iHealth BEAT
Reporting the Internet's Impact on Health Care
California HealthCare Foundation

Opinion

Pearls from across the pond: Improving patient safety in the U.S. health care system

by Dr. Barry P. Chaiken
McKesson Corporation
December 20, 2002

For more than 50 years, American innovation and discovery in medicine has driven the development of lifesaving strategies, technology and pharmaceuticals that are valued the world over. During 17 of the last 20 years, an American researcher has received the Nobel Prize in medicine. Yet with all this success, the U.S. health care system faces criticism about patient care that is far from safe.

In two stunning reports released by the Institute of Medicine (IOM) over the last three years, the IOM has criticized the American health care system for widespread problems in quality and patient safety. A report released in November outlined the need for research demonstration projects to identify ways to correct numerous problems in our health care system, including issues of patient safety.

At a November meeting of the International Society for Quality in Health Care (ISQua) in Paris, researchers and public health experts from Europe to Australia spoke about the patient safety challenges in their home countries and their first initiatives to address the problem. This is a significant shift in focus from just five years ago, when the emphasis was on disease-specific quality assurance rather than overall patient safety.

Problems caused by bad processes, not people

Unfortunately, other countries also have sentinel events in patient safety that are dramatically changing the way health care is delivered in those countries. For example, the National Health Service (NHS) in the United Kingdom has embarked upon a major effort to address patient safety after the tragic events at the Bristol Royal Infirmary. Over a period of more than a decade, children under one year of age on the cardiac surgery service received poor quality care, with a mortality rate more than double what would be expected. In addition, this high mortality rate went on for years without notice or intervention.

These deaths led to an official inquiry by Parliament. Although many problems were identified at Bristol, a July 2001 report on the inquiry clearly eliminates one cause.

“The story of the paediatric cardiac surgical service is not a story about bad people,” the report found.

In fact, the report praises the dedication and motivation of the people who worked at Bristol, stating that the providers “were victims of a combination of circumstances which owed as much to general failings of the NHS at the time than to any individual failing.”

Throughout the Paris conference, presenters returned to the same theme – patient safety is not about bad people, but about bad processes. These bad processes include not monitoring performance, not having in place a means to rework processes, and not forming a multidisciplinary team that has good lines of communication and promotes an atmosphere of teamwork. The latter issue is something that is not heard much here in America, but is ringing loudly abroad.

Communication is key to improvement

Patient care is provided by a broad-based team of professionals. Each professional possesses a unique skill set to address appropriately assigned responsibilities. Safe, high-quality patient care requires this team to work synergistically, remain focused and communicate efficiently to be sure that each member has the required patient data to do a job well. Without effective communication, health care professionals are known to sometimes work at cross-purposes, providing suboptimal or even dangerous care.

Effective communication among care team members is not an easy thing to accomplish. The processes, customary professional interactions and hierarchy that are usually in place do not facilitate a team approach to care. From the first days of training, health care professionals are separated into silos where communication across these silos is neither taught nor encouraged. Once on the wards delivering patient care, these professionals are forced to form “teams” where

they improvise their communication, often at a level that is barely acceptable.

Although health care delivery in the United States is the most advanced in the world, the processes that facilitate that care suffer from the same challenges seen elsewhere. The problems are many, yet solutions are readily available.

Process re-engineering must become part of the fabric of American health care delivery. Looking for individuals to blame for medical errors must be tossed aside and replaced by more enlightened thinking that can influence patient safety in the long run. Lastly, true patient care teams must be formed where team members work together to make patients better. This requires a sea of change in the way we educate our health care professionals and how we teach them to work together.

The rest of the world greatly benefits from the achievements of our health care system. It is time for us to learn from their experiences in an effort to make our system even better.

References:

The Report of the Public Inquiry Into Children's Heart Surgery at the Bristol Royal Infirmary Bristol Hospital 1984-1995, Learning From Bristol, Bristol Royal Infirmary Inquiry; Presented to Parliament by the Secretary of State for Health by Command of Her Majesty, July 2001, CM5207(I)

About the author:

Barry P. Chaiken is vice president of medical affairs for McKesson Corporation, a health care IT firm. He can be reached at bchaiken@docsnetwork.com.

The views expressed in this Opinion column are those of the author and do not represent the views of the California HealthCare Foundation or the Advisory Board Company.