

DOCTOR AND PATIENT

# Holding Doctors Accountable for Medical Errors



Dr. Robert Wachter, center, with colleagues Dr. Andy Auerbach and Dr. Arpana Vidyarthi at the University of California, San Francisco, Medical Center.

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Ten years ago, a national panel of health care experts released a landmark report on medical errors in the American health care system. Published by the [Institute of Medicine](#), “To Err is Human: Building a Safer Health System” estimated that as many as 98,000 people died in [hospitals](#) each year as a result of preventable mistakes. Being hospitalized, it turned out, was [far riskier than riding a jumbo jet](#).

While the report offered comprehensive strategies to improve safety, its main conclusion was that medical errors were primarily a result of “faulty systems, processes and conditions that lead people to make mistakes or fail to prevent them.”

Spurred on by this finding, health care leaders across the country began addressing errors believed to be a result of systemic flaws. They instituted more rigorous hospital accreditation standards and procedures, increased public reporting and transparency and established systemwide safety changes like the mandatory use of checklists, the placement of hand sanitizing gel dispensers throughout hospital wards and the regulation of physician duty hours. For nearly a

decade, this paradigm of systems failure defined the national movement to improve patient safety.

But more recently, some health care safety experts have begun questioning the assumption underlying the report's conclusions: that only health care systems, and not individual clinicians, could be held accountable for medical mistakes.

Dr. Robert M. Wachter, a professor of medicine at the [University of California, San Francisco](#), and a national leader in patient safety, recently published two critiques of the safety movement, one in [Health Affairs](#) and one in [The New England Journal of Medicine](#). Both urge physicians to begin acknowledging their individual roles in medical errors. "A blame-free culture carries its own safety risks," [he writes](#). "As we enter the second decade of the safety movement, while the science regarding improving systems must continue to mature, the urgency of the task also demands that we stop averting our eyes from the need to balance 'no blame' and accountability."

I spoke to Dr. Wachter recently about his assessment of the patient safety movement, the need for increased accountability and the impact of some of these changes on the patient-doctor relationship.

**Q. In one of your critiques, you give the patient safety movement a grade of "B-," a modest improvement over the "C+" you gave five years ago. How would you have graded patient safety 10 years ago when the Institute of Medicine report was published?**

A. I would have given it a "D-." Ten years ago, safety happened almost randomly; you happened to have good people or you got lucky. But 10 years is not a long time, and I've been extraordinarily impressed with the progress so far.

That being said, when my kids come home with a "B-," they all get a talking to.

**Q. What is a major patient safety area that still needs to be addressed?**

A. Ten years ago, we approached patient safety as a series of system flaws; we believed that most errors were committed by good competent people doing something no more complicated than forgetting a cellphone. But in the last few years some of us in the patient safety field have begun to feel uneasy about that approach. When there are reasonably safe standards available, what do you do

when people simply don't adhere to them? At some point, it's no longer a "systems problem."

**Q. In one of your articles, you use the example of hand hygiene to illustrate your point.**

A. Hand hygiene seemed like a good place to start studying how we might find a new balance between "no blame" and accountability. We know that this particular problem can be morbid, sometimes fatal, and that the systems issues, such as the availability of sanitizing gel dispensers in hospitals, have by and large been fixed. But even with those changes in place, few health care systems have had sustainable rates of hand hygiene over 80 percent. We have not achieved the rate we would expect of ourselves, and that our patients would expect.

Most hospitals and health care organizations are starting to step up to the idea of individual accountability, but in very haphazard ways. For instance, I can lose my hospital privileges if I fail to sign a dictated discharge summary or operative note. But if I don't clean my hands for the next 10 years, nothing will happen to me.

One of the fundamental problems of safety is embedded in this example. We operate in an environment where there are regulatory sticks and payment incentives; and in this particular example, it's difficult to submit to an insurer if the doctor hasn't signed off. When there's money at stake, organizations get motivated enough to stop being too fuzzy.

Promoting safety — really doing it right — takes time and money. Ethics and professionalism are important but not enough.

**Q. Do you think the safety movement has eroded trust between patients and doctors?**

A. It has eroded trust in safety, but I think that was absolutely necessary. The idea from the I.O.M. report that launched this field was that there was a jumbo jet's worth of people dying every day.

The only way we are going to fix this problem is to become much more open and transparent. That transparency will drive us to improve and allows us to educate each other.

I really do believe that most doctors, nurses and administrators are good people, but it takes hard work and a lot of time to improve patient safety. We need to figure out what milieu will allow people to focus on safety and quality in the way that they need to. And I don't see how we can get to that stage if people don't have the appropriate level of concern.

**Q. Has this erosion of trust had a detrimental effect on the patient-doctor relationship?**

A. The chaos of everyone doing things their own way is incredibly dangerous, and it is that chaos which gets in the way of the relationship. You can make health care better, safer and less expensive while strengthening the core of the patient-doctor relationship. You can standardize certain parts of care based on clear evidence, which will free up doctors to focus on those pieces of the health care puzzle where there is no data — those issues that are uniquely human and that require judgment, expertise and empathy.

The challenge, though, is to standardize care in a way that will improve safety while retaining the parts that make medicine human. The last thing we want to do is to regiment empathy or to create something so regulated that doctors cannot do something nuanced or innovative for patients.

**Q. What are the roles of patients and of doctors in the patient safety movement?**

A. If I were a patient or a loved one, I would do what everyone recommends — have a loved one by your side, look for signals that a hospital is safe, check that a physician is board certified. But I am also intensely ambivalent about how responsible patients should be for safety and the prevention of error. Medical mistakes are our bad. Why should patients bear the responsibility to receive the right medication or to have the correct leg amputated? When I get on a plane, I don't worry about safety and errors.

As for doctors, patient safety can't happen if physicians aren't smack in the middle of it. We can either facilitate safety or we can stand its way. We will stand in its way if we embrace our historical approach to these problems, if we instinctively engage in finger-pointing, if we aren't willing to listen to others.

We have a huge role in creating the kind of environment where people will feel comfortable questioning anything that seems strange or out-of-place and where doctors are open to different opinions from others.

As doctors, we have to admit first that we don't deliver care that is of the quality and safety our patients deserve. Then we have to get past our professional arrogance. We don't have the answers to all of these issues, and we have to be open to others who may have the answers or who can approach it from different angles.

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