SOAPBOX

By Binseng Wang

Don't Waste Your Time Trying to Reduce Medical Errors

After reading the Institute of Medicine (IOM) report on medical errors released last year and numerous articles carried by the media, you are probably tempted to march into your CEO's office and say you have the perfect solution for reducing medical errors. After all, you grew up with the electrocution scare in the '70s and got your institution through the Y2k bug unscathed. Nobody in your organization is better trained in analytical thinking and process management than you are.

Don't do it! You will probably be banned forever to the biomed dungeon, if not escorted off of the premises immediately. That was what I learned at the recent HealthTech meeting in Dallas where the American College of Clinical Engineering (ACCE) held two sessions to discuss the issue. One included two invited speakers, Robert Pollack, MD and Edward Richards III, JD, and several experts in incident investigation and risk management. Obviously, I am responsible for my own conclusions presented here.

First, contrary to all the publicity and anecdotes of misuse, there are very few errors related to equipment. In fact, the IOM report never mentioned errors related to devices. Similarly, JCAHO's Sentinel Event Database for 1999 showed only 3.5 percent of incidents may be related to medical equipment. Previously, an analysis performed by ECRI on the FDA's medical device reporting database also found little evidence of a widespread problem.

This is not to say there is no problem at all. Everyday, you probably see users who are not properly trained, equipment with an inappropriately-designed interface, lack of sufficient and rested clinicians to take proper care of patients, etc. You could probably contribute towards solving, or at least attenuating, many of these problems. Fortunately, these problems rarely end up in injuring a patient. This may be because healthcare is so inefficient, the redundant processes and procedures catch mistakes before they cause a disaster. Studies show it takes a sequence of two-to-four mistakes before a serious injury or death occurs.

It would be tragic if we let the government take the extreme measure of forcing everyone in healthcare to report every incident that could be considered an error. As the Safe Medical Device Act of 1990 demonstrated clearly, it is difficult to force healthcare organizations to report problems, particularly "user errors" that could be used in litigation. Most hospital administrators and counsels have learned that it is much more cost-effective to suppress such reports than to admit errors and ask for forgiveness from patients and juries. In the few cases the problem cannot be "swept under the rug," the preferred "solution" has been to fire the employee(s) involved, blaming them for the error.

As pointed out in the IOM report, the root causes of most errors are system or process failures rather than mistakes made by individuals. This fact was confirmed by the experts at HealthTech. Unlike manufacturing or business-service industries, healthcare organizations seldom plan activities to achieve goals with maximum efficiency and minimum cost and risk. It is no wonder that many mistakes happen during hand-offs from one person or department to another. User training is often insufficient. Communication among clinicians is often poor and ineffective. Decreasing staffing to reduce costs only exacerbated these problems.

If you really want to help reduce medical errors, don't talk about it at all. No administrator is willing to invest money in reducing errors. Liability is no longer a good motivator. Insurance is only a small percentage of overall operational costs. Medical errors cannot be reduced through mere sound analytical thinking and good process management. You have to approach it from the cost-reduction perspective.

In other words, try to get involved in activities to reduce cost and improve efficiency. As many quality gurus have already proven, the natural way to reduce cost and improve efficiency is through continuous quality improvement. As you improve process quality, you will reduce errors. Follow this advice and you will not only help reduce errors; you may even get promoted for reducing costs!

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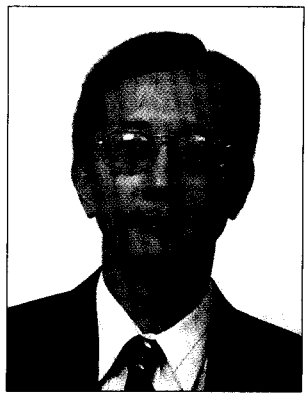

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