IT'S HOW MEDICINE

SHOULD BE

# Quality, Safety and Malpractice

## Changing a Culture

*Robert A. McNutt, MD, FACP*

# Safety Culture in US

- IOM report published in 2000
- Humans naturally make mistakes, so do not punish
- Make humans better - training and new systems to support our weakest moments
- National attention
  - Agency for Healthcare Research/Quality
  - Others

# Safety Culture in US

- **National standards established (many!)**
  - Core measures

- ***But, outcomes of care similar between high and low performing hospitals on national measures!***

- **So, need "local" efforts to inform national standards**

# Hospitals Responded

## Top down

- **Chief Medical Officer**
  - Safety officers
  - Robust adverse event reports

## Bottom up

- **Patient Safety Research**
  - Standardize review of adverse events
  - **Research** to show can reduce events

# Safety as Research

- 90 publications
- 4 grants
- Faculty program in patient safety research
- Center for Patient Safety Research

# What we learned

- **Quality is hard to define, hence, measure and leads to disagreements, not solutions**

- **Safety is definable and measurable, hence, can help organize a plan of care**

- **What is safety?**

# What is safety?

Safety is

- Finding simple ways to deliver care
- Doing less, not more
- Reducing variation
- Developing systems that do least necessary to produce good outcome

# So……

- Safety is "culture"
- Safety is advanced from local concerns, not national agendas
- Culture of safety must include culture of malpractice to advance all patient safety

# What Change in Culture?

**Patient Safety System**

**Versus**

**Malpractice System**

# Safety and Malpractice: Old

## Safety System

Adverse event

Safety System

**Project:**
- PDSA

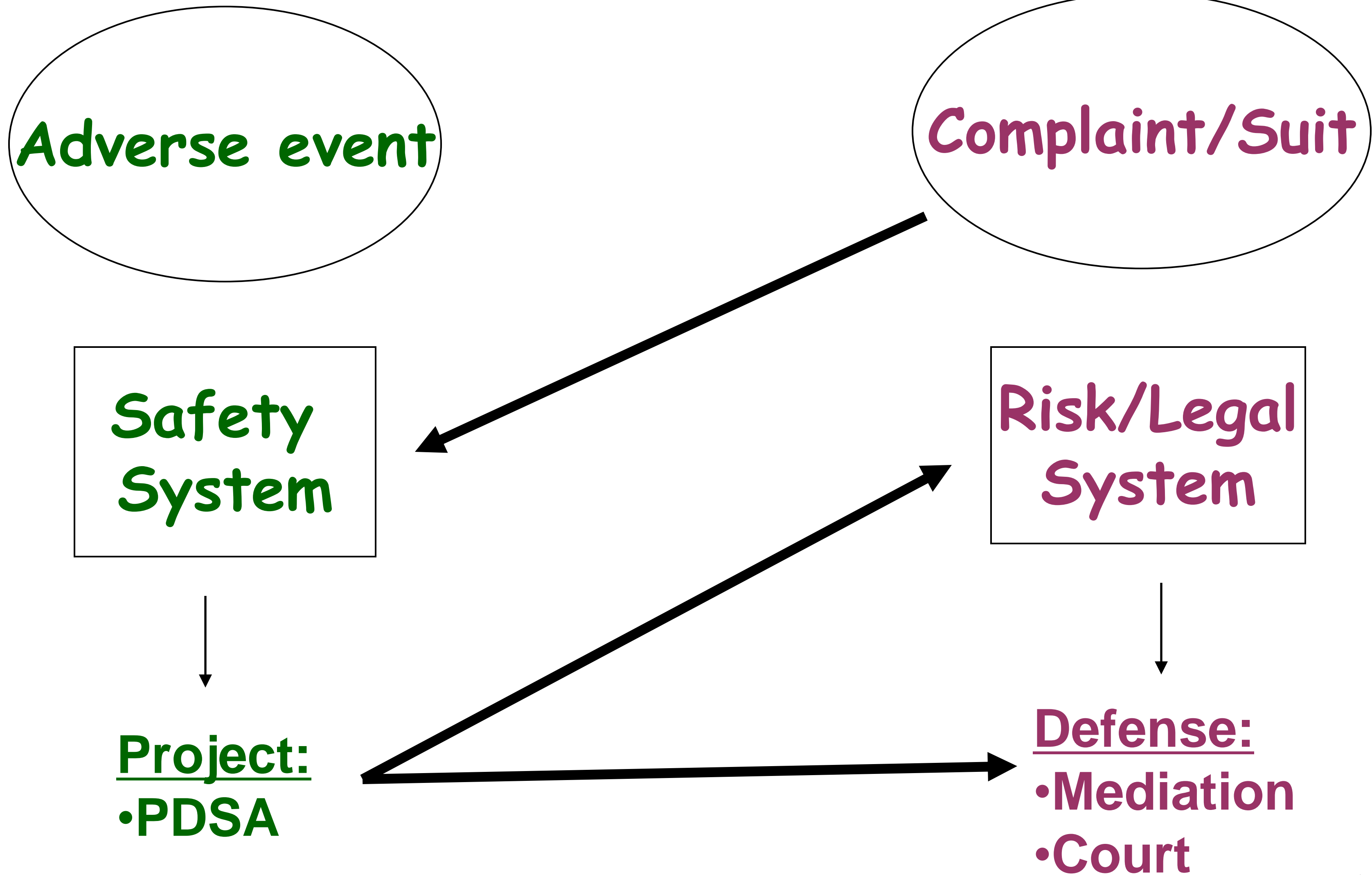
## Malpractice System

Complaint/Suit

Risk/Legal System

**Defense:**
- Mediation
- Court

# Safety and Malpractice: New



# Safety integrated with Law

- **Grant to review cases going to court**
  - What could we improve?
- **Safety officer at court**
- **Evidence-based medicine in court**

# Safety in the court room

- **Disc surgery** - foot drop after procedure
- **Sub-dural hematoma** - after a fall
- **Transplant** - of HIV organ
- **Chest pain** - no MI, but dies at home
- **Spinal-stenosis** - paralyzed after epidural

# Safety and the court room

## Insights

- **Adverse events are different; inevitable**
- ***Informed-consent is major safety issue***
- **Evidence-based medicine can resolve dispute**
- **Malpractice system not improve care**
- **Need to combine safety and malpractice culture**

# New Culture: Safety and Law

## New Culture

- **All systems must align for safety**
- **Some $$ for malpractice go to safety**
- **Evidence-based medicine helps**
- ***Informed-consent*** **is a way to know when doing less is actually doing more for individual patients**

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