An Error By Any Other Name

by Karen Wolk Feinstein

Complications: A Surgeon’s Notes on an Imperfect Science
by Atul Gawande

The amazing thing about Complications: A Surgeon’s Notes on an Imperfect Science is that it got published at all. Not that this book isn’t highly publishable; it’s well written, engaging, candid, and moving. But it enters dangerous territory in a litigious society: Atul Gawande exposes the fallibility, uncertainty, and mystery of medicine in true stories about real people. In a world where overly cautious attorneys protect physicians and hospitals from overly zealous trial lawyers by urging clients to cloak and hide errors, Complications is testimony that at least one doctor in one system was permitted to speak openly about medicine’s failures. He does so to make an important point: Where errors are hidden, learning is squelched, and so, like Sisyphus, workers in these systems are compelled to err and err again.

“What you find when you get in close, however, is how messy, uncertain, and also surprising medicine turns out to be.” Gawande gets us up close. We experience the havoc as the inexperienced and exhausted resident misapplies a central line (a catheter inserted into a major vessel, terminating at or near the heart). We understand how a doc “who’s gone bad” continues to harm his patients because those who witness his crimes are silenced by a cult of secrecy. We see how information failures at the point of care, when decisions must be made instantly under great pressure, prevent the application of best practices. In each anecdote, lives are on the line, and medicine, an “imperfect science, an enterprise of constantly changing knowledge, uncertain information and fallible individuals often fails to do the right thing.”

This isn’t just a sensational collection of tales of medical fiascoes. These stories are accompanied by a very clear prescription for healing. In the chapter titled “When Doctors Make Mistakes,” the author applies a surgeon’s precision to dissecting the reasons behind the mess and uncertainty of medical care as well as the interventions that will provide relief. This chapter should be assigned reading for all health professionals and students. Gawande believes that we can narrow the limitations of science and of human fallibility. While never exonerating the individual from a responsibility to shoot for perfection when human lives and suffering are at stake, he does not regard avoiding error as merely a matter of will. All humans will err occasionally, but they tend to err in predictable ways. Systems that do not adjust for these realities can end up exacerbating rather than eliminating error.

Gawande calls for a closer examination of the process, and less of the individuals within it. He advocates for removing the system failures that result from a lack of standardized protocols, a culture of secrecy, poorly designed technology, inadequate training, thin staffing, and poor teamwork. He calls for rigorous statistical reporting and sharing of information.

Equally interesting is what Gawande does not prescribe: more regulation, a better business case for quality, more disciplinary action,

Karen Feinstein is chair of the Pittsburgh Regional Healthcare Initiative and president of the Jewish Healthcare Foundation.
more legal recriminations. In fact, he argues, if medical error were due to a subset of dangerous doctors, you would find a concentration of malpractice cases, not the uniform bell-shaped distribution that exists. If his stories tell us anything, it is that in most instances there is great difficulty in assigning blame for errors. They are embedded in faulty processes, unresponsive systems, and lack of teamwork.

“The deeper problem with medical malpractice suits,” he writes, “is that by demonizing errors they prevent doctors from acknowledging and discussing them publicly.” He argues that those docs who have “gone bad” should be referred rapidly for assessment and treatment. The others—those who commit the random, unintentional mistake—should be rewarded for their candor.

We can only hope that Gawande is the vanguard of a new generation of health professionals. Relentlessly patient centered, truth seeking, and improvement driven, such leaders could transform the culture of their institutions. Errors would be aired, tracked, analyzed, and corrected and the lessons shared within and among professionals and institutions. Acknowledgement of inexperience or uncertainty would be open and instantaneous; support and rapid access to experienced staff or reliable information would be immediate.

The institutional culture that did not regard the patient’s emotional and physical well-being as the major organizing principle would be replaced. The entire health enterprise would rethink its organization of equipment, information, supplies, training, rewards, and human resources to give every patient the best possible care, every time. When needless human suffering is concerned, zero would become the only acceptable error rate.

But this won’t be achieved easily, no matter how many physicians, nurses, trustees, patients, and purchasers would welcome this transformation. I’m speaking from experience. In Pittsburgh we have a regional collaborative that includes forty-two hospitals, all of our leading purchasers and health plans, several hundred physicians, nurses, the state attorney general, and other stakeholders who are committed to working together to achieve the best patient outcomes in the nation. We have installed common databases to uncover medication errors and infections; we use our state’s health care cost containment data to track and improve outcomes in five clinical conditions. We have set up learning lines in several hospitals where we are testing our Perfecting Patient Care model for best practice at the point of care, using the teams that actually deliver care. We have had some promising early results. But progress could be much faster.

There are three necessary conditions for the cultural change that would produce, collectively, better outcomes, greater patient and worker satisfaction, fewer errors, and less waste and inefficiency. I call them the three “Ls.” The first is leadership. We need executives and trustee chairpersons who will replace an aversion to risk with the conviction that the greatest risk is retaining the closed-system citadels that we have now. We need leadership willing to hold firm to the principle that their institution’s business is patient care; anything that interferes with patient outcomes and satisfaction is an error to be acknowledged, studied, and remedied systemwide. Second, we need a reliable, experienced labor force that is trained and exhorted to practice good processes with every patient encounter. We must reward perfect care with the same diligence that we reward new medical discovery or invention. We need to guarantee workers the same emotional and physical safety and satisfaction that we give to patients. Third, everyone involved in such a system needs the legal protection to acknowledge error and mistakes and to share the lessons learned.

To minimize Atul Gawande’s challenge would be unwise. Equally unwise would be to minimize the cost of ignoring it.

“We must reward perfect care with the same diligence that we reward new medical discovery or invention.”