

JCAHO—A Fallacy of Best Efforts

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A recent Modern Healthcare editorial apparently bothered Dennis O'Leary over at JCAHO. The editorial ("Not taking the lead: Healthcare community goofs again on medical errors", December 13, 1999, p 18) referenced the Institute of Medicine's report of long standing data that as many as 100,000 deaths and 1.3 million injuries occur annually at the hands of America's caregivers and their error-prone systems. The report carried the imprimatur of the National Academy of Sciences, and created widespread wrath from consumers, employers, payers, and regulators. The JCAHO remains in denial with Mr. O'Leary's response that the editorial "simply misses the mark" (Modern Healthcare, January 3, p 23), and yet seemingly remains without a clue as to what needs to be done. Let's examine the thinking of JCAHO's improbable logic lest following the blind lead us into the ditch.

First, the JCAHO's objection to your editorial asserts they have been working for medical error reduction for the past five years, during which time another 500,000 Americans died unnecessarily. There is scant evidence that medical errors have been reduced by JCAHO's efforts, so should we continue on this track another five? It puts me in mind of a Texas friend who observed that when they see a snake in Texas, they shoot it. On the other hand, when the JCAHO sees a snake, they set up a committee on snakes. Then they launch a conference on snakes, set up a database on snakes, and five years later there are snakes all over the place.

Deming warned of the "fallacy of best efforts," the notion that working hard and trying our best is all that counts. This failure by JCAHO to accept accountability for their system's lack of results simply does not stand in the real world of management expectation or of legal liability. O'Leary puts forward that JCAHO's voluntary reporting system for medical errors has created a "growing database" which says very little since it represents only a miniscule percentage of the total number of adverse incidents. He correctly states that "voluntary reporting is insufficient", and recommends mandatory reporting with statutory protection for such events. It's doubtful that oddsmakers would bet on that happening given Americans belief that they have a constitutional right to "seek a redress of grievances." Does Mr. O'Leary realistically expect that politicians are going to hold the healthcare system harmless for killing some mother's infant? This fuzzy thinking hasn't taken us anywhere to date and isn't likely to in the future, so let's move on to some more workable propositions.

A current analogy is that hospitals should operate more like the airline industry, with mandatory reporting of adverse events and full investigative efforts. Under such an approach, error discovery generally leads to punishment only when correct practices were not followed. If such a corrective mechanism were applied in healthcare it is highly likely that it would force providers to follow standardized and approved best practices. Why might this work?



Mandating that providers implement best practices provides the needed impetus to kick into gear knowledge we already have. And the law should also provide that providers who are following defined and endorsed best practices are granted protection from prosecution. The only safety the law should allow is that we did the best that any of us knows. Perhaps an incentive to assist the process would be a one-year moratorium on prosecutions for providers who are in process of switching to national standards—a get-into-alignment safety period.

Among other actions that might be taken, I have proposed that best practice clearinghouses be established by each healthcare profession.* Already beginning to appear on the internet in the way of defined protocols, these specifics can be downloaded and implemented nationally. The essential core of quality improvement is the removal of variance from a standard. Profession-endorsed best practices represent a current year 2000 standard. Annual updating should be required to keep ratcheting healthcare upward as we gain more knowledge. Eventually professions that did not define best practices might not be reimbursed or allowed to practice. At heart, this standards issue is simply a knowledge management problem, a problem now entirely solvable.

In defense of this horrific national scandal of ill-defined practices and sloppy compliance, O'Leary tiredly reports that JCAHO has cosponsored yet another meeting on medical errors. "So what?" one asks, "Where are the actual changes among provider practices?" He further asserts that knowledge of what to do "will come from in-depth analyses of medical errors." But don't we already know much of this in the hundreds of reports and research that's been done for years? A common error among failing staff people is to think the answer lies in yet another stalling study. Effective leaders know that a bias for action supersedes data gathering. Put another way, what do we already know that can be put into practice now? Courage and action is called for, components sadly missing in this recent JCAHO commentary.

Instead of attacking those pushing for change, the JCAHO should consider abandoning its recommendations for meeting minimal standards. What's needed is a push for universal compliance with best practices. That conceptual difference is a light year away from the old disproved notion that accreditation has had any connection to quality. The premises, strategies and tactics of the JCAHO are bankrupt. This crashing failure to address the issues suggests its time to move on to some new approaches.

**Raising Standards in American Healthcare: Best People, Best Practices, Best Results, Jossey Bass, 1999.*

—Modern Healthcare Editorial, 2/00

