

Don't put this on patients: Sick people are supposed to monitor medical errors? Really??

October 18, 2012

By Karen Wolk Feinstein

I read with interest The New York Times article published in the Post-Gazette Sept. 23, "Feds Want Patients to Report Medical Provider Mistakes." Essentially, the Obama administration wants consumers to report mistakes and unsafe practices by those who provide medical treatment. This is considered a worthy countermeasure to compensate for the lack of reporting by health providers themselves. Even the American Hospital Association and the Agency for Healthcare Research and Quality bless this idea.

As Seth Meyers would say on Saturday Night Live, "Really??"

The reporting of errors by hospitals, doctors and other providers is almost always voluntary and therefore often ignored, so the burden is passed to the patient?

Why is it voluntary in most settings for doctors to mark a surgical site before cutting, for staff to wash their hands, for hospital and examining rooms to be thoroughly cleaned, for safety checklists to be employed? Why do whistleblowers get marginalized? Why are interns and residents afraid to report mistakes they witness? Why are clinicians who often over-treat with unnecessary interventions and tests or who routinely under-treat and fail to perform evidence-based best practices allowed to continue doing these things? What if a patient isn't even aware that medical mistakes are occurring? How could they tattle on their docs?

"Really??"

Would a person eat a meal in a restaurant where they had a 25-percent chance of getting sick because staff don't wash their hands or clean the kitchen well, or where they use expired food or cook food improperly? What if the customer routinely got a meal they didn't order or excess food or meager portions? Would anyone get on a plane or live within 50 miles of a nuclear power plant or purchase an automobile from a manufacturer where safety precautions were optional? OSHA has mandatory reporting for harm done to employees. But there is no mandatory reporting for harm done to patients.

Again, "Really??"

Far more powerful as a barrier to harm would be absolute insistence on the part of hospital boards, CEOs, practice managers and clinical leaders that every health professional report every error -- by themselves or others -- and observe a comprehensive set of safety precautions in every instance without exception while practicing medicine according to proven protocols. Deviations from best practices would be reported to leadership and studied by interdisciplinary teams to determine how to prevent harm in the future. Responsible countermeasures would be tested and adopted systemwide if effective.

These responses to error could be simple, such as increasing the supply or improving the location of sanitary supplies, or punitive if necessary. An example is a local health system's rule -- I don't know if it's ever been enforced -- to levy fines for not washing hands. To reinforce this insistence on safe practices, managers should have the full support of medical, nursing and pharmacist associations.

Leaders have support right now from certain health associations. The American Board of Internal Medicine has instituted a Choosing Wisely campaign. It lists 45 procedures and diagnostics that are useless and sometimes harmful and that could be almost entirely eliminated, preventing danger to patients, saving money and promoting smart medicine. Physician offices and hospitals could adopt and energetically regulate these practices.

The recent widespread adoption of electronic health records by physicians and hospitals makes irresponsible behavior easier to track and identify. It could be required that both mistakes and near-misses be immediately reported. This practice has made aviation and air-traffic control reliably safe.

A national reporting system could record medical errors and the names of health professionals who have been dismissed from their organizations for serious violations of safe practices. Penalties would exist for hospitals and offices that pick up such clinicians without evidence of significant behavior change.

The gist of this argument is apparent. Please don't ask patients to create systems that are safe, efficient and reliable. After all, they are sick or hurt! This is a role for health care leadership, supported wholeheartedly by professional associations who represent clinicians.

In the Aug. 2 edition of The New England Journal of Medicine, Dr. Thomas H. Lee, network president for Partners Healthcare System, described a total makeover of his organization. "Our system's overall goal is to improve care with value defined by the patient. This is our overriding strategy. And we measure progress daily, because we are focused on outcomes. The status quo is unacceptable."

Isn't this the ultimate solution: to design and govern our health systems so that the protection and needs of patients come before everything else? To see that every pathway for error is shut down and that all care is organized to ensure optimal outcomes. To make sure that day-in/day-out practices to reduce preventable harm are tested, implemented and shared.

Really.

###

Karen Wolk Feinstein is president and CEO and the Pittsburgh Regional Health Initiative and a co-founder of the Network for Regional Healthcare Improvement, a national coalition of Regional Health Improvement Collaboratives