

the care, but have “vivid memories of what somebody said to them. Those memories could be very positive—exactly the right word when they needed to hear it—or searingly negative, creating anger that never goes away.”

Beyond merely tolerating such straightforward conversations, the Harvard hospitals’ medical malpractice insurer is funding

the training program. Controlled Risk Insurance Company/Risk Management Foundation (CRICO/RMF), the self-insurance vehicle for the University’s teaching hospitals, has also produced a documentary, directed by Koplow-Tullis professor of general medicine and primary care Thomas L. Delbanco, that features interviews with victims of medical injuries and their fami-

lies. Many of the sentiments expressed aren’t pleasant—“One doctor told me I had a 50 percent chance of living...and then he walked away,” one woman recalls—but the insurer uses it because “sometimes it’s hard to hear the voice,” says Robert Hanscom, the foundation’s vice president for loss prevention and safety. “You can only spend 10 minutes with this patient—gotta move on

Inevitable Mistakes, Avoidable Harm

The culture of medicine has long tried to keep doctors from making mistakes by indoctrinating them to believe that they *shouldn’t* make mistakes. “It’s the way we’re trained as physicians,” says Tejal Gandhi, executive director of quality and safety at the Harvard-affiliated Brigham and Women’s Hospital. “Unfortunately, a lot of times, people feel like they need to be perfect.”

But doctors are human and therefore prone to error, so many in the healthcare industry are urging a culture shift: assume that mistakes will happen and focus on catching them before they harm a patient, by building double- and triple-checks and balances into systems. This way, mistakes become breakdowns in the system, rather than personal failings. “It isn’t a case of an individual failing a patient,” says Gregg Meyer, senior vice president for quality and safety at Massachusetts General Hospital. “It’s a case of the system failing both the patient and the provider.”

The old culture of perfection may actually hold hospitals back. Amy C. Edmondson, Novartis professor of leadership and management at Harvard Business School, has shown that the way hospitals handle mistakes, and employees who make them, is integral to improving patient safety (see “Secret Errors Kill,” March-April 2001, page 11). Consistent reporting of errors is crucial, but employees won’t report mistakes—colleagues’ or their own—unless the hospital has cultivated an environment of what Edmondson calls “psychological safety.” Nurses and other clinicians whose status is relatively low hesitate to speak up, even if they see a doctor making a mistake that could hurt a patient, if they feel the doctor will respond harshly to criticism or questioning. That dynamic exists in many workplaces, but in an operating room, the consequences can be grave. “We need surgeons to be unbelievably confident,” says Edmondson. “But they also need to be confident enough to embrace someone else bringing up something they might have missed, like the fact that the x-ray is on the light box backwards.”

Some Harvard teaching hospitals have tried to create the receptive environment Edmondson describes. Brigham and Women’s now responds to each report of a mistake or a near miss, telling the person who filed the report what action was taken so staffers know their comments aren’t being ignored. At Beth Israel Deaconess Medical Center, the obstetrics unit reduced adverse events by 25 percent by borrowing practices from another high-stakes environment: the airline industry. The approach, known as “crew resource management,” strictly defines rules for communication and requires increased aware-

ness of the distribution of patients within the unit. Before, says Kenneth Sands, the hospital’s senior vice president for healthcare quality, one of two obstetricians on duty might be taking a break in the lounge, waiting out a slow delivery, unaware that the other is handling three difficult births simultaneously. Today, Sands says, frequent huddles keep the staff abreast of everyone’s workload.

These new approaches to reporting mistakes, and to communication in general, are part of what the industry calls “quality improvement”: diagnosing ailments promptly and accurately; making sure patients get the right medication in the right dose; taking precautions to keep patients safe from hospital-acquired infections; and setting up systems that make serious errors—such as wrong-site surgery and mixed-up patient charts—all but impossible. The Institute for Healthcare Improvement (IHI), a Cambridge nonprofit, estimates that 15 million medically induced injuries occur each year, and recently launched a nationwide campaign aimed at preventing five million medical injuries in two years. Hospitals volunteer to participate by implementing changes that include taking steps to prevent adverse drug interactions, bedsores, surgical-site infections, central-line infections, and ventilator-associated pneumonia. “Historically, there have always been byproducts of care that have been considered inevitable,” says IHI vice president Joseph McCannon ’99. “We want to say today’s unpreventable, unavoidable form of harm might be tomorrow’s avoidable form of harm.”

In January, Beth Israel’s board took a step that aligns closely with the IHI initiative: it called for the hospital to eliminate all preventable harm by 2012. Sands says this effort requires evaluating skills and practices that range across everything the hospital does: “Supervision, communication, training, culture—if you go after these, you’ll fix several different types of adverse events at once.” That decision followed a Massachusetts Hospital Association announcement that member hospitals would no longer charge patients for costs associated with nine types of so-called “never events”—complications such as bedsores, injuries caused by falls, leaving a surgical instrument inside a patient, or giving a patient a transfusion with the wrong blood type.

For hospitals that don’t go for the carrot, there’s also a stick: Medicare recently announced that it will no longer pay bills for care in the wake of “never events.” Says Lucian L. Leape, an adjunct professor of health policy and a leader in the patient-safety movement: “There is clearly a rising acceptance...that there are certain things that shouldn’t happen, and therefore patients and insurance companies shouldn’t pay for them.”