No research group has so patiently, methodically, and relentlessly pursued peer review like the Vanderbilt University Medical Center (VUMC) research team led by Gerald Hickson, the senior author of the article, “Using Coworker Observations to Promote Accountability for Disrespectful and Unsafe Behaviors by Physicians and Advanced Practice Professionals,” which appears in this issue of The Joint Commission Journal on Quality and Patient Safety. More than 25 years ago, Hickson and colleagues began to study the factors that prompted patients to file malpractice claims. Since, the team has relentlessly examined the human side of patient injury/medical malpractice—remarkable when one considers the fact that their work straddled a considerable period of time in which it was politically correct to insist on a “blameless culture” and to emphasize systems not people in the search for root causes of avoidable patient injury.

As Wachter has pointed out, “As with many aspects of trying to improve patient safety, finding the appropriate balance between a systems approach and individual accountability is the most challenging aspect of the RCA [root cause analysis] process.” Many persons believe, as I do, that the pendulum had swung too far in those days at the expense of individual accountability. Human beings are of course behind every operational aspect of health care—and are responsible for the creation and maintenance of dangerous cultures, dangerous systems, and, worse, for harboring dangerous individual caregivers.

In this new article, VUMC researchers report their latest advancement in peer review, the Co-Worker Observation Reporting System (CORS). This system provides a practical road map to unlocking one of the most frustrating challenges: How to tap the rich-but-elusive body of information on quality and patient safety that exists in every health care organization. With its nuts-and-bolts approach, much of which is built on earlier foundational work, the VUMC researchers show that it is feasible for any organization to tap that resource within arms’ reach of every patient care organization: its own staff.

It seems axiomatic that improvement generally must follow a simple, logical flow. As depicted in Figure 1 (page 148), problems must be first recognized and captured and, next, analyzed for root causes, with improvements then designed to address them. Those “fixes” must be studied for both effectiveness and to guard against unintended consequences, and, finally, the experience must be reported within the organization to encourage staff to observe the positive tangible consequences of raising issues in the first place. Satisfying the algorithm should produce a self-perpetuating spiral that feeds a culture of continual improvement.

Sadly, producing actual evidence of caregivers engaged in dangerous behavior has been largely the result of a lagging indicator too reliant on a pattern of harm—how many complications does it take before we finally identify a caregiver whose clinical behavior is problematic? How much staff turnover will we tolerate before we acknowledge an individual’s abusive behavior as a root cause? How many injuries do we tally until we realize that a process or a colleague may be to blame? Want to know which physician to avoid? Ask a nurse. Want to know who is dangerous in an operating room? Don’t ask another surgeon, ask an anesthesiologist. We’ve known for decades that our own staff goes home every night holding close the worst-kept secrets—secrets so valuable to that all-important first step of recognizing the problem—and precious few are willing to talk.

Caregivers engaged in dangerous behaviors or who work with personal or clinical competency challenges are never a secret to those with whom they work. The conspiracy of silence, however, is real. As Wachter has stated, “[I]t is undeniable that doctors and hospitals tend to protect their own, sometimes at the expense of patients.” In my days as a trial lawyer representing hospitals, I rarely investigated a claim of patient injury without other staff members confidentially disclosing observations such as “It was only a matter of time before someone fell through the cracks” or “Every member of this department has had concerns about her for years.” Several years ago, I looked into a birth-trauma case for a client—an infant born with global brain damage, the result of blatant misreading of a fetal-monitor tracing. In interviewing the department chair, after noting that the error seemed pretty basic, I asked if there were other concerns about the particular caregiver. The response was chilling: “You don’t know the half of it.” Yet, in that...
or individual competence concerns. In their article, the authors name any staff, and precious few described dangerous behavior. In 2015, dramatic increases in the number of incidents reported. In 2015 alone, the University of Michigan Health System logged nearly 30,000 incident reports, the vast majority of which did not name any staff, and precious few described dangerous behavior or individual competence concerns. In their article, the authors describe concrete steps that organizations truly interested in advancing patient safety can take to tap their own staff for information, as well as offering guidance as to how to use it carefully and thoughtfully. Encouragingly, they report success with patient complaint monitoring and intervention programs at 135 collaborating medical centers and medical groups. As has been well demonstrated, better patient safety directly correlates with higher staff satisfaction, fewer employee injuries, and greater productivity overall. This positive spiral can only serve everyone involved in delivering patient care—and their patients. Hopefully, the VUMC group will next describe how organizations that courageously followed their lead are demonstrating that their staff’s threshold tolerance for disrespectful or dangerous behavior and substandard clinical competence has rapidly changed in service to improved safety as reporting-associated-with-positive-change becomes the norm.

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References