https://www.modernhealthcare.com/opinion-editorial/despite-progress-were-still-waiting-truly-safer-healthcare-system

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Despite progress, we're still waiting for a truly safer healthcare system

Dr. Don Berwick

Dr. Don Berwick is president emeritus and senior fellow at the Institute for Healthcare Improvement in Boston. He was a member of the Institute of Medicine's Committee on Quality of Health Care in America, which drafted *To Err is Human,* released in 1999.

In the 20 years since *To Err is Human*, so far as we can determine, the progress toward truly safer patient care remains frustratingly slow and spotty.

Terror. No softer word captures what I felt that night 45 years ago when I almost killed a baby. The decades have fogged a few of the details, but not the emotions: guilt, humiliation, self-loathing, loneliness. They flood back easily, untempered, with the memory.

The core fact was simple: I gave the newborn infant the wrong blood transfusion. His heart rate rose astronomically, his blood pressure fell and his kidneys began to fail. Intensive care saved him, but the shame I felt made me reconsider for a long time my decision to become a doctor. "How could I have been so stupid?" I wondered, over and over again.

Every doctor and nurse knows that feeling. After all, "to err is human." Normal human fragilities cause fathers to mix up hilariously their own daughters'

names, chefs to forget the salt and weary homebound commuters to turn left when they darn well knew to turn right. Our human brains have human limits—we are vulnerable to memory lapses, fatigue, distraction, and countless other “human factors.” The errors in daily life are usually just annoying or amusing. In riskier settings, like airplanes, nuclear power plants or medical care, they are no less common, but not so funny. They can be lethal.

Smart designs build guardrails around human frailties. They protect us against ourselves. Smart safety initiatives eschew blame because, after all, what sense could there be in demanding that humans become superhuman? The pioneering scientists of safety began learning that more than a half-century ago, which is why airplane travel, for example, in the mid-20th century became literally 100 times safer in just a few years. The bad news is that healthcare was much slower to wake up.

The 1999 Institute of Medicine report *To Err Is Human* brought a dramatic inflection into the world of medicine: the entry of science into the pursuit of safer care. That report had three main points: First, it assembled incontrovertible evidence that errors in healthcare, most of them avoidable, were killing tens of thousands of hospitalized patients every single year; second, it asserted that this harm could not reasonably be attributed to some miscreant or incompetent subset of clinicians—in other words, the harm was a “system property” and therefore the risks affected everyone; and, third, it recommended a concerted effort to reduce the toll by redesigning care, not by blaming people.

How distant were these conclusions from my headspace that night in the neonatal intensive-care unit! I thought I was alone in my error—that I was the exceptional fool. I thought that I was the sole and blameworthy cause; I had no concept of a “system” at work, setting me up to fail. And I had no chance at all to change the system to prevent future harm. Indeed, the harm was, and remained, a secret.

In the 20 years since *To Err Is Human*, many, if not most, U.S. healthcare organizations have worked on patient safety projects. Programs have become common aiming to reduce hospital infection rates, pressure sores in bedridden patients, surgical complications, and medication errors, and—at this project level—results are well-documented. Central venous line bacterial infections have fallen by 50% or more, for example. We have learned that surgical “timeouts” and checklists in operating rooms can make surgery safer.

But, overall, so far as we can determine, the progress toward truly safer patient care remains frustratingly slow and spotty. Doing projects is not the same as transforming a system. Well-run airlines don't rely on "safety projects"; the scientific pursuit of safety infuses absolutely everything they do, all the time.

Disturbingly, surveys of hospital boards and executives in the past few years show the opposite. Patient safety and other quality improvement goals have slipped down the priority list, displaced by concerns about changing payment models, drugs prices, clinician burnout, and more.

We still lack a reliable and agreed-upon summative metric of the safety of a hospital or health system, but most experts seem to agree: The systemic pursuit of improved patient safety has stalled. A 2015 report from the National Patient Safety Foundation (which has since merged with the Institute for Healthcare Improvement), *Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human*, called for a renewal, centering patient safety in the core strategic plans of healthcare organizations and for the nation as a whole. So far, on the whole, we are still waiting.

And that means that both too many patients and too many clinicians remain needlessly vulnerable to injury, both physical and psychological.

If this were a disease outbreak, killing tens of thousands and harming millions, as patient injuries do every year, mobilization would be complete. Perhaps in the case of patient safety, it will take an angrier public, more assertive payers, and a more surveillant government to ignite the response we really need.

https://www.modernhealthcare.com/opinion-editorial/one-size-fits-all-approach-patient-safety-improvement-wont-get-us-ultimate-goal

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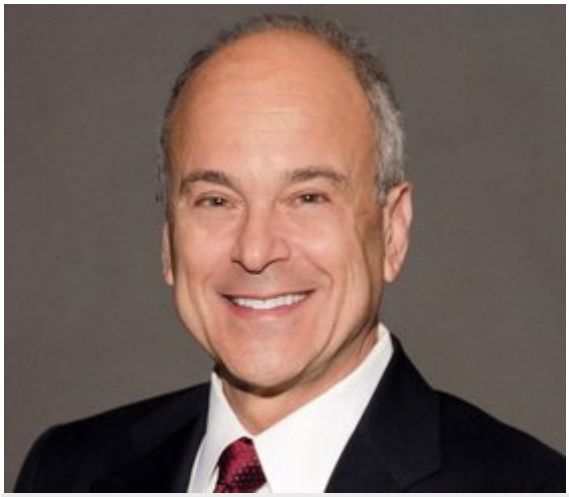
One-size-fits-all approach to patient safety improvement won't get us to the ultimate goal—zero harm

Dr. Mark Chassin



Dr. Mark Chassin is president and CEO of The Joint Commission. He was a member of the Institute of Medicine's Committee on Quality of Health Care in America, which drafted "To Err is Human," released in 1999.

The success that the Institute of Medicine achieved by raising awareness of the seriousness and ubiquity of safety and quality problems has not been matched by our ability to solve them.

The Institute of Medicine reports *To Err is Human: Building a Safer Health System*, published 20 years ago, followed by *Crossing the Quality Chasm: The IOM Health Care Quality Initiative* two years later, have led to considerable efforts to improve healthcare. Despite that work, no one can be satisfied with the levels of safety and quality we have attained so far.

Familiar quality problems persist at unacceptably high rates. Hand-hygiene noncompliance, patient falls with injury, and wrong-site surgery are just a few. Best estimates, for example, suggest that invasive procedures on the wrong patient or body part occur about 45 times every week in the U.S. The success that the IOM reports achieved by raising awareness of the seriousness and ubiquity of safety and quality problems has not been matched by our ability to solve them. The challenge now is to reap far larger gains from all the resources devoted to improvement. Doing so will require three major changes in the way we carry out quality improvement.

First, we must articulate a much more ambitious goal. Healthcare leaders should commit themselves to achieve the ultimate goal of zero harm, meaning zero complications of care, zero injuries to caregivers, zero episodes of overuse, and zero missed opportunities to provide effective care. The passionate commitment to zero harm lies at the heart of industries in the U.S. like commercial aviation and nuclear power that have established such

exemplary safety records and earned them recognition as high-reliability organizations. Clearly, this is a heavy lift for healthcare, and it will not be achieved rapidly. But if zero harm is not the right goal, then how much harm is acceptable?

Second, leaders must drastically overhaul the culture within their organizations. Too many caregivers are too often subjected to disrespectful and demeaning behavior when they raise concerns about safety and quality. Such behaviors drive critical information about unsafe conditions underground, not to be discovered until patient harm results. Leaders cannot delegate this responsibility. They must personally move to the forefront of efforts to celebrate the reporting and mitigating of quality problems. In addition, leaders must establish programs that hold every caregiver—regardless of seniority or professional affiliation—accountable for consistent adherence to safety protocols and agreed-upon safe practices. Failing to address these problems leaves healthcare organizations vulnerable to myriad risks.

Third, leaders must face the reality that healthcare safety processes very often fail at rates of 50% or more. Hand-hygiene compliance and hand-off communication are two of the more conspicuous examples. Major gains will develop only from the work done by healthcare leaders and their organizations. Other interested stakeholders—government, business and patient advocacy groups—cannot deliver the results we all want. Nor will market forces. Realizing those gains requires sober consideration of the magnitude and nature of the progress we have made, which has been significant if not sufficient, and an understanding of the limitations of the methods we have used to achieve that progress.

The improvements we have achieved over the past 20 years have largely resulted from healthcare organizations undertaking a series of focused projects: to reduce central-line infections or pressure ulcers or medication errors, etc. Broadly speaking, the method we have employed is the “one-size-fits-all” best practice. Experts review evidence and come to a consensus about how to solve a problem. Then we produce a variety of guidelines, toolkits, checklists and protocols that every healthcare organization is expected to use in the same way. The result, with very few exceptions, has been modest and inconsistent improvement that is difficult to sustain and even more difficult to spread. We cannot continue to use the same methods and expect different results.

Evidence is accumulating that process improvement methods long used successfully in industry—Lean, Six Sigma, and change management, taken together—are far more effective than the “one-size-fits-all” best-practice approach. What’s different about them is their capacity to pinpoint and measure the frequency of the critical few key causes of persistent quality problems. Interventions targeted to eliminate the key causes lead to major improvements. The key causes differ from place to place, however, which necessitates the identification of those key causes before deploying interventions.

That is why applying the same best practice everywhere yields such disappointing results. Published reports document that hospitals and health systems using these methods have achieved improvements of 50% to 70% in reducing falls with injury, risks of wrong-site surgery, and hand-hygiene noncompliance, among others. Leaders should apply these improvement methods systematically and broadly to facilitate the transformation of their organizations from low to high reliability.

Achieving zero harm is a daunting challenge. Satisfaction with the status quo in quality and safety is untenable. We need to break new ground. Meanwhile, some healthcare organizations are starting to show us that zero is possible. Leadership commitment to the goal, strong action to improve organizational culture, and the enthusiastic adoption of new, highly effective improvement methods will advance healthcare on its journey to zero harm.

https://www.modernhealthcare.com/opinion-editorial/err-human-thats-still-true-20-years-later-some-solutions-problem-arent-helping

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To err is human. That’s still true 20 years later, but some solutions to the problem aren’t helping

Dr. Christine Cassel

Dr. Christine Cassel is senior adviser for strategy and policy in the department of medicine at the University of California at San Francisco and formerly was CEO of the National Quality Forum. She was a member of the Institute of Medicine's Committee on Quality of Health Care in America, which drafted "To Err is Human," released in 1999.

Some experts believe that the attention to measurement and pay for performance has obscured more fundamental drivers of quality that would enhance the intrinsic motivation of the human beings on the front lines of care.

When the Institute of Medicine's Committee on Quality of Health Care in America, of which I was a member, published the landmark report *To Err is Human: Building a Safer Health System* in 1999, I was working in New York as department chair of geriatric medicine at Mount Sinai School of Medicine, so I got the cold calls early that morning to appear on the news shows. The report prompted a lot of interest with its estimates of up to 98,000 deaths every year from preventable mistakes in hospitals.

Our recommendations focused on ways the systems of care could be redesigned to reduce the likelihood of errors. The message "to err is human" was intentionally meant to say that in the complex world of modern medicine, error cannot be totally prevented by individual clinicians, no matter how well trained or how vigilant they may be. In spite of that message, many reporters at the time were relentlessly focused on the question: "How can the public find the bad doctors?"

Media coverage of healthcare quality has become much more sophisticated since that time. And huge amounts of performance data now surround us. There have been advances in measurement science, proliferation of "report cards," and growth in accreditation and certification organizations of various sorts. These are now linked to payment in many ways, and we have seen

progress in quality of care in many domains. But using performance metrics to evaluate individual doctors and pay them for “value” is fraught with problems.

The performance of a physician or advanced-practice clinician involves so many different dimensions of competence, knowledge, skills and emotional intelligence that it is hard to imagine five or 10 specific publicly reported measures will capture the quality of care delivered. More importantly, clinicians everywhere are now part of teams and systems. Care of the patient depends on many people and technical resources controlled by delivery systems and organizations. The metrics are necessary to help the team and the system know where they should focus on improvement, but those metrics don’t really paint a picture of the individual doctor or nurse.

Some experts believe that the attention to measurement and pay for performance has obscured more fundamental drivers of quality that would enhance the intrinsic motivation of the human beings on the front lines of care, and create more patient-centered coordinated care. Perhaps the adage “to err is human” also applies to the many well-meaning policies and procedures we’ve put in place in our efforts to drive safety and quality.

The National Academy of Medicine (previously the IOM) released another report this year that marks the next challenge for healthcare quality: clinician well-being. Documenting high levels of burnout among doctors, nurses and other clinicians, the report points to the complex systems and bureaucracies that clinicians have to navigate and recommends human factors analysis and systems engineering approaches to reduce the barriers to the effective and fulfilling work of patient care. Like *To Err is Human* made clear 20 years ago, we do not see the answer solely in increasing resilience of individual clinicians, but call on leaders, managers and policymakers to develop the road to relief.

There are many factors leading to the stresses on clinicians, and some of them stem from demands for performance measurement and documentation for billing. While this isn’t the only factor, information technology creates more demands, not fewer. We must now ask ourselves how much of this information is truly useful, and how much could it be reduced or technologically streamlined? Over the coming decade, advances in the use of artificial intelligence, machine learning and cloud-based information systems should also help to remove much of the drudgery and frustration surrounding clinical practice, and allow clinicians to experience joy in the ability to use advanced science combined with their fundamental humanity to connect with our core mission of healing and caring.

Dr. Don Berwick, when he led the Institute for Healthcare Improvement and as administrator of CMS, championed the “Triple Aim”—advancing quality care, population heath and affordability. The new construct, the “Quadruple Aim,” recognizes that the well-being of the healthcare workforce is necessary to achieve the other three.

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Culture of silence contributes to lack of progress on patient safety

AURORA AGUILAR

Aurora Aguilar
Editor

Mistakes can be prevented, but that requires admission of guilt and an action plan that sets goals and holds people accountable if they don’t meet them.

Twenty years ago, the Institute of Medicine reported that 98,000 patient deaths per year stemmed from medical errors. But not enough has changed, and it’s even affected the leaders who are trying to improve healthcare.

Dr. David Blumenthal, a patient-safety expert and president of the Commonwealth Fund, lost his father about nine years ago due to a medical error. Martin Blumenthal underwent neurosurgery for a brain abscess at a prominent, but unnamed by David, teaching hospital in New York City about

10 years ago. While recovering in the neuro ICU the day after surgery, the 88-year-old retired businessman got out of bed, fell and suffered a traumatic brain injury. He died a year later.

David told Modern Healthcare reporter Harris Meyer that he doesn't recall anyone at the hospital talking to him or his family about how the error happened or what the hospital would do to avoid similar events in the future.

"This was totally preventable, and it certainly deserved careful investigation and remediation," Blumenthal said.

This week's series "To Err is a Leadership Failure" examines the reasons why not enough has changed in the past 20 years. Maria Castellucci and Harris Meyer learned that part of the problem is inertia and another part lies in the very human nature to avoid that which makes us uncomfortable—admitting we've made a mistake.

Healthcare still has a prevalent culture of silence. Front-line workers worried about litigation or job loss cover up mistakes and leaders fail to address medical errors even in a preemptive fashion, almost as if not to jinx their luck.

A few months ago, the World Health Organization reported that 40% of patients in primary and outpatient care around the world are harmed by medical errors. Another 10% of patients acquire infections in hospital settings.

After the IOM report in 1999 estimated the cost in additional care, lost income and disability at $17 billion to $29 billion a year, stakeholders rallied. Both industry leaders and policymakers made promises. They organized task forces. They put money behind the efforts. Hospitals set bold goals and invested millions of dollars in technology and hundreds of hours in staff training to prevent surgical, diagnostic, medication and system failures.

Mistakes can be prevented, but that requires admission of guilt and an action plan that sets goals and holds people accountable if they don't meet them. It also requires a change in the mentality of some providers, who might see patients in the aggregate instead of individuals, with families and friends who are left behind to grieve their loved ones and question their trust in the healthcare system.

It also might require healthcare leaders admitting they can't do it on their own. In a recent op-ed in Time magazine, Kathleen Sutcliffe, a Bloomberg Distinguished Professor at Johns Hopkins University and co-author of a

forthcoming book *Still Not Safe: Patient Safety and the Middle-Managing of American Medicine*, suggests that experts outside of medicine be consulted on improving patient safety.

“We live in an era of multifaceted problems that call for multidisciplinary approaches,” Sutcliffe wrote.

It wouldn’t be the first time healthcare learned something from other industries. Lean management first introduced by the automotive industry has made healthcare more efficient and improved patient care. Principles of retail-based customer service are being implemented by progressive healthcare leaders across the country to ensure patient satisfaction.

Few professions require the level of trust that’s necessary for healthcare to run smoothly. Patients must believe that the decisions made by the providers they choose are in their best interest, aren’t wasteful and are prudent. Providers rely on patients to adhere to medication and treatment regimes.

Life is too fragile a thing to take chances. And it’s true, to err is human. But to do as little as has been done in 20 years is inexcusable.