Creating ‘Accountability’ in a ‘No Blame’ Culture: The Yin and Yang of the Quality and Safety Revolutions

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Two Disconnected Conversations

No Blame

Accountability
At the Junction, the Message Gets a Little Garbled...
Let’s Not Belabor the Point: Quality and Safety Stink

- 44,000-98,000 yearly deaths from errors
- 54% adherence with evidence-based practice
- Clinically indefensible variations, with high cost often associated with poor quality
Why Can’t You Just Be...

- As safe as commercial aviation
- As predictable as FedEx
- As reliable as Toyota
- As innovative as Apple
- As customer-centric as the Ritz-Carlton
The BBC’s “Wrong Guy”

Guy Goma

Guy Kewney

http://news.bbc.co.uk/1/hi/entertainment/4774429.stm
Anchor: “Guy Kewney is the editor of the technology website ‘Music Online’… were you surprised by today’s verdict?”

The Wrong Guy: “I was very surprised…”
The EPS Case

“The mistakes are all there waiting to be made.”

Chessmaster Savielly Tartakower (1887-1956)
Who Would You Blame For the Morris/Morrison Fiasco?

- The EP nurse who failed to use full ID when she called ward?
- The ward nurse who released her patient to EP?
- The EPS attending who failed to reintroduce himself to the patient?
- The neurosurgery resident, who allowed his concerns to be allayed without checking?
- Somebody else?
... at least 17 distinct errors, no single one of which could have caused the adverse event by itself.
The central theme of the patient safety movement has been “No Blame”
But “No Blame” Sounds Right... So What’s the Conundrum?

Virtually every element of our society instinctively turns to “Accountability” when faced with an underperforming system.
In Essence, We Struggle With Two Competing Mental Models

- Most errors are committed by caring, competent people who are trying hard to get it right
- Therefore, shaming and suing them doesn’t help, it stifles open discussions and learning

- The system produces low quality, unsafe, unreliable care partly because there’s been no incentive to do otherwise
- Therefore, putting skin in the game creates accountability, which generates action, focus, and resource flow
Define & measure errors, reporting systems, IT, new TJC standards, reform education, provide $s, establish “no blame” culture …

Accountability at individual and organizational level

TOO HARD!
What’s the Right Target for Individual/Organizational Accountability?

- The hospital: the logical focus of accountability
  - Multiple tools: TJC, Medicare COPs, state health departments, media scrutiny
  - Big #s, data-handling & change capacity

- Individual physicians: a tougher target
  - Accreditation (ie, board certification) voluntary
  - Measurement tougher (small #s, attribution ?s)
  - Malpractice: a blunt and often arbitrary tool
The Dysfunctional Organizational Dichotomy of American Medicine

- The hospital, the accountable entity, controls:
  - Nurses, Pharmacists, QI, Safety, Compliance, PT, OT, Risk Management…
  - Culture corporate and hierarchical; clear lines of authority

- Meanwhile, the doctors are self-employed
  - Culture is individualistic, entrepreneurial

- Oops… I forgot the “Organized Medical Staff”
This asinine organizational framework could survive only if the hospital and the physicians were under absolutely no pressure to... provide the highest quality, safest care at the lowest possible cost. But over the past decade this bit of healthcare exceptionalism (since it is unlike virtually every other part of the market-based economy) has eroded like a polar ice cap, aided by a variety of strategies (regulatory, accreditation, legal, public reporting, differential payments) that have created immense pressure to perform. This New Reality has exposed the fatal flaws in the typical hospital/medical staff relationship: how can a hospital ever achieve excellence when it is governed by two parties that are at best wary but collegial; at worst, overtly venomous.
What Does Accountability Look Like?

- Reasonable performance expectations
  - Applied fairly, expectations similar for all
  - Appropriate carrots and sticks used to drive system toward excellence

- “No blame” remains the dominant front-line culture
  - But only for innocent slips and mistakes

- Clear demarcation of blameworthy acts
  - Individual, managerial, and organizational
  - E.g., Gross incompetence, disruptive behavior, failure to heed reasonable safety/quality rules
### Best Hospitals Honor Roll

**Posted July 10, 2008**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Hospital Name</th>
<th>Location</th>
<th>Points</th>
<th>Specialties</th>
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<tr>
<td>1</td>
<td>Johns Hopkins Hospital, Baltimore</td>
<td>Baltimore, MD</td>
<td>30</td>
<td>15</td>
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<tr>
<td>2</td>
<td>Mayo Clinic, Rochester, Minn.</td>
<td>Rochester, MN</td>
<td>28</td>
<td>15</td>
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<tr>
<td>3</td>
<td>Ronald Reagan UCLA Medical Center, Los Angeles</td>
<td>Los Angeles, CA</td>
<td>25</td>
<td>14</td>
</tr>
<tr>
<td>4</td>
<td>Cleveland Clinic</td>
<td></td>
<td>25</td>
<td>13</td>
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<td>5</td>
<td>Massachusetts General Hospital, Boston</td>
<td>Boston, MA</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>6</td>
<td>New York-Presbyterian Univ. Hosp. of Columbia and Cornell</td>
<td></td>
<td>22</td>
<td>12</td>
</tr>
<tr>
<td>7</td>
<td>University of California, San Francisco Medical Center</td>
<td>San Francisco, CA</td>
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<td>11</td>
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<tr>
<td>8</td>
<td>Brigham and Women’s Hospital, Boston</td>
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<td>18</td>
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<tr>
<td>8</td>
<td>Duke University Medical Center, Durham, N.C.</td>
<td>Durham, NC</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>10</td>
<td>Hospital of the University of Pennsylvania, Philadelphia</td>
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<td>University of Washington Medical Center, Seattle</td>
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<td>18</td>
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</tbody>
</table>
That’s Nice, But…

Percent of Pneumonia Patients Given Pneumococcal Vaccine

AVERAGE FOR ALL REPORTING HOSPITALS IN THE UNITED STATES
AVERAGE FOR ALL REPORTING HOSPITALS IN THE STATE OF CALIFORNIA - NORTHERN & CENTRAL
UCSF MEDICAL CENTER

www.hospitalcompare.hhs.gov

* Top Hospitals represents the top 10% of hospitals nationwide. Top hospitals achieved a 80% rate or better.
In the words of Golda Meir…

Don’t be humble.
You’re not that great
Managing Group Accountability by Creating Meaningful Competition

Feather River Hospital
Paradise, CA
Pneumovax rate: 32%

UCSF Medical Center
Pneumovax rate: 10%
Pneumonia Patients Assessed and Given Pneumococcal Vaccination

July 2007 to June 2008 | Select End Date

Hospital Performance

UCSF MEDICAL CENTER, CA

View Data Over Time »

National Average

California State Average

93.40%

81.00%

78.00%

Rosie says, “Get your patient a

www.whynotthebest.org

Feather River Hospital

Adventist Health

Feather River Hospital

5974 Pentz Road, Paradise, CA 95960
Main Phone Number: (530) 877-9361
Individual Accountability: The Hand Washing Story

- Typical hand hygiene rates circa 1999: 20-30%
- Public reporting of / “no pay” for/lawsuits for HAIs: tremendous push to improve
- Many organizations now at 40-70%, and stuck
- “It’s a Systems Problem”: Education, dispenses every 3 feet
- A systems problem? Really?
Who Decided that a 50% Hand Washing Rate is a “Systems Problem”?
A More Accountable Solution

Arrowsight Medical
When Is the Accountability Approach Correct?

- The practice is important and works
- The systems have been fixed
- Unintended consequences have been addressed
- Physicians understand the practice, its value, the auditing strategy, and the penalties
- A single transgression has led to a warning

At that point...
Weakness is provocative
Which Practices are Ready for an Accountability Approach?

- Hand hygiene
- OR checklists (including time out, sign your site)
- Central line checklists
- Read backs of key data
- Disruptive behavior

In most hospitals, a physician will be suspended for not signing his dictations, but never suspended for not cleaning his hands.
The Bottom Line: Leaders and organizations will be accountable

“No blame” is not a moral imperative (even if it seems so to providers, it most definitely does not to patients). Rather, it’s a tactic to achieve ends for which you will (quite appropriately) be held accountable.