

## **No Blame, More Gain: New Business Paradigms in Health Care**

By Dan Harvey, for *Radiology Today*

When former President Bill Clinton looks back on his White House years, most likely he'll view his failure to implement his envisioned healthcare plan as one of his biggest disappointments. However, he may find solace in the fact that, by the end of his tenure, his administration helped heighten awareness about medical errors.

This was achieved by the administration's rapid response to the information contained in "To Err is Human: Building a Safer Health System," the Institute of Medicine's 1999 report on medical errors. So sobering was this report that, within 60 days of its release, the administration proposed a series of initiatives supporting almost every recommendation presented.

### **The IOM Report**

You could say that the IOM report is to the healthcare industry what Martin Luther's 95 Thesis was to organized religion, or what the National Assembly's "Declaration of the Rights of Man and the Citizen" was to the emerging revolutionary spirit in France circa 1789. It has affected thought and prompted action. Consider some of the information contained in the report:

- Between 44,000 and 98,000 people die each year from medical errors.
- More people die each year from medical mistakes than from motor vehicle accidents, AIDS, or breast cancer.
- Errors take place in every healthcare setting—from outpatient clinics and retail pharmacies, to nursing homes and home care.
- More than 7,000 deaths occur annually from medication errors alone.

To help combat medical errors, the report offered a comprehensive strategy for government, industry, consumers and healthcare providers. The strategy included a creation of a national center for patient safety and the implementation of national mandatory and voluntary reporting systems that would also protect the confidentiality of patients and individual healthcare professionals.

Most significantly, the IOM suggested the creation of a "no blame" culture—that is, a culture that eschews finger pointing and instead focuses on modifying systems. A no-blame culture, proponents say, encourages the prevention, detection, and minimization or elimination of errors.

### **Emergence of the No-Blame Paradigm**

Actually, at the time of the IOM report's release, the concept of a no-blame culture was hardly new. In the corporate world—where there is a propensity for adopting revolutionary work processes—the idea was almost firmly entrenched. Engineers, especially, probably would have found much that was familiar about IOM's recommendations. Throughout the 1980s and 1990s, the idea of a no-blame culture was being developed, accepted and implemented.

For many, the concept of no-blame is, at first, hard to grasp if not accept. In fact, it can raise eyebrows. A book that helped introduce the idea to the general public was *The Challenger*

*Launch Decision*, a 1996 work that made some headlines because of the ideas spelled out by author Diane Vaughan, a Boston sociologist. The basic thesis of the book is that the 1986 shuttle disaster occurred not because of human error but because of operating systems. Any mistakes NASA made occurred in the normal course of operations. In other words, there was no one to blame, at least in the traditional sense.

Surprised as the press might have been by Vaughan's conclusions, the ideas she presented were nothing new to thousands of engineers. In the business sector—from the corporate offices to the shop floor—a new management paradigm of “no blame” was already emerging. Thanks to concepts like TPM, Total Quality Management, and Defect Elimination, large companies were engaging in less finger-pointing and taking a more proactive approach to improving and managing quality. To get to the root cause of problems, they focused on systems instead of individuals.

The IOM report resonated with the concept, as it asserted that the majority of medical errors weren't the result of individual carelessness. Rather, they resulted from the way healthcare systems are organized. Along with this assertion, the report advocated the placement of a no-blame culture.

For a no-blame culture to flourish, the report suggested, a system for reporting errors must be fostered. Only in that way could errors be identified and eliminated. Of course, cultural change never comes easy. Some felt a system of reportage would have an opposite and negative effect. It would only encourage cover-ups, increase finger pointing, create more regulations, and lead to more litigation. Others saw it as essential to patient safety improvement.

The argument may be stifled by the Clinton plan, which requires mandatory reporting of serious and preventable medical errors and “close calls.” (In 2000, only 23 states had reporting systems to help track preventable errors and help providers take corrective action. The proposed national system would be state-based and phased in over time.)

### **In the Radiology Department**

Though the IOM didn't make specific mention of radiology, the report still had significant impact in the field. Christine Lung, government relations manager with the American Society of Radiologic Technologists (ASRT), said that the organization looked at the report very closely and is carefully considering many of its suggestion, especially those involving the reevaluation of processes and enhancement of patient safety. “We are looking to find ways to incorporate those suggestions into the radiology department,” she indicates.

As in other areas of the hospital, the radiology department has intrinsic mistakes. Bruce W. Long, MS, RT(R) (CV), associate professor of radiologic sciences at Indiana University, Indianapolis, feels the two mistakes that have the most potential for harm involve labeling and image production. He says that incorrect labeling of the patient/part orientation and suboptimal image production result in failure to identify the problem. “For example, marking an extremity radiograph left when it was a right extremity could result in confusion during treatment,” he points out.

Suboptimal image production can result in a missed diagnosis, he adds. Long also says that, with the recent increase in the use of sedation in radiology, medication errors may become more prevalent.

Jill Schultz, Vice Chairperson of Quality Management of ASRT and Quality Control Compliance Technologist at the Breast and Bone Health Institute in Sioux Falls, SD, feels another area where errors could occur is the recording of information.

“Certainly the potential is there,” she says, “whether it is a typographical issue in reporting or something similar. Other areas where errors might occur could involve rejected and repeated film and exposure errors.”

“From anecdotal information that I’ve either read about or have heard about from technologists,” says Lung, “common errors involve mislabeling of examinations, patient identification, and miscalculations of radiopharmaceuticals in the nuclear medicine lab. Errors involve injecting the wrong radiopharmaceutical or the incorrect dosage for a particular examination. The Nuclear Regulatory Commission actually has evidence of that taking place, and the NRC considers it a reportable event.”

Whatever the errors may be, Lung feels strongly that most have a systemic source.

“Each department within a hospital has its protocols and procedures that its workers must follow,” she says. “If the processes aren’t developed and streamlined and constantly looked at and evaluated, you are going to get a bad outcome. Individuals need to be responsible as far as knowing the differences between right and wrong and knowing what can and can’t lead to a poor patient outcome, but constant reevaluation of those processes needs to take place.”

“If the system errors are taken care of,” says Schultz, “then the majority of things should fall into place from there.”

### **Strategizing for Safety**

As might be expected, in the wake of the IOM report, new approaches to dealing with medical errors are being put in place. Last October, for instance, the National Patient Safety Foundation (NPSF) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) launched a new initiative designed to save lives by putting patient safety research and learning into common practice. The initiative involved the dissemination and promotion of patient safety solutions proven to reduce healthcare errors and improve patient safety. Solutions were disseminated through a “Compendium of Solutions,” later to be co-published by NPSF and JCAHO.

In the meantime, both JCAHO and NPSF have been moving forward in their efforts to help reduce medical errors. JCAHO recently approved standards focused on patient safety and medical error reductions. These standards are added to the organization’s standards that relate to patient safety. Requirements have been added in the following areas:

- Leadership—Hospital leaders must create an environment that encourages error identification and the steps to reduce the likelihood of recurrence. Individual blame and retribution should be minimized. Instead, leadership should concentrate its efforts on creating an organization-wide patient safety program that employs internal and external knowledge and experience to prevent recurrence. Also, leadership should seek to improve organization performance and implement a program for proactive assessment of high-risk activities related to patient safety.
- Management of information—Hospitals are to collect patient safety-related data and information to identify risk to patients; apply knowledge-based information to reduce these risks; and effectively communicate this to all those involved in patient safety issues. The intent is to guide and improve professional and organizational performance. Also, hospitals must place appropriate emphasis on patient safety in areas such as patient rights, education of patients and families, continuity of care and management of human resources.

JCAHO anticipates implementation of the new standards by July 2001.

The NPFS is convening workshops in patient safety initiatives that bring together experts of diverse backgrounds to address patient safety needs. The first such workshop took place in late October 2000 and involved the Renal Physicians Association (RPA) and Forum of End Stage Renal Disease (ESRD) Networks.

Spurred by the results of its own survey, the Robert Wood Johnson Foundation (RWJF) has created a \$20.9 million initiative called “Pursuing Perfection,” a three-year campaign that would grant doctors and hospitals money to improve health care. The survey, conducted in March and April of 2001, involved 600 physicians, 400 nurses and 200 senior-level hospital executives. The results were as disquieting as anything included in the IOM report. According to the RWJF survey, 58 percent of respondents feel health care in the United States isn’t very good, 72 percent said fundamental changes were needed, and 61 percent accept common medical errors as routine. Most alarmingly, 95 percent of physician respondents reported that they had witnessed a serious medical error. Under the initiative, 12 groups will receive money to develop business plans while six will receive money to implement system-wide changes.

### **The CARE Bill**

The one item that has the most direct impact on radiology is the Consumer Assurance of Radiologic Excellence Act. Better known as CARE, the bill is designed to ensure that health professionals performing radiologic procedures or radiation therapy are properly qualified.

CARE directs the Department of Health and Human Services to establish federal minimum standards of education and certification standards. The bill would amend the Consumer-Patient Radiation Health and Safety Act, a 1981 law that established minimum standards for the education and credentialing of radiologic technologists. But compliance with that act is voluntary and only 35 states have enacted licensure laws for radiographers while only 28 states license radiation therapists and only 21 states license nuclear medicine technologists. In states where no licensure exists, individuals can perform radiologic procedures without any formal education.

“There are errors going on that would not happen if people had the right education,” says Schultz.

The bill hit a bit of a stumbling block when Representative Rick Lazio, who first brought the bill to the floor of the House of Representatives, was defeated in his bid for a Senate seat by, ironically enough, Hillary Rodham Clinton. But Congresswoman Heather Wilson (R-NM) picked up the dropped baton last March, when she introduced the bill as HR 1011 in the 107<sup>th</sup> Congress. Representative Wilson feels uniform standards will ultimately improve patient care by improving the quality of images, reducing patients’ exposure to radiation and ensuring proper diagnosis and treatment.

The CARE bill will require the 35 states that regulate medical imaging and radiation therapy personnel to make their standards current and the 15 remaining states to implement standards and regulations. “The ASRT feels the bill will help reduce medical errors by having educated and credentialed technologists performing examinations,” says Lung.

The bill is supported by the Alliance for Quality Medical Imaging and Radiation Therapy, a coalition of radiologic science organizations representing more than 250,000 healthcare professionals (*see sidebar*). In fact, the ASRT has been instrumental in the Alliance’s establishment.

“From the ASRT’s point of view, the IOM report only made more obvious the need for educated and credentialed technologists,” says Lung. “ASRT recognized the need to take a stand as a professional organization for technologists and as advocates for quality patient care. And we feel that, through the CARE bill, we have done that.”

If passed by the house, the bill then goes to senate for consideration. If passed in the senate, it will then be presented to President Bush, who can either sign it into law or veto it. If the bill becomes law, it would require compliance to the act of 1981 or would result in a restriction of federal monies for state-operated healthcare programs in non-compliant states.

## **Conclusion**

As the title of IOM report suggests—and Shakespeare ably demonstrated—errors are a part of the human condition.

Accepting that knowledge is one thing; managing it properly is another. Sacrificing a “scapegoat” serves no good end. It stymies a proper investigation that could ultimately lead to the root cause of the problem. Fortunately, as far as the elimination of medical errors is concerned, the healthcare industry appears ready to cast aside provincial thinking in favor of a more proactive approach. In this new climate, concepts like no-blame make a lot of sense. And why do we need uniform standards for education and certification? That’s an easy question to answer.

Why haven’t we had uniform standards before? Now that’s the tough one.