What's New in the Patient Safety World

July 2013

"Bad Apples" Back In?

One of the slides we still show on occasion dates back to the work of Lucian Leape and colleagues from the Harvard Medical Practice Study (Leape 1991, Brennan 1991, Leape 1994) noting that "**bad apples**" accounted for only 2% of errors encountered in their study. Since that seminal work we have always focused on the "**systems**" nature of errors that lead to adverse events.

But in recent years we have begun to focus more on the effects that disruptive physicians (and other disruptive healthcare workers) have on quality and patient safety. In 2008 Joint Commission issued Sentinel Event Alert #40 "Behaviors That Undermine a Culture of Safety" and most hospitals have taken steps to identify egregious behaviors and deal with them appropriately. The "**Just Culture**" philosophy has always recognized that there are some behaviors that are not tolerable. Even Lucian Leape has begun to rethink some of our underlying root causes in adverse outcomes. Our July 2012 What's New in the Patient Safety World column "A Culture of Disrespect" summarized what he considers to be the number one problem in patient safety today: we have a **culture of disrespect**. His argument is that our pervasive culture of disrespect is what is blocking our ability to move to a culture of safety. While he includes the classic disruptive physician type behaviors in his 2-part series on the culture of disrespect (Leape 2012a, Leape 2012b) and related video "Lucian Leape on Key Lessons in Patient Safety", he emphasizes the much more subtle behaviors we exhibit that undermine the safety culture.

But the "bad apple" theme won't go away. This month's issue of BMJ Quality and Safety has a provocative study on complaints about physicians in Australia (Bismark 2013) and three accompanying editorials (Gallagher 2013, Paterson 2013, Shojania 2013).

The study by Bismark et al. found that 3% of Australia's medical workforce accounted for 49% of all complaints by patients and 1% accounted for 25% of the complaints. Moreover, there was a striking dose-response relationship, i.e. the more complaints about a physician the higher the likelihood that there would be yet further complaints. For example, a doctor with a third complaint had a 38% chance of a further complaint within a year and 57% chance of another complaint within 2 years. For one with a fifth complaint, the chance of another complaint within 1 and 2 years, respectively, was 59% and 79%. The authors point out that we are often too late to respond to physicians who have attracted multiple complaints and that we should really look at complaints as

sentinel events. The hope is that early response may result in changes in physician behaviors.

So is the recent emergence of a focus on "bad apples" really in conflict with our more global "systems" view of patient safety? Shojania and Dixon-Woods (Shojania 2013), in an editorial accompanying the Bismark study, argue that it really is a systems problem and that we need to focus our resources on identifying such individuals and dealing with them. They also note that, in some cases, there may be multiple system problems that lead to a physician attracting multiple complaints (eg. understaffing in a clinical area).

In another accompanying editorial Paterson (Paterson 2013) notes that patient complaints are the "canaries in the coal mine" that should alert us to deeper problems and should not be ignored.

The third editorial (Gallagher 2013) focuses on the need to end our silence and speak up and tell our colleagues about ways they can improve their care and communicate better. They argue we need to do a much better job acting locally (at the departmental, medical staff, academic unit, and clinical unit levels) to address these behaviors before they need to go to higher levels. They also note the need to develop better metrics for incorporating measures of patient satisfaction.

Of course, it is not just patient complaints we need to consider. Complaints from staff are equally important and it should come as no surprise that the same physicians who attract patient complaints likely have had multiple staff complaints as well. Our January 2011 What's New in the Patient Safety World column "No Improvement in Patient Safety: Why Not?" and our March 29, 2011 Patient Safety Tip of the Week "The Silent Treatment: A Dose of Reality" discuss failure to change the culture as barriers to patient safety and good healthcare. Turning a blind eye or deaf ear to such problems just continues to make the working environment worse for all parties involved. We've seen numerous occasions where staff had previously stepped forward to report such behaviors, only to be ignored or, worse yet, suffer retribution for their actions. So the organization as a whole needs to ensure a supportive environment is present so that staff do not feel uncomfortable in confronting such individuals or in addressing such threats to patient safety. You can have all the policies and procedures in the world but if your culture is not conducive to eliminating these hazards we will never move patient safety to that next level.

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"Lucian Leape on Key Lessons in Patient Safety" (video)
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