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Medical Error and Individual Accountability

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Wachter RM, Pronovost PJ. Balancing “no blame” with accountability in patient safety. *N Engl J Med.* 2009;361(14):1401-1406.

The tenth anniversary of the Institute for Medicine’s report *To Err is Human* has sparked much discussion on the status of patient safety, whether we have made progress, and what we should be doing to continue our efforts to decrease errors. In their article “Balancing ‘No Blame’ with Accountability in Patient Safety,” Wachter and Pronovost examine how the traditional blame-oriented culture has evolved into a widely accepted “no-blame” culture and how that should now be balanced with individual accountability in patient safety. Their analysis proposes that while “no blame” should be embraced, it is not always the most appropriate framework; accountability should be emphasized when necessary [1].

Wachter and Pronovost begin by acknowledging that most errors are caused by good, hardworking people who are trying to do what’s best for their patients. Some leading institutions in patient safety, however, have begun to question the sole embrace of the “no-blame” culture and the safety risks it poses in and of itself. The authors use hand hygiene as a prime example. There is ample evidence that cleansing has been approached as a systems-level problem, removed from the context of blame. But with many interventions, such as administrative championship of improving hand hygiene, information campaigns, and strategic placement of hand-gel dispensers—in place for as long as a decade—hospitals continue to have low hand hygiene rates, and very few have sustained rates above 80 percent. The authors suggest the hand hygiene problem is no longer a systems issue; it is an accountability issue. They also mention widespread national education campaigns and success stories regarding wrong-site surgery and bloodstream infections that, nevertheless, have not wiped out all errors [2].

The authors go on to propose that the reason some patient safety issues remain unresolved even after an extensive systems review and change is a lack of accountability [3]. Absent a penalty, health care professionals may perceive that the intervention is ineffective and choose not to bother with changing their habits. Once a reasonable safety rule has been broken more than once, and ample education, counseling, and other means of positive corrective action have not fixed the problem, the authors think that sufficient penalties should enforce accountability.

They do not propose punishing those who do not have the appropriate education, knowledge, and training. They fully acknowledge that education and awareness are by far the most critical pieces of this puzzle. But, they say, if those are not enough, then more drastic measures are essential. The authors propose different levels of punishment—education and loss of privileges for 1 or 2 weeks, with counseling depending on the nature and number of the violations. They also emphasize the need for consequences to be consistent among physicians, nurses, and technicians, regardless of their employment status [4].

Wachter and Pronovost believe that accountability is necessary in some instances of repeated deviation from the norm to correct the fundamental misunderstanding of the nature of errors that pervades health care, as opposed to, for example, the airline industry's view of errors. Granted, pilots and other industry personnel are employees of a company, whereas many physicians are self-employed or employed by a large private practice group and contract with hospitals. Inherently, the latter arrangement emphasizes autonomy, and hospitals shy away from making physicians do things they do not wish to do or understand for fear of losing them [1].

Wachter and Pronovost argue that, despite these differences, health care should take a page from the airline industry's playbook: after a reasonable safety rule has been clearly vetted by experts (e.g., pilot checklists prior to takeoff), it should be widely adopted and strictly adhered to. The failure to enforce these rules allows the culture to shift from one of "accountability" to one of "no blame" [3]. In the end, Wachter and Pronovost acknowledge that balancing the "no-blame" culture with accountability will be tricky [4] at best.

In his 2011 commencement speech at Harvard Medical School, Atul Gawande proposed a somewhat different approach. He asserted that health care professionals from all parts of the care spectrum should work as pit crews for patients. This means cultivating skills currently uncommon in the health care world. Gawande focuses on three: (1) the ability to recognize when you've succeeded and when you've failed for patients; (2) the ability to devise solutions for the system problems that data and experience uncover (for example, by use of checklists); and (3) the ability to implement, at scale, the functioning of colleagues along the entire chain of care as pit crew members [5]. Gawande stated, "These values are the opposite of autonomy, independence, self-sufficiency. Many doctors fear the future will end daring, creativity, and the joys of thinking that medicine has had. But nothing says teams cannot be daring or creative or that your work with others will not require hard thinking and wise judgment" [5].

Gawande's approach calls for accountability to be diffused throughout the team. Though this is not incompatible with Wachter and Pronovost's approach, it takes a different tone. Wachter and Pronovost appear to feel that a certain degree of harshness is necessary to make the needed changes. Gawande, on the other hand, does not explicitly state that individual physicians should be targeted for corrective

action; instead, he focuses on holding the entire team accountable, an approach that may be more palatable to health care professionals.

References

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