Letters

JCAHO still in denial about medical errors

A recent MODERN HEALTHCARE editorial apparently bothered Dennis O'Leary, M.D., president of the Joint Commission on Accreditation of Healthcare Organizations. The editorial ("Not taking the lead: Healthcare community goofs again on medical errors," Dec. 13, 1999, p. 18) referenced the Institute of Medicine's report on 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 JCAHO remains in denial with O'Leary's response that the editorial "simply misses the mark," (Jan. 3, p. 23) and yet seemingly remains clueless about what needs to be done. Let's examine the JCAHO's improbable logic, lest following the blind lead us into the ditch.

First, the JCAHO's objection to your editorial asserts the organization has been working on reducing medical errors 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 the JCAHO's efforts, so should we continue on this track another five? It reminds me of a Texas friend who observed that when people see a snake in Texas, they shoot it. When the JCAHO sees a snake, it sets up a committee on snakes. Then it launches a conference on snakes and sets up a database on snakes. Five years later there are snakes all over the place.

O'Leary proposes that the JCAHO's voluntary reporting system for medical errors has created a "growing database," which says very little, since the database represents only a minuscule 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. Does O'Leary realistically expect that politicians will 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 more workable propositions.

An 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 would probably force providers to follow standardized and approved best practices.

Mandating that providers implement best practices would provide the needed impetus to kick into gear knowledge we already have. And the law should also ensure that providers who follow defined and endorsed best practices are protected from prosecution.

Among other actions that might be taken, I have proposed in *Raising Standards in American Health Care* that each healthcare profession establish best practice clearinghouses. 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. Eventually, professions that did not define best practices might not be reimbursed or allowed to practice.

In defense of this horrific national scandal of ill-defined practices and sloppy compliance, O'Leary tiredly reports that the JCAHO has co-sponsored yet another meeting on medical errors. 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 from the hundreds of reports and research that have 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 bias for action supersedes data gathering. Put another way, what do we already know that can be put into practice now? Courage and action are called for, components sadly missing in this recent JCAHO commentary.

V. Clayton Sherman
Chairman, Management House
Boynton Beach, Fla.
Author, Raising Standards in American Health Care

Accreditation piece noted north of border

Thanks for a revealing article on accreditation (Nov. 15, p. 32), obviously written for your American audience and covering most of the bases. I was surprised, however, to see that you made no mention of the Canadian Council of Health Services Accreditation program. We were well-integrated into the Joint Commission on Accreditation of Healthcare Organizations before becoming separate.

The CCHSA is also a member of the International Society for Quality in Healthcare (ISQua). Our chief executive officer, Elma Heideman, is president of the ISQua, and our program has been accepted in some European and Caribbean countries.

In jest, you probably did not want to give any marketing advantage to the accreditation competition north of the border.

I did find the article informative.

G.A. Hollingsworth
Administrator and CCHSA surveyor
Jordan Memorial Home
Riverglade, N.B.

Corrections, clarifications

A Governance Institute survey of the best-governed healthcare systems ranked the systems on an 18-point scale, not 20 points as stated in a story on the study (Jan. 17, p. 38). The incorrect information was supplied by the institute.