# Truth Talk: We Have a Duty to the Patient

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# A Personal Encounter with Patient Safety











# **Doing the Right Thing**

- "Data have shown that focused efforts to reduce discrete harms, such as nosocomial infections and surgical complications, can significantly improve safety."
  - Landrigan et al. New England Journal of Medicine Nov. 25, 2010

# **Helping Change to Happen**

Consciousness



Culture



Cash



# Consciousness Raising (and Not)

"Clinicians have labeled virtually harm as inevitable for decades." – Peter Pronovost and Elizabeth Colantuoni, *JAMA*, 2009

"To do things differently, we must see things differently. When we see things we haven't noticed before, we can ask questions we didn't know to ask before." – John Kelsch, Xerox

"To become competent, you have to feel bad." – Hubert Dreyfus, Philosopher, Univ. of California-Berkeley

# More Consciousness Raising (Research + Press + Politics)

#### Statistics

The Baker-Norton Study, published by CMAJ in 2004, found that between 9,250 and 23,750 hospital patients die each year due to adverse events. The report also said that 7.5 per cent of patients admitted to a Canadian hospital - one in 13 - suffer harm as a result of their care.

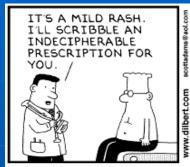
Also in 2004 the Canadian Institute for Health Information reported:

- One in nine adults with health problems reported being given the wrong medication or dosage by a doctor, hospital or pharmacist.
- One in 16 reported an adverse event for themselves or a loved one.
- One in 152 deaths were associated with preventable adverse events for medical/surgical patients in acute care hospitals.
- One in 1,124 people over age 65 suffered in-hospital hip fractures.
- One in 6,667 had a foreign object left in their body after a surgical procedure.
- One in 72,046 were infected with hepatitis B from a blood transfusion.
- One in 10 million were infected with HIV from a blood transfusion.
- One in nine adults contracted an infection while in hospital, ranging from pneumonia to SARS.
- One in nine patients received the wrong medication, or the wrong dose.
- One in 20 women suffered severe tearing during childbirth; one in every 81 babies born vaginally suffered trauma, emerging with injuries such as a broken shoulder.
- One in every 299 patients receiving a blood transfusion had a reaction;
- One in every 1,124 adults over age 65 suffered a broken hip during a hospital stay.
- One in every 6,667 surgery patients would have a foreign object left behind in his or her body.
- The treatment of patients subjected to medical errors adds up to more than 1.1 million hospital days and costs \$750 million a year.



Maryann Murray describes the adverse event that resulted in the death of her 22-year-old daughter, Martha.

## Ridicule, Anyone?







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**'Employees Must Wash Hands' Signs Top Iraqi Hospital Wish List** 



# The Challenge of Culture Change

"Science and Technology revolutionize our lives, but memory, tradition and myth frame our response."

--Arthur Schlesinger, Jr.



# The G(ood) O(Id) D(ays)

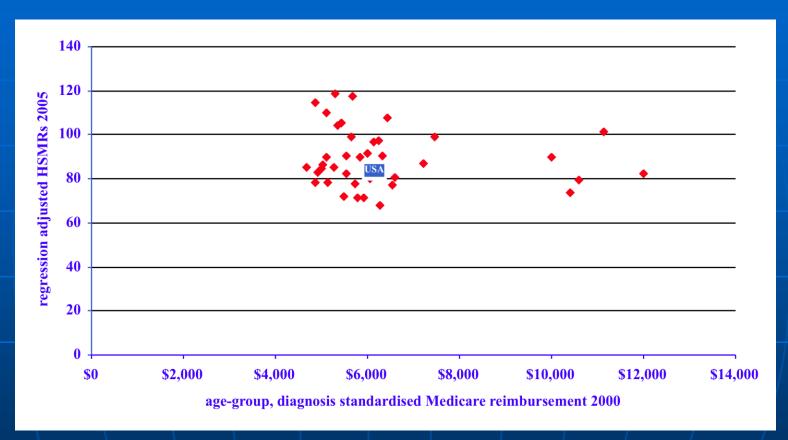
"The application of knowledge at the bedside is largely the function of the *sagacity* inherent in or personally developed by *the individual physician.*"

–Hermann L. Blumgart, MD, 1973



"There is a continuing lack of conviction [by doctors] that improvement is needed. The conviction is, 'We're darn good, why don't people pay us what we want?" –Donald Berwick, MD, 1995

# **Eminence Isn't Enough**

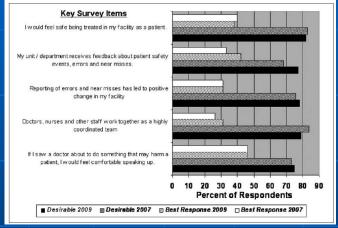


### Massachusetts Hospitals Hospital Standardized Mortality Ratio (Jarman)

# **Baylor Pursues Perfection**



#### Intention



### Implementation

#### Results

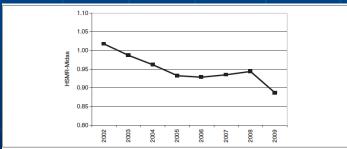
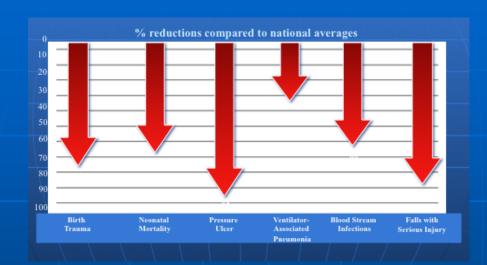


Figure 5. Baylor Health Care System (BHCS) hospital-standardized mortality rate (HSMR) trend, 2002 to 2009\*
H-SMR-MIDAS is the Hospital Standardized Mortality Ratio and is equal to observed deaths divided by expected deaths, where the latter is
determined as part of the 3M Datavision product based on analysis of administrative data. For each point, the "all hospital" population of 350 to
517 US hospitals was selected as the reference data set.

Source: Am J Med Qual, 2011

## **Ascension Tracks "No Harm" Push**



#### Ascension Health System Observed Minus Expected Mortality Rate per 100 Discharges

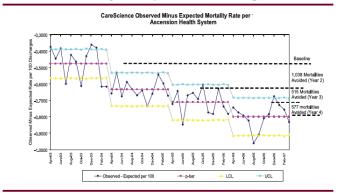


Figure 1. At the current rate, more than 2,000 lives have been saved a year compared to baseline mortality. This figure was developed by Ascension Health using Care Science risk-adjusted data from the Ascension Health Outcomes Measures database.

Sources: Ascension Health, Jt Comm Jnl

# Doing Things Right By the Numbers How My Wife was NOT Harmed



# **Cash and Complications**

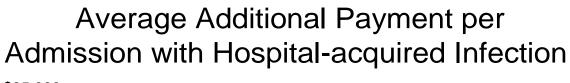
### Hospital costs and reimbursement for surgical patients

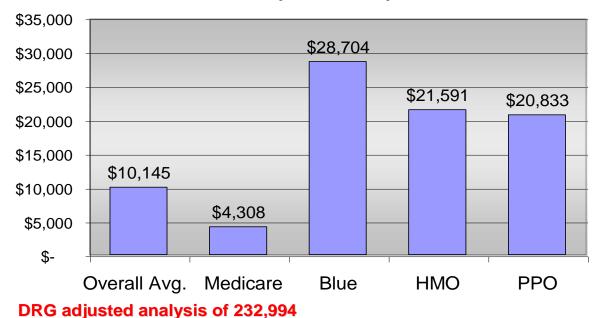
	Costs: resources used by the hospital (\$)	Reimbursement: amount paid to the hospital (\$)	Hospital profit (profit margin) (\$)
No complications	10,978	14,266	3,288 (23)
With complications	21,156	21,911	755 (3.4)
Increase in reimbursement		7,645 (54)	

"When surgical complications occur, hospitals experience a decline in profits and profit margin per case, but reimbursement usually covers their costs. In contrast, payors always lose money with complications."

Source: JB Dimick et al. J Am Coll Surg, 2006

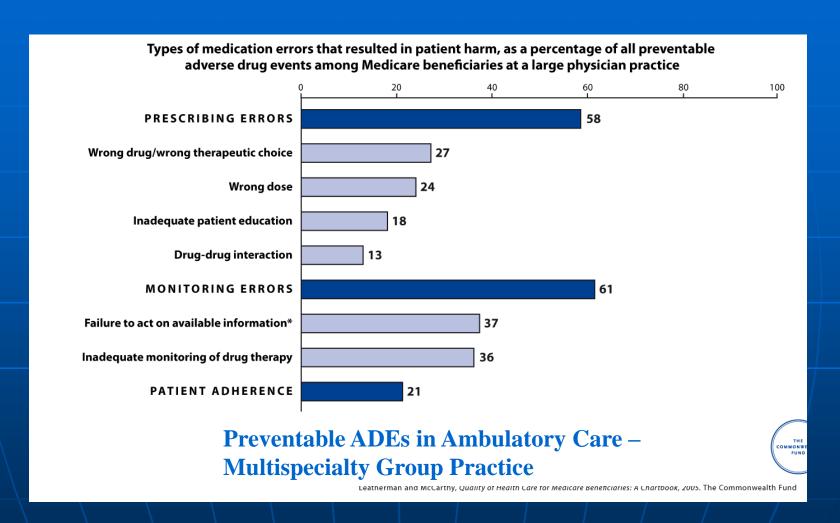
# **ROI on Not Hurting People**





DRG adjusted analysis of 232,994 admissions in 5 states across 13 facilities

# Your name and numbers, please

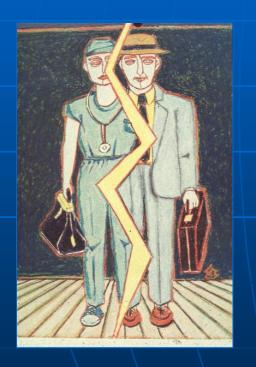


Source: Gurwitz et al., JAMA 2003

# **Malpractice Claims and Patient Harm**

- "Patient safety outcomes were strongly correlated with the number of medical malpractice claims....When risky incidents declined...so did malpractice claims."
  - RAND Institute for Civil Justice, 2010

# What We're Asking Doctors to Be







As for the future, your task is not to foresee, but to enable it.

- Antoine de Saint Exupery

