Addressing the Barriers and Political Pressures to Safety

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ABSTRACT
Numerous high profile inquiries in UK, Australia, and U.S. reveal subtle and overt external pressures that enable and support unsafe care. Understanding these 'political' pressures on clinical service executives to execute a government policy regardless of evidence on quality of care is essential to transforming healthcare systems. This article reviews key findings and recommendations from several international inquiries and identifies how to overcome barriers to improvement. Identifying the barriers that contribute to patient harm in national inquiries shows the important influence of external political pressures. Reviewing the commitment across professions represented by specialty boards, royal colleges, academic medical centers, and professional unions to protect patients is key. Understanding that a culture of blame can affect patient safety in healthcare systems and how they manifest depends on the political and healthcare provision characteristics of each country. Transparency - the ability to openly discuss and address opportunities for improvement in the healthcare system are a recurring theme in national inquiries. All stakeholders must be involved at all stages and mechanisms for ongoing, effective consultation and communication should be provided at the local and state levels.

Keywords: Adverse Events, Barriers to Change, Culture of Safety, Patient Safety, Public Inquiry, Teams

INTRODUCTION

"The value of history lies in the fact that we learn by it from the mistakes of others, as opposed to learning from our own which is a slow process.” W. Stanley Sykes (1894-1961)

Every day, clinical adverse events occur within our health care systems, causing physical and psychological harm to one or more patients, their families, staff (including medical staff), the community, and the organization (Kohn, Corrigan, & Donaldson, 1999; Landrigan, Parry, Bones, Hackbarth, Goldmann, & Sharek, 2010). In the crisis that often emerges, what differentiates organizations, positively or negatively, is their culture of safety, the role of the board of trustees and executive leadership, advanced planning for such an event, the balanced prioritization of the needs of the patient and family, staff, and organization, and how actions immediately and, learn, and improve the future care.

Five years ago, a group of American activists set out to protect millions of human lives; not from global scourges such as malnutrition or preventable disease, but from the ravages of the world’s most expensive and sophisticated health-care system, that of the United States.
of America (Berwick, Calkins, McCannon, & Hackbarth, 2006). The "100,000 Lives - Let's Make Harm History" campaign was not a tasteless First-World parody of Third-World misery, but a serious effort by the non-profit Institute for Healthcare Improvement (IHI) to draw attention to the considerable risks of harm and death caused by modern health-care systems.

It has long been recognized that medical care itself has the potential to cause harm. However, general acknowledgement that much iatrogenic injury may be due to preventable human error or system failure appears to have been slow in the coming. Healthcare is a risky business. Simply being in an acute hospital in Europe carries, on average, a 200-fold greater risk of dying from the care process than being in traffic, and a 2000-fold greater risk than working in a chemical industry, or flying on a plane (Leape et al., 1991; Baker, O’Neill, Ginsburg, & Guohua, 1992).

Recent health policy reports in US, Europe and Australia estimate that approximately 50,000, 40,000, 3000, respectively, people die in hospitals each year as a result of medical errors (Landrigan et al., 2010; Wilson, Runciman, Gibberd, Harrison, Newby, & Hamilton, 1995; Vincent, Ennis, & Audley, 1993). Nonfatal “adverse events” and near misses are ten- to hundredfold more numerous than deaths due to errors (Barach & Smalls, 2000). Several federal reports estimate that total national costs for adverse events (lost income, lost household production, disability, health care costs) are between $38 and $50 euro annually (Orszag & Emanuel, 2010). Current approaches are not producing the pace, breadth, or magnitude of improvement that EU stakeholders desire.

Healthcare systems across Europe must demonstrate how they enhance the value of care for patients and their families while making patient safety and value highly visible in their existing strategic plans. Healthcare systems will be measured by their ability to:

- Provide exemplary, value added, cost effective, safe, patient-centered care, to address the central issue of value, with the goal of improving the net ratio of benefits obtained per euro spent on health care;
- Advance patient care quality, safety and cost effectiveness through linking research and scholarship to measurable outcomes of care; and,
- Implement innovative programs that prepare a range of health care professionals to lead, assess and improve the quality, safety and value of patient care while lowering costs.

**NHS Mid-Staffordshire Inquiry**

A recent public inquiry in the UK estimated that between 400 and 1200 people died from medical harm (The Mid Staffordshire NHS Foundation Trust, 2010). The inquiry announced in 2010 into the systemic failings at Mid-Staffordshire NHS Trust was a welcome opportunity to publicly discuss the wider issues of transparency that could reduce the chance that a similar incident could occur elsewhere. We know that surgical staff knew there were problems that could endanger patients and had raised concerns internally but were frustrated by the lack of urgency in action, and, because of their contracts of employment, could not go public.

The Francis inquiry found that the hospital “routinely neglected” patients and displayed systemic failings in its approach to care (Ellicot, 2010). Mid Staffordshire NHS Foundation Trust, the hospital’s parent body, lost sight of its responsibility to provide safe care after managers became preoccupied with cost-cutting and government targets. The report concluded that:

> “The events at Mid Staffordshire were a tragic story of targets being put before clinical judgment and patient care, focusing on the cost and volume of treatment not the quality,” health secretary Andrew Lansley said in a Commons statement today. “That is why I want to move away from targets and replace them with measuring what matter most to patients – their experience of the NHS, the quality of their care and the outcome of their treatment.”
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