

# UPDATE!

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## Message From The Chair: Patient Safety and Medical Error

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The mission of the Washington Medical Commission (WMC) is “promoting patient safety and enhancing the integrity of the profession through licensing, discipline, rule making, and education.” All actions taken by WMC are intended to promote patient safety and the integrity of the profession. No matter how skilled the clinician, given the complexity of our environments, preventable adverse events happen. Adverse outcomes don’t normally occur because of incompetence or a lack of knowledge.

There are a lot of ways to look at error. There are errors of omission and errors of commission. Errors of omission are failing to do something that needs to be done. An example would be writing a note that a follow-up CT scan needs to be ordered to rule out cancer, but then forgetting to write the order. Errors of commission would be doing something that shouldn’t have been done, such as giving a patient an antibiotic to which they are allergic. There are also cognitive

errors, such as making the wrong diagnosis or misidentifying a structure at surgery.

There are 4 major sources of error that operate in a dependent fashion:

- Human factors and cognitive errors;
- System problems;
- Cultural problems;
- Unnecessary variation (which is actually both a system problem and a cultural problem).

### Human Factors and Cognitive Errors

Physicians operate in complex situations with major time constraints. There are a myriad of normal human reactions that serve us well in most circumstances, but contribute to error in others. In an emergency, our field of vision tends to narrow and alternatives diminish. That is helpful when quick action is necessary, but if our normal course of action

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**We function in an extremely complex environment and bad things will happen that are preventable, no matter how good the clinician.**

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doesn't work, our tendency is to not see alternatives which might be lifesaving. An example of this would be to persist in trying to intubate when a glide scope or cryothyroidotomy is required. Another factor is the compression of time in an emergency; we often misjudge how long we have taken to do something in situations when time is critical. A third human factor is that we see what we expect to see. Unfortunately, that may lead us to cut the common bile duct because we saw it as the cystic duct. A fourth human factor is cognitive dissonance, in which we persist in believing that we are correct in the face of overwhelming evidence to the contrary. This is actually one of the most common problems resulting in medical error, and it is one that all of us are subject to from time to time. Human factor issues, including cognitive errors, are universal and not unique to medicine.

and change the system so no one will make that error again, hopefully. We have to change the culture, so everyone feels safety is his or her responsibility, and identifies hazards before someone gets hurt." One of the interesting things in Dr. Leape's statement is that there is no reference to harm. Is the misadventure that produces no actual harm, but could have, any different from the exact same action that did produce patient harm?

### Cultural Problems

Cultural problems include work-arounds, where everyone does it to get through the day, but safety precautions are bypassed. Cultural problems include a culture of blame, which leads to pushing error underground, and to developing complex explanations of bad outcomes rather than examining those outcomes for improvement opportunities. A culture of

## There are Three Types of Cognitive Error:

1. Errors of anchoring, where we fixate on early data, which subsequently skews our thinking.
2. Errors produce by recent case bias. We remember recent cases, especially if they were dramatic, which may influence or bias our thinking regarding future cases.
3. Errors produced by preconceptions or stereotypes. We make judgment based on preconceptions or stereotypes and may overlook data.

Human factor errors can be minimized by teams, by the leveling of hierarchy so that anyone can speak up or stop things, and by developing systems that prevent these errors from reaching the patient. **Human factors cannot be fixed by education or trying harder.**

### System Errors

Every system is designed to achieve exactly the results that it gets, including the errors that occur. An example of a system error would be the presence of an unlabeled liquid or syringe on an operating table. That liquid or syringe will, sooner or later, be used in the wrong place. Allowing unlabeled material to be on the operating table is a flawed system. To quote Dr. Lucian Leape, Adjunct Professor of Health Policy, at the Harvard School of Public Health and a Co-Founder of the National Patient Safety Foundation, "We need to quit blaming and punishing people when they make mistakes and recognize that errors are symptoms of a system that's not working right, and go figure out

tolerating disruptive clinicians results in the disruption of team performance, produces fear that delays the management of problems and may lead to the bypassing of safety measures. The medical profession must make a cultural change that moves from shame and blame induced secrecy to a "just culture." Just culture is described in Washington Medical Commission Guideline MD2015-08 titled "[A Collaborative Approach to Reducing Medical Error and Enhancing Patient Safety.](#)"

Just culture is an approach to reducing error in high-risk, complex industries by recognizing that errors are often the result of flawed systems. Blaming individuals for human error does not make systems safer. A just culture describes an environment where professionals believe they will be treated fairly and that adverse events will be treated as opportunities for learning. A just culture encourages open communication so that near misses can serve as learning tools to prevent

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future problems, and adverse events can be used to identify and correct root causes. It holds individuals accountable for the quality of their choices and for reporting errors and system vulnerabilities. It holds organizations accountable for the systems they design and how they respond to staff behaviors. In that guideline, The WMC commits to endorsing just culture principles. The WMC encourages institutions, hospitals, clinics and the health care system to adopt a just culture model to reduce medical error and make systems safer. Likewise, the WMC will use just culture principles in reviewing cases of medical error. This is a step towards accountability and away from punishment. In a just culture, physicians and physician assistants accept responsibility for the problem, bring the issue to the attention of others involved, and look to see how to prevent others from making the same mistake in the future. Does the WMC take this into consideration when evaluating a complaint? Yes, we do.

### Unnecessary Variation

Unnecessary Variation: To quote Edward Deming, "Uncontrolled variation is the enemy of quality." It is disruptive to teams, as when team members change, what is expected will also change. There is evidence that following protocols in the ICU results in better outcomes than not following those protocols. There is good evidence that if two processes are relatively equal in their outcomes, results are better if one process is chosen rather than allowing uncontrolled variation. UTI bundles have clearly reduced the incidence of urinary tract infections. However, standardization needs to be cautiously and appropriately developed and outcomes measured to determine the efficacy of standardization. In order to effectively control variation, analytics are required to understand what variation is significant and what is not.

Reduction of medical error, and to a significant degree the reduction of bad outcomes in general, requires that we not be afraid to look at outcomes. In this regard, our profession has been seriously lacking. Most importantly, we need to investigate and develop effective, multidisciplinary peer review. There are organizations in this state that do peer review extremely well, but most do not. It requires data, teamwork, and analytics. It requires participation by physicians who are already too busy.

To improve patient safety requires incorporating the principles of safety developed in other complex industries and it needs to be physician driven. Medical organizations, led by physicians, need to acquire the attributes of a highly reliable organization, including a preoccupation with failure, a reluctance to accept simple explanations for problems, a deference to expertise regardless of titles or experience, a sensitivity to operations (i.e. how things are working) and resilience (preparation in how to respond to failures and continually find new solutions, refine the ability to improvise, or quickly develop new ways to respond to unexpected events).

The WMC supports the Communication and Resolution Program promoted by the Washington Patient Safety Coalition and have agreed to consider their findings when assessing cases for disciplinary action. In addition WMC will take into consideration effective peer review, and may find that we have nothing more to add in our role of protecting the public. Patient safety is our most important responsibility. The greatest improvements will come through local measures and physician

involvement. WMC supports these efforts.

Thank you for your attention,

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## Upcoming Buprenorphine Waiver Trainings as of June 20, 2019 (No cost)

Chemical Dependency Professionals are welcome to attend upcoming, no cost trainings to learn more about the use of buprenorphine for treatment of opioid use disorder. If you have any questions, please contact the [program director](#).

Completion of the 4-hour in-person course as well as a 4-hour online follow-up allows physicians to apply for the waiver to prescribe buprenorphine for office-based treatment of opioid use disorder.

[Learn more](#) about dates and locations.