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PROFESSION

Fear of punitive response to hospital errors lingers

Most health professionals remain reluctant to discuss problems or report mistakes freely, despite appeals to hospitals that they stop pointing fingers when things go wrong.

By KEVIN B. O'REILLY, amednews staff. *Posted Feb. 20, 2012.*

For more than a decade, patient safety leaders have urged medicine to shift from an approach that shames and blames individual doctors and nurses for medical errors to a "culture of safety" where open discussion and reporting about adverse events, mistakes, disruptive behavior and unsafe conditions are prized rather than punished.

This less-punitive model of medical-error prevention, inspired by the aviation industry's safety record since the 1980s, is a key element of the Joint Commission requirements hospitals must follow to get paid by Medicare. And a growing body of evidence is showing that higher safety culture scores are correlated with better clinical outcomes and lower rates of hospital-acquired conditions.

Yet data released in February by the Agency for Healthcare Research and Quality show that most physicians, nurses, pharmacists and other health professionals working in hospitals believe their organizations are still more interested in punishing missteps and enforcing hierarchy than in encouraging open communication and using adverse-event reports to learn what's gone wrong.

Half of the nearly 600,000 staffers surveyed at more than 1,110 hospitals nationwide said they believe their mistakes are held against them, and 54% said that when an adverse event is reported, "it feels like the person is being written up, not the problem."

Nearly two-thirds said they worry that mistakes are being held in their personnel file. A little less than half of respondents said they "feel free to question the decisions or actions of those with more authority."

These numbers have not substantially improved since AHRQ released its first patient-safety culture report in 2007. About one-fifth of hospitals have improved their performance in the category of "nonpunitive response to error." But 16% have worsened with time, while the majority of hospitals have treaded water on this key indicator of safe culture. A similar pattern has prevailed on the open-communication metric.

"This is a major problem in hospitals, that we still have this residue of a pretty punitive culture," said James B. Battles, PhD, social science analyst for patient safety at AHRQ's Center for Quality Improvement and Patient Safety in Rockville, Md. "We have our work cut out for us."

How fear hurts safety

A medical setting that discourages adverse event reporting hampers efforts to protect patients from harm, said Bob Wachter, MD, chief of the medical service at the University of California, San Francisco Medical Center.

"You could see how the traditional approach -- an event is reported and someone is written up -- has a hall monitor in elementary school feeling to it," said Dr. Wachter, author of the medical textbook *Understanding Patient Safety*. "It's extraordinarily destructive in a patient safety context."

Simply pledging to avoid finger-pointing after mistakes is not good enough, said Bryan Sexton, PhD, who developed a popular safety-culture survey tool separate from the one used by AHRQ.

"They say all politics is local. Well, all culture is local. That's why it is that we say this is so important and yet we don't see a lot of traction," said Sexton, a medical psychologist and director of the Duke University Health System Patient Safety Center in Durham, N.C.

"We've given more rhetoric than we have resources to this problem in health care."

American Medical Association policy supports nonpunitive mechanisms for reporting safety incidents. The Joint Commission and many patient safety experts say hospitals must create an environment where health professionals feel comfortable admitting mistakes and gaps in knowledge, do not fear discipline or punishment for revealing errors, and where unsafe conditions are identified and addressed. Hospitals are advised to specify that acts of intentional harm or reckless noncompliance with safety

protocols will be punished, while promising that other incidents will be investigated with an eye toward preventing future mistakes instead of disciplining the individuals involved.

Implementing such an approach is easier said than done, said Sara J. Singer, PhD, assistant professor in the Dept. of Health Policy and Management at the Harvard School of Public Health in Boston.

"You have to back up a policy like that with repeated, demonstrable acts of organizational learning and systems thinking," said Singer, who has published widely on the link between quality improvement and what she calls the "safety climate" in hospitals.

Patient safety experts said fear of medical liability lawsuits, regulatory action and news media scrutiny also discourage open communication about safety problems. But they noted that those factors are beyond health care organizations' direct control, whereas hospitals can affect the culture that prevails within their walls.

Transparent model may help

Some hospitals have reported steady progress in ditching the shame-and-blame approach. Officials at the University of Illinois Medical Center in Chicago say their policy of investigating and disclosing adverse events to patients and directly offering compensation when appropriate has helped foster a less punitive environment.

In 2005, a year after the hospital adopted its policy, 86% of health professionals said they would not hesitate to report an unanticipated adverse event to the hospital's safety and risk management department. That figure rose to 97% in 2011. The annual number of safety incidents reported by staffers more than quadrupled from 2,000 in 2005 to 9,000 in 2011, including among medical residents. A $3 million grant from AHRQ is aimed at helping other Chicago-area hospitals implement the transparency, disclosure and compensation approach.

Fear of discussing safety problems appears less dire in physician practices than it is in hospitals, according to a 2010 AHRQ survey of 470 medical offices. Where 37% of hospital staffers said they "are afraid to ask questions when something does not seem right," only 30% of physicians, nurses and other health professionals or clerical staff in medical offices feel that way. Some 43% of physician-practice respondents said they feel mistakes are held against them, and nearly 60% said "providers and staff talk openly about office problems."

Patient safety experts said it may be easier for physician practices to create less-punitive environments because they are smaller and less bureaucratic than hospitals, and because mistakes in the office setting are less likely to result immediately in serious patient harm. AHRQ plans to survey more physician practices this year and release a report comparing responses over time in 2013.

Leaving shame and blame behind for good is difficult for hospitals, said Nancy Foster, vice president for quality and patient safety policy at the American Hospital Assn. "In some cases, it might be two steps forward and one step back," she said. "That's unfortunately the nature of the beast in developing culture change."

Improving something as seemingly hazy as the cultural mood at a hospital is certainly complicated, but that reality should not be accepted as an excuse, said Harvard's Singer.

"I don't think you should give hospitals a free pass on this," she said. "Yes, it's hard -- and it's critically important that they do it anyway."

ADDITIONAL INFORMATION:

Hospitals get poor marks on handoffs and workload

Lack of open communication and fear of retribution are not the only ways health professionals rate their hospitals poorly. In a recent survey, the following percentages listed other areas that have the potential to hurt safety efforts:

59%: Things "fall between the cracks" when transferring patients from one unit to another.

56%: Problems occur in the exchange of information across hospital units.

55%: Shift changes are problematic for patients.

50%: Workers are in "crisis mode," trying to do too much too quickly.

44%: There is not enough staff to handle the workload.

39%: Hospital management seems interested in patient safety only after an adverse event happens.

38%: It is just by chance that more serious mistakes don't happen around the hospital.

Source: "Hospital Survey on Patient Safety Culture: 2012 user Comparative Database Report," Agency for Healthcare Research and Quality, February (**www.ahrq.gov/qual/hospsurvey12**)

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"Hospital Survey on Patient Safety Culture: 2012 User Comparative Database Report," Agency for Healthcare Research and

Quality, February (www.ahrq.gov/qual/hospsurvey12)

"2010 Preliminary Comparative Results: Medical Office Survey on Patient Safety Culture," Agency for Healthcare Research and Quality, November 2010 (www.ahrq.gov/qual/mosurvey10/moresults10.htm)

"Identifying organizational cultures that promote patient safety," *Health Care Management*, October-December 2009 (www.ncbi.nlm.nih.gov/pubmed/19858915)

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