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Learning to Keep Patients Safe in a Culture of Fear

By PAULINE W. CHEN, M.D.

One afternoon during my training, I watched as one of my closest friends, another surgery resident, was led into the office of the department chief. A week earlier she had been on call when a patient developed a rapid and irregular heart rhythm. He became unconscious and would have soon died if my friend had not stepped in and resuscitated him.

Her intervention, I thought, really proved her mettle.

But there had been a misunderstanding that night about the timing of one of the medications administered. Questions turned into a heated discussion between my friend and a nurse, and what should have been cause for celebration quickly turned into a blistering debate. The next morning, my friend found herself the subject of an "incident report," a form that hospital workers can use to report accidents. The nurse believed my friend had committed malpractice by ordering the medication too quickly, despite her saving the patient's life.

"It doesn't matter if I'm right or wrong," my friend told me after learning of the report. "That incident report will be a permanent mark on my record."

I could not argue with her; she was expressing what all of us doctors-in-training believed to be true. While we often talked about errors among ourselves, dissecting the events with great precision, we also went out of our way to avoid any formal documentation of mistakes we had seen. For it seemed that once these mishaps were discussed in department meetings or written up, the narratives called out for someone who could be held accountable. Incident reports, described to us on our first day on the job as a tool for decreasing errors and increasing transparency, became a way for others in the hospital "to hang the residents out to dry."

Even now, my heart skips a beat when I hear the words "incident report."

But over the last decade, hospitals have increasingly made patient safety a priority.

Incorporating the lessons learned in high-risk industries like aviation and nuclear energy, medical centers across the country have begun promoting protocols, procedures and checklists to prevent health care errors.

Chief among these initiatives has been a push for greater disclosure and transparency — and less fear. We should talk about our errors. We should, if necessary, bring up the topic with one another. We should say we're sorry. And we should write up incident reports. All of this, doctors have been assured, will improve safety while decreasing blame and the risk of malpractice lawsuits.

But a recent study indicates that current doctors-in-training may still be hesitant to document errors. Last month, The Joint Commission Journal on Quality and Patient Safety reported that the majority of residents have never written up an incident report. And according to a paper issued this week from a committee of leading experts in medical education and health care working with the Lucian Leape Institute of the National Patient Safety Foundation, young doctors are still going out into practice with little education or training in patient safety.

Changing a health care culture that undermines some of the most important principles of error reduction — trust, teamwork and communication — has proved to be much more difficult than a safety checklist would lead one to assume.

“Young doctors are being educated in a toxic culture,” said Dr. Lucian L. Leape, a leading patient safety expert at the Harvard School of Public Health who was chairman of the report's committee. “The current environment is hierarchical, stressful for the individual, driven by the fee-for-service payment system and humiliating, all of which works against improving patient safety.” To ensure safer health care, doctors-in-training need time to reflect on their actions, a sense of community with colleagues and other health care workers, and the support to engage freely in disclosing errors.

Remarkably, medical schools and clinical training programs have long neglected patient safety in their required curriculum, but in the last few years, several institutions have tried to do so, with varying degrees of success. Many have had difficulty finding financial support, supportive leadership and experienced physician-teachers with formal training in patient safety.

And without appropriate expertise and leadership, institutions are at risk of overlooking even the obvious. In the study of residents and incident reports, for example, researchers found that hospital administrators and educators had told most of the trainees about the importance of patient safety. “But the residents were not told about the procedure for filling out incident reports or even where they could find the forms,” said Rangaraj Ramanujam, an associate professor of management at the Owen Graduate School of Management at Vanderbilt

University in Nashville and senior author of the study. "It seems procedural and mundane, but in terms of shaping behavior, this kind of basic information is pretty important."

The reward for institutions that have managed to make patient safety education a priority has been dramatic for both students and patients. Six years ago, the University of Illinois at Chicago College of Medicine instituted an extensive patient safety education program that involved a series of required workshops and lectures for medical students beginning in their first year. Graduates have since gone on to take leading roles in patient safety at other hospital systems and academic medical centers. More recently, the university has begun incorporating safety education into their residency programs. Residents at the medical center, who once feared incident reports and filed none, now submit over 100 a month.

"We are a much safer hospital now," said Dr. David Mayer, co-executive director of the medical school's Institute for Patient Safety Excellence. "We have been fortunate enough to have incredible leadership in the medical center that has allowed us to move forward with this. No one would ask twice about what we are doing."

I called my friend from residency this week, and she laughed when I brought up her fateful incident report. Despite her worst fears at the time, the division chief did not fire her. Instead, he spent their meeting discussing ways doctors could better collaborate with nurses.

"I've filled out incident reports since," my friend said to me, recalling the event. "Things are starting to change. But I think you have to feel like what you're saying really matters and that those in charge are really listening."

"Otherwise," she added, "it's like the not-so-good old days."