that led to the deaths and injuries of pediatric and adult patients.

The revelations of systematic problems at these major hospitals have disturbed safety experts, who wonder whether healthcare leaders have truly learned the painful lessons of how to reduce patient harm. These cases, they say, demonstrate holes in the culture of safety, transparency, and routine measurement of errors and adverse events.

“Once harm occurs, some leaders aren't interested in hearing about it,” said Dr. Stephen Swensen, former director of leadership and organization development at Mayo Clinic. “They may be thinking, ‘If this got out, what would that do to our U.S. News rating, our brand, or our referrals?’ ”

In some recent instances, system leaders knew of the safety problems while they were occurring but took little or no corrective action until the news reports were published. Even then, some of the systems initially defended their quality of care and denied there were safety lapses.

“The key thing is their own people were telling them you have a problem,” said Dr. Brent James, former chief quality officer at Intermountain Healthcare. “But they weren’t paying attention to that signal, which tells me it wasn’t high on their priority list.”

At Baylor St. Luke’s, part of CHI St. Luke’s Health, the Houston Chronicle and ProPublica documented a high rate of deaths and complications for heart, liver, and lung transplants, as well as poor outcomes for heart bypass surgery. In addition, a patient died in the emergency department after staff used the wrong blood type for a transfusion, which the CMS found to be part of a pattern of blood labeling errors.

At least two Baylor St. Luke’s physicians said they told administrators about problems with cases done by the hospital’s transplant surgical director and asked for an external review, without success.

At Johns Hopkins All Children’s Hospital in St. Petersburg, Fla., the hospital’s mortality rate for heart surgery patients tripled from 2015 to 2017, and the post-surgical infection rate soared, the Tampa Bay Times found. Front-line staff had warned supervisors that procedures were endangering patients, but hospital leaders waited more than a year to halt them.

At UNC’s North Carolina Children’s Hospital, the New York Times found that the facility had a higher mortality rate for cardiac surgery than nearly all of the 82 hospitals nationwide that publicly report their death rates.

The newspaper also obtained secret audio recordings in which cardiologists expressed urgent safety concerns to the chief cardiac surgeon and chief pediatrician, who shared their fears but worried about lost revenue if the cardiologists sent their patients to other hospitals.

At MD Anderson, the death of a young patient from a bacteria-contaminated blood transfusion prompted a CMS investigation that found systematic safety issues at the hospital, including nurses not properly monitoring patients’ vital signs while administering transfusions.

Baylor St. Luke’s and All Children’s subsequently replaced their top leadership. The North Carolina Children’s Hospital temporarily halted complex heart operations. The CMS terminated federal funding for heart transplants at Baylor St. Luke’s. The agency imposed a systems improvement agreement on All Children’s.

Johns Hopkins Health System, whose Armstrong Institute for Patient Safety and Quality is a leader in promoting safety around the world, commissioned an independent review of what went wrong at All Children’s.

In June, the reviewers from the law firm Gibson Dunn & Crutcher, after interviewing 119 current and former employees, recommended prioritizing “a culture of absolute commitment” to patient safety, including promoting a “see something, say something” culture of reporting safety concerns. They also suggested having the Armstrong Institute focus on safety oversight within the Johns Hopkins system.

The Johns Hopkins Medicine board announced that a monitoring team will track and report progress on the recommendations at all six Hopkins hospitals.

Johns Hopkins declined to make any executives available to discuss lessons learned from the All Children’s experience. In June, Johns Hopkins Health System president Kevin Sowers said “we are committed to doing everything we can to ensure that what happened never occurs again at any of our hospitals or at other hospitals around the country.”

UNC, Baylor St. Luke’s, and MD Anderson also declined to make any executives available to talk. Several other hospital executives, who have dealt with medical errors under their tenure and in some cases publicly apologized, also declined to comment for this story.

In September, an external advisory panel of medical experts said UNC had made “significant investment and progress” in improving the heart surgery program at North Carolina Children’s, after which UNC said it may resume complex heart procedures.

MD Anderson said in a written statement that blood transfusions “carry inherent risks ... and in rare instances severe reactions occur.” It went on to say that “we recognize and embrace the opportunity to further enhance and improve our patient care efforts and robust safety measures ... and we already have implemented changes in our clinical practice.”

A number of experts said these cases highlight the need to build an institutional culture where staff are encouraged to report safety problems they see.

“The culture issue in medicine hasn’t moved as much as we’d like,” said Dr. Ashish Jha, professor of global health at Harvard University. “We’d like to get to the point where people are celebrated for identifying errors and making the system better. But that happens very infrequently.”

Some hope that this tragic cluster of preventable deaths and injuries at top hospitals will spur a renewed focus on patient safety, the same way Betsy Lehman’s death did 25 years ago. But the disclosure—and the reputational and financial damage they caused—also could have the opposite result.

“These big national scandals drive the agenda forward, creating political momentum and funding,” said Dr. Robert Wachter, chair of the department of medicine at University of California, San

Francisco, who has written a standard textbook on patient safety.

On the other hand, he warned, the disclosures also may cause healthcare organizations to become more secretive about errors. “It’s so disruptive that it might tamp down internal openness to understand your own flaws and solve the problem,” he said. “It’s an incredibly tricky problem.”

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Inline Play

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