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Error Reporting and Safety Protocol Compliance: An Alternative to Punishment and Enforcement

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An article published in the New England Journal of Medicine focuses on personal responsibility for medical error, suggesting that restoring the balance between personal accountability and a "no-blame" system is the key factor in eliminating medical error [1]. The authors of this article write as if there has been a "no-blame" system in place and that it is now time to reinstitute personal responsibility. We believe the opposite has been true. The current medical culture of blame, malpractice and reactionary punishment—all of which are based on the idea that one human or a team of humans is responsible for an error—has been in place for decades and has failed to improve safety [2]. The concept of personal responsibility and liability has been in place from before the IOM report on medical error in 1999 and things have not changed [3].

Lucian Leape has suggested a new medical culture based on transparency, the engagement of all involved parties, care integration, education reform and the restoration of the joy and meaning of work [4]. It is time to institute a new system. One such system exists and has proven effective. The Federal Aviation Administration (FAA) and National Aeronautics and Space Administration (NASA) have developed anonymous mechanisms for error reporting therein encouraging confidential, voluntary and non-punitive reporting for pilots [5], aviation mechanics [6] and air traffic controllers [7] as well as other aviation professionals. To encourage error reporting further, the FAA "…has also chosen to waive fines and penalties, subject to certain limitations, for unintentional violations of federal aviation statutes and regulations which are reported to Aviation Safety Reporting System (ASRS) [8]." This voluntary data has identified areas of concern and provided leadership with the raw data; the tools and the insight to make meaningful change in improve safety. Just imagine if the government granted similar immunity and indemnity to physicians and surgeons for errors and near misses which were reported. This stands in contrast to a culture of individual blame and should result in increased personal responsibility of physicians by public reporting, as has happened in aviation.

The authors write, "Why Is Enforcement of Safety Standards So Weak? Our failure to create real accountability for patient safety partly represents a fundamental misunderstanding regarding both how other, safer industries carry out their safety activities and the nature of errors [1]." The authors then suggest punishment for the commission of an error. Safety is not about enforcement of policy or punishment for a mistake, but rather achieving 100% buy-in from all involved parties. In California, enforcement is already happening at the institutional level without proven benefit. The California Department of Public Health is levying substantial financial punishments for medical errors [9]. This system of blame and punishment has the potential to create an environment where people withhold error data and cover up events from which important safety lessons could be learned and shared. The FAA voluntary reporting database was not widely utilized by aviation professionals until it gave management authority to NASA because people did not believe that their data would be truly non-punitive if managed by a regulatory body, i.e., the FAA, and companies held their pilots liable if an event was discovered by a source other than the pilot. As things stand today in modern medicine, blame and punishment continue to trump error reporting, transparency and safety. Medical professionals must develop a national system that allows the non-punitive sharing of data so that specialists can identify and analyze errors for the benefit of all patients. General surgeons have started but their database does not include all surgical specialties [10].

Malpractice is one outside influence on the medical system which has helped perpetuate a culture of blame, punishment and excess spending in the billions of dollars in the form of defensive medicine simply by promising the unfortunate patient the potential for a large payday [11,12]. National systems for error reporting will not be successful without liability reform to mitigate this powerful influence which has changed practice patterns and cost billions…again without proven patient safety benefit.

The authors of this paper do take some initial steps in the right direction by mentioning a blameless system but they struggle to balance this with the notion of accountability [1]. We agree that a distinction between error and volitional violation needs to be defined. Repeated willful violations such as the following may merit the restriction of one's ability to place patients at risk: 1) Hazardous behaviors leading to patient harm despite warnings; 2) Operating when under the influence of drugs or alcohol; 3) Intentional deviation from protocols such as the Time Out; 4) Clinical research when the principle investigator does not provide the patient with a valid informed consent or minimizes the risks of participation. There is a difference between error with unintentional and unforeseen consequences and volitional violation.

A culture shift is underway, just as was in aviation decades ago. A culture of blame and punishment, as well as the outside agencies which propagate it in medical care, should become extinct; and a new culture of safety, transparency, reliability, data sharing and shared responsibility for health will emerge. As Lucian Leape implies, we hope that this will rekindle the joy and art of practicing medicine [4,13]. And rather than be frightened away by the number and extent of medical errors, we dream of a future where doctors and patients unite over safety. There will be an unspoken promise and professional responsibility to deliver

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the safest care possible; and this will help strengthen the foundation of the doctor-patient relationship for generations to come.

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