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Learning From Our Mistakes

MEDICAL MISTAKES - WHY CAN'T WE SEEM TO LEARN FROM OUR MISTAKES.

In 2006 three babies in Indianapolis died when they received adult doses of heparin, the same mistake happened at the same hospital 5 years earlier. Recently new attention has focussed on the exact same thing. This time in Los Angeles with the twins of actor Dennis Quaid. Why can't we seem to learn from our mistakes.

Welcome to the Clinician's Round Table¸ I am Dr. Leslie Lundt, your host, and with me today is John Nance. John is a decorated Military Pilot Attorney, Global Airline Safety Expert and one of the Founding Members of the National Patient Safety Foundation. He is the author of the recently published "Why Hospitals Should Fly: The Ultimate Flight Plan to Patient Safety and Quality Care."

DR. LESLIE LUNDT:

Welcome to ReachMD, John.

JOHN NANCE:

Thank you Leslie. It is good to be with you.

DR. LESLIE LUNDT:

John would don't you fill us in on the heparin tragedies. Give us the background.

JOHN NANCE:

Well, this is one of those things where we had a dress rehearsal and then we had to repeat as you mentioned in Indianapolis with tragic results for 3 babies, but we did not have a systemic way of really informing the entirety of the medical world that Hep-Lock, the pediatric version of heparin and heparin itself can easily be mixed up and the labels were really the problem, but the fact was that even if the

pharmaceutical company had not taken or did not and ultimately did not until after another tragedy make a move to make those more different. The fact is that the medical profession itself had no method of communicating universally. In aviation, just to give you an example and I know aviation is just one of several industries like this that can do it, but aviation stands out because if we have a problem with for instance a Boeing 737 this afternoon. By tomorrow morning every operator of a 737 on the planet will know what the problem was and how if we do have an answer, how to solve it. Now agreed that is an individual machine. We are talking about human beings, but human beings are very similar and we do have a responsibility to make sure that we do not have to have 15 or 20 or 1000 deaths from the same cause like for instance undiluted potassium chloride left on a unit in undiluted fashion, which eventually will get injected and stop a heart. That was hit list #1 item for the joint commission a number of years ago because we killed 1000s before we realized that needs to be pulled off the units. Now in the case of heparin and Hep-Lock, the Dennis Quaid case was a repeat of what happened in Indianapolis and they had had problems in the past with mixes of medication. In this case, there was not even a picture symbol, but the medication got in the hands of the nurse, it was the wrong stuff, it was the adult version, and it got injected. This must not happen again, but it should never have happened a second time.

DR. LESLIE LUNDT:

How can we learn from how aviation has handled these sorts of things. You know it seems overwhelming in your scenario that if we had a Boeing 737 with something wrong to have it in everybody's hands the next day. How realistically can we do that in a system so vast as a medical system.

JOHN NANCE:

Actually, a lot easier than you might think. If we have an ability to give alerts in areas for instance in Pediatrics, there are specific things just like this. Now, thanks to the fact that it was Dennis Quaid and that he is a famous individual, most everyone in healthcare has heard about this and that massage has now gotten around, but we need a method that does not involve a near-miss or a tragedy involving a famous individual or their child in order to make sure that for instance a doctor who comes in for an operation on a particular day has a little list of alerts to look at very short, very sweet, very to the point of things that might affect his or her practice. If we have the ability to share our information outside awaiting for lawsuits to bring it out which sometimes takes 10 years. We can change this thing very rapidly. The second part is we still have this approach that there is a root cause to every problem. Well there is no such thing as a root cause and a root cause analysis. As root cause is, there is never just 1 reason for a medical mistake that impacts a patient or could impact a patient. If we look at all the things that contribute, we will fix systems much, much more rapidly than we do now and for instance if it is not just a matter that a nurse made a mistake, but all of the things that supported that mistake, we can probably interdict 15 other mistakes in the future that are dissimilar in terms of their final impact, but had the same causation pattern. In other words, problems with the pictures, problems with the medication chain, problems with communication, every accident or incident has a unique chain out of which we can derive all sorts of things that need to be immediately altered.

DR. LESLIE LUNDT:

But who has the time to look at that complex set of events.

JOHN NANCE:

Well, of course, I could turn that around and say who can afford not to, but in fact, the reality is that every hospital has a risk manager. Many hospitals now have people who are responsible in a larger sense for instituting safety and certainly we know since the IOM report in 1999 that this is not something that can be bypassed or considered to be something your quality program takes care of. So, whatever it takes and then boards who are understanding this more and more as our CEOs that if they do not have an infrastructure that can take care of looking at these items and certainly extracting every possible piece of information from their own internal failures, then they are

continuing to put themselves out in a way that certainly in the current legal system almost guarantees not only a tragedy for the patients, but a tragedy legally for the hospital. Because if anybody out there thinks that the attorneys, the plaintiff attorneys do not understand the latest cutting edge methodologies of communication problems and how to fix them, etc., think again they certainly do and we just don't have the luxury of time in medicine to sit around and wait for something to develop. We have got to take the aggressive steps to take the information from each and every accident, a near-miss, etc., and repair the system. Whatever it takes is what we have to do.

DR. LESLIE LUNDT:

But in order to do that don't people have to admit that there was a mistake.

JOHN NANCE:

Well that's another fascinating area. First of all the cultural change that has to occur here is going to probably take 20-25 years to be fully realized. Now that doesn't mean we can't change things in a particular hospital in 3-6 months. You just have to maintain your hand on that throttle of change for a long period of time, but what happens here is also a process of learning to say and I teach docs to do this and they are much the better for it as they will tell you afterwards just like I had to as a captain, an aircraft commander in the Airforce. I had to learn to stop saying I am a senior leader, so therefore I am perfect and be a leader by saying you know I am very good at what I do. I am a very good doctor, I am very good aircraft commander, but I am a human and I am incapable of being perfect. I very seldom make mistakes, but when I do, my pride is in knowing that and in being ready, willing, and able to take that mistake and publicize it so that nobody else will follow down that same path including me. Now that takes a lot of courage, but that is the world that we are now creating and where we create it, we have people who are eager to exchange information about things that went wrong, so they can make them not go wrong again, bad English, good concept.

DR. LESLIE LUNDT:

If you are new to our channel, you are listening to the Clinician's Round Table on ReachMD XM-157, the Channel for Medical Professionals. I am Dr. Leslie Lundt, your host, and with me today is John Nance. You were discussing medical mistakes.

John, one of the most incendiary statements in your book, at least to me was that we should all assume that meds are lethal until proven otherwise. Tell us about that.

JOHN NANCE:

Well, when you look at as I have thousands of medication disasters. In almost every incidence, there is an assumption, well back to those 3 assumptions, communication and perception. We have an assumption that the medicine that that nurse is taking to the bedside is the right medication, the right dose, and she is getting ready or he is getting ready to put it in and the right method of application every time. Now, when you time that assumption around, if we could do it, if we could change the assumption, we would cause another check, another level of concern to be there each and every time and in so many, many, many cases that would have made the difference. I can't tell you how many of these reports end with a nurse having said you know I had a feeling something was wrong, but I did not have any validation of it and I was…….**Incomplete dictation**