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

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“The IOM Report”
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The BBC’s “Wrong Guy”
Guy Goma  Guy Kewney
http://news.bbc.co.uk/1/hi/entertainment/4774429.stm
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…”

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/Accreditation
- Reporting Systems
- Clinical IT
- Balancing “No Blame” and Accountability
**Regulations/Accreditation: 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
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
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

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

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…)
Why We Needed a Systems Approach

Two Disconnected Conversations

At the Junction, the Message Gets a Little Garbled…
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 insufficient pressure to fix it. Therefore, the last 10 years have seen a variety of initiatives to create accountability, which generates action, focus, and resource flow.

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

Accountability at individual and organizational level

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
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”?

When Is the Accountability Approach Correct?

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
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.