Evolution of quality and patient safety in Israel

We arrived on the ward in the morning and heard the senior physician say: ‘We need to draw blood from this patient, but because he has no veins in his hands we will need to find another place, perhaps the neck?’ One of us approached the patient and drew blood from the jugular vein; he wanted to use a venous clamp to aid him, intending to tie it around the patient’s neck. Another patient post prostate surgery had a catheter in his urinary tract. He called the nurse and complained about severe burning in his penis. The nurse calmed him down and immediately brought an antacid solution, with which she irrigated the urinary catheter. ‘The burning in the urinary tract will now pass and you will feel better’ assured the nurse.

Thirty years ago these anecdotes and many others were told by us, hospital residents, as popular stories, at social gatherings. There was awareness about patient safety, but when it came to errors in treatments or in administering medications, we dealt with the subject jovially and with a sense of humor, without a need for full, organized reporting.

In those days, we believed that physician safety took precedence over patient safety and that there was no real connection between quality of medicine and patient safety. We learned, and we taught the next generation, that for example, liver biopsies needed to be performed before noon because if the biopsy was performed in the afternoon and complications ensued, not all of the needed staff would be present at this time of the day in the hospital. We as physicians might then find ourselves in a situation, where we would endanger our license as well as the patient’s life. All at once, the age of investigative committees established by hospital management came to an end and a system for risk management was established. Quality was pushed aside. The investigation was still not from the patient’s perspective but rather for the benefit of the physician, the hospital and the insurer.

In 1995, following a High Court of Justice ruling, the investigators were senior physicians, who interviewed those involved, and recommended to management measures and preventive steps to be taken.

In 1995, following a High Court of Justice ruling, the paternalistic approach to patients came to an end. A young engineer, attempted suicide by cutting his veins. He was brought to the hospital in critical condition and was operated on by a multi-disciplinary team of surgeons who saved his life. A few days later, he jumped to his death from the seventh floor of the hospital. I set up an ad hoc investigative committee that interviewed the treating team. As was customary at the time, the investigative committee had no work guidelines and the testimony of the staff was not given under legal supervision. The family of the suicide charged the hospital with negligence and lack of proper supervision appropriate for such a patient. In order to help their case, they requested a copy of the hospital’s internal investigative report. We refused to provide this copy, claiming that the internal report was confidential. The District Court and later the High Court determined that the Committee’s reports need be given to the family. Needless to say, the Committee’s work was not in compliance with the law; the testimony was not given under the direction of an attorney and therefore there was both personal and institutional incrimination. With the help of these internal reports, the institution was sued for significant damages and was required to pay great sums of money.

In 1996, a Patients’ Rights Law was legislated in Israel [1]. The purpose of the legislation was to establish the rights of the individual requesting or receiving medical care, thereby protecting his dignity and privacy. The law requires that appropriate treatment be provided on a professional, medical and human level. It details the subject of informed consent; limits medical treatment provided without informed consent; and deals with quality assurance committees and the legal privileges applied to their work.

The IOM report from 1999: ‘To Err is Human’ [2] impacted us, as all other health care systems, and in response an atmosphere of lesson learning from accidents and near accidents began.

In 2000, another change was made in our approach to quality and patient safety. Parallel to the Risk Management Committee and with the help of a senior anesthesiologist, who invested a significant amount of time in the field of patient safety, we started to re-enact, accidents and near accidents in front of the entire hospital staff. For example, located between the two surgical theatres of the
Cardio-Thoracic Surgery Department is a refrigerator which holds blood units of those being operated on at any given time. One day, following surgery, a patient was transferred to the intensive care unit, together with a non-matching blood unit taken from this refrigerator. The nurse that noticed the error rushed to report the incident and, literally at the last minute, stopped the team from giving the patient the wrong blood. We re-enacted and photographed the entire event, showed the film and discussed the lessons to be learned in a meeting of the entire hospital staff. We have found that this open educational approach is beneficial in minimizing the number of accidents and near accidents, on the one hand and improving the quality of patient treatment and care, on the other. From that point forward, we occasionally re-enact anomalous events and discuss the events and lessons learned for the future.

Today when I receive reports of accidents and near accidents, I cannot help but recall the process we have gone through over the last 30 years. We have gone from a time when only instrument failures and breakdowns were reported, to a time when we report anomalous events and near accidents in drug administration, patient treatments and other issues that in the past were only a source of gossip and social conversations.

From my point of view, responsibility for safety begins at the top with the CEO and from there proceeds downwards to the rest of the hospital staff. What is needed today is an organizational culture and climate that encourages reporting; parallel to a system that is designed to prevent errors and take corrective actions aimed at improving quality and patient safety.

I view education as a key factor. Education needs to begin during medical school and continue, part and parcel, in the ongoing professional training of interns, residents, and specialists. Among hospital personnel there needs to be a willingness to report errors without fear of punishment. All hospital management levels need to assimilate a culture of safety and include the entire staff in finding solutions and applying them. We, who stand at the head of the pyramid, must immediately find ways to prevent errors and lessen the physicians’ work load. For example, prior to every surgical procedure the chief surgeon should gather his team for a team briefing. Patient friendly informed consent forms will make life just a little easier [3]. Simulations can also be used as an educational tool. Exercises, simulating medical errors, can be analyzed by the staff.

I also believe that reporting to the press, including the professional press, about such events and the preventive and corrective steps taken will lead to improvements. When patients know, which hospital takes proper steps to prevent accidents or near accidents; which hospital supplies quality medicine; and within which hospital there is a safe environment and climate, there will be healthy competition based on both safety and quality, between hospitals to the benefit of the patients.

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References