Health Economics, Policy and Law (2007), **2:** 449–455
© Cambridge University Press 2007 doi:10.1017/S1744133107004240

Review Essay

Coping accountably in a dangerous world

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Errors, Medicine and the Law
Alan Merry and Alexander McCall Smith
Cambridge: Cambridge University Press, 2001

Management Mistakes in Healthcare
Paul B. Hofmann and Frankie Perry
Cambridge: Cambridge University Press, 2004

The world is a dangerous place, and so is the health system; hospitals in particular.

This was not self evident to this author before observing 20 years of health policy evolution in Western countries, together with some personal experience. This perspective is furthered by the two volumes reviewed here. In the view of this author, health policy is moving beyond, or at least supplementing, the structure and process emphasis, provided mainly by economists, but with under-girding from other disciplines, that has dominated during the last two decades. The new focus in health policy is not only on quality, but on what to do when quality breaks down and we cannot rely, however much we desire, on a clear systematic framework of standards, incentives, regulations, and controls (Chinitz, 2002). How do we go forward in a realm where the stakes are so high? While not providing all the answers, the two volumes examined by this essay certainly lay out the dilemmas and provide some realistic propositions, for moving forward in health policy and management. And, not surprisingly, economics loses its pre-eminence to other disciplines, especially law, organizational theory, and management.

Health policy is often divided into three eras with some overlap between the last two: the age of expansion (circa 1883–1975), the era of cost containment (circa 1975–present), and, finally, the age of efficiency, quality, and accountability (circa 1985–present). The emergence of health technology

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https://doi.org/10.1017/S1744133107004240 Published online by Cambridge University Press

assessment and, even more, evidence-based medicine have been the hallmarks of the third era.

This evolution has been catalyzed by perceptions of health and health care as, justifiably, special, and, in some sense, held to the highest standards of performance; almost reflexively, patients, consumers, providers, and policy makers, associate these realms with outcomes that are frequently referred to as matters of life and death. Road construction, driver education, and pollution are perhaps tightly coupled to existential issues, but somehow societies and their policy systems manage to deal with these issues without the same drama imputed to health care rationing decisions. A corollary to this heavy baggage is that publics, providers, payers, analysts, and policy makers would prefer to have health care policy decisions based on, at least in perception, neutral, objective, scientific knowledge. Hence the pre-eminent role assumed currently by evidence-based medicine. Intuitively, stakeholders know that bad, sometimes tragic outcomes are inevitable in health care, but if decisions are evidence based, then negative outcomes can be attributed to random events 'out of anyone's control'.

Obviously too good to be true, health systems are embarking on a fourth era: one focusing on accountability for reasonableness in health care decision making, and a realistic and mature approach to risk. Elsewhere, I have referred to this as the art of 'qualitics' (Chinitz, 2005), the management of the political economy of risks associated with health care. The main component of this conception is that even if we are talking about life and death, and even if we would like to aspire to zero errors, tradeoffs will have to be made among alternative allocations of resources, and incentives, management, and regulation will have to be continually adjusted, just as in any other area of public policy. As an example, the watershed report of the US Institute of Medicine on the shockingly high frequency of fatal medical accidents in the US, was titled, in an almost reconciliatory way, *To Err is Human*. The excellent book, *Errors, Medicine and the Law* by Alan Merry and Alexander McCall Smith advances this approach by forthrightly laying out the multifaceted dilemmas and interdisciplinary web one confronts when attempting to hold health systems accountable for outcomes. Paul B. Hoffman and Frankie Perry offer a worthy parallel with their edited account of notions regarding *Management Mistakes in Healthcare*. These two volumes apply decision theory, organizational psychology, management, law, and ethics to risk management and accountability in health systems in a manner highly useful to theorists and practitioners, with the potential to help us into the next era of health policy.

Law provides the main framework for Merry and McCall Smith. The chapters follow a systematic treatment of the legal aspects of accountability in health care. In a chapter of examples of health system 'accidents', the authors eliminate any possibility of reverting to simple technocratic solutions. The cases presented, for example, a sleeping anesthesiologist or mistaken injection of an imaging substance leading to death, readily illustrate the tangled web of organizational

https://doi.org/10.1017/S1744133107004240 Published online by Cambridge University Press

context, standard operating procedures, bounded rationality, negligence, opportunism, and outright malfeasance that might be attached to any medical mishap. The stage is then set for a systematic treatment in subsequent chapters of human factors, errors, violations, negligence, recklessness, blame, standards of care, expert witnesses, and compensation to the injured. Each chapter considers its subject not in terms of absolute ethical or utilitarian criteria, but instead forthrightly exposes the dilemmas and tradeoffs inherent in the subject. Is a mishap the result of intentional violations, or the clash between the exigencies imposed by organizational structures and processes and the inevitable fact of human fallibility? Do blame and sanction lead to more careful, responsible and higher quality health care, or to defensive medicine, blind adherence to guidelines, and undue reduction of professional autonomy? Where is the line between individual and organizational responsibility for outcomes?

While Merry and McCall Smith manifest a desire for a more mature, balanced approach to medical error, Hoffman and Perry are more about raising consciousness to the lesser known realm of management mistakes in health care. While the boundary between managerial and professional influences is readily seen to be blurry, the authors provide an important service in paying special attention to management. The volume is based on contributed chapters divided into two major sections: Addressing Management Mistakes in Healthcare, and a series of case studies of management mistakes, with a conclusion that draws together themes and lessons derived from both sections. A nice feature is a comment by a number of British authors on the usefulness of the case analysis from a UK perspective.

Management errors need to be recognized, argue the first six papers. The context of errors is discussed, and, in a manner paralleling the work of Merry and McCall Smith, errors are classified, approaches to correction and prevention assessed, and the dilemmas of accountability are addressed. Of particular interest is the paper by Carol Bayley that makes the links between medical errors and management mistakes, which illustrates the seamless boundary that makes this area both fascinating and frustrating at one and the same time.

While Merry and McCall Smith use their philosophical analysis and examples to get across the message that accountability for errors is a balancing act, and that, for example, punitive measures may constitute a double edged sword, Hoffman and Perry are more prescriptive. Each of the cases, written by Perry, are commented on by a fellow author, and identify the management failures that led to error. For example, the story of the relationship between a CEO and a hospital board emphasizes the negative impact of the passivity and lack of awareness of the board on the flexibility of action of the CEO in his attempts to meet new contingencies facing the hospital. The commenter begins by admitting that using a 'retroscope' enables identification of mistakes that cannot be seen in real time. Thus, the prescriptions following from the case – for example, establishing a culture of excellence, setting in place clear

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evaluation practices and not letting 'feelings' get in the way of facts – are presented as 'guiding principles for the future'. Nonetheless, these 'guidelines', as occurs throughout the book, come perilously close to rising too far above the realism of the dilemmas and cases presented and sounding a bit too utopian in the manner of management speak. The book would do better to maintain a contingency approach; namely, that the particularities of each situation will determine what options for managerial behavior should be selected in order to prevent, identify, and sanction errors. The authors can be forgiven for their normative tone, in view of the fact that they have identified a new area of managerial errors and, in the end, the volume conveys the important message that such errors must be addressed in all their complexity, especially at the interface with medical errors.

Reading these two volumes is refreshing as we come to the close of the third era of health reform. No longer limited to silver bullet, technocratic solutions to complex problems, the two books offer a more sophisticated take on health policy, allocation and treatment decisions, and evaluation and assignment of responsibility for outcomes. A number of recent volumes have addressed these issues in a useful way as well: notably *Quality, Risk and Control in Health Care* by Ellie Scrivens (2005), and *Cultures for Performance in Health Care* by Manion *et al*. (2005), jointly awarded the Baxter Prize by the European Health Management Association in 2005. These contributions to the field of health policy and management resonate with Jon Elster's (1992) concept of 'local justice': a framework for understanding social values and preferences as revealed by various allocation mechanisms that fall somewhere in between the totally arbitrary and the completely, ethically, systematic. A paradigm, more sensitive to the dilemmas of quality in health care, is replacing, or more appropriately, supplementing, the more mechanical, technocratic approaches manifested by evidence-based medicine.

The tension between the third and fourth eras of health policy constitutes, in and of itself, the kind of challenge taken up by these books. On the one hand, health policy makers, managers, and providers must avoid the temptation to abdicate accountability by placing all their eggs in the evidence-based medicine basket. On the other hand, they cannot throw their hands up in the face of complexity and plead victimization by the randomness of human error, inappropriateness of technical measures of performance, or simple lack of resources for implementing normative prescriptions aimed at avoiding managerial errors in health care.

Moreover, as suggested by institutional economists, perhaps most notably Douglass North (1993), the public – citizens, consumers, and patients – also need to be aware of the dilemmas of quality in health care. Otherwise, decision makers and providers are caught in a maelstrom of accountability for life and death outcomes. Without public sensitivity to risk, and the inevitability of error, institutions charged with making difficult health policy, management

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and treatment decisions will become, as warned by Merry and McCall Smith, paralyzed by fear of sanction leading to suboptimal performance.

This leads, inevitably, to notions of trust in health care, a theme arising as a by product in both of the volumes reviewed here. Trust in health care has usually been examined at the level of the patient/physician relationship at the micro level. However, given the context so well described by these authors, it is obvious that trust at the meso level of health organizations, and the macro level of health policy and regulation, is also essential. Yet, trust is a squishy concept, based in social culture, and analysts are reticent to take it on. In most pluralistic democracies, conventional wisdom holds that trust, in particular in political institutions, is waning. To suggest, in such an environment, that stakeholders abandon what are perceived to be clear, objective scientific and legal standards for accountability in health care, seems naïve at best, and escapism at worst.

A familiar example is provided by attempts in the United States to use case mix adjusted measures to rate and compare hospital quality in the area of coronary artery bypass surgery (Werner and Asch, 2005), and present these to the public in the form of report cards. What appeared to be a straightforward, technical market-oriented tool aimed at greasing the wheels of the hospital market by informing consumer choice, turned out to be rife with unexpected, if also predictable, outcomes. Hospitals began to alter their case mix so as to appear of higher quality. Patients and insurers ignored the report cards and continued to employ the services of sub-par performers. Controversy persisted over the validity of case adjustment, enabling providers to claim that their particularly difficult circumstances were not taken into account. In Israel, a nearly 'perfect' case-adjusted quality improvement program was derailed by leakage of what were supposed to be anonymous results to the press including identification of individual hospitals' performance (Simchen *et al*., 1998). Issues of methodology, secrecy, and asymmetrical control over data plague such efforts. Responses to such outcomes often emphasize the need to create a culture of quality, but rarely provide substantive options for achieving this. And trust is usually a component of such a culture, but remains a 'I know it when I see it' or, more exactly, when I 'feel' it phenomenon.

Where can health systems go from here, from this seam line between the third and fourth eras of health policy? One of the blockages to developing a paradigmatic model for the fourth era is the relative success of market-based paradigms in handling the dilemmas posed by cost containment during the third era. While the disorganized health market of the US is clearly not an example of this success, a number of health systems have managed to move forward, combining cost consciousness with evidence-based practice in some kind of quasi market arrangement. The British NHS provides an example, with its internal market and National Institute for Health and Clinical Excellence (NICE). But the paradigm of regulated competition can only be taken so far. In particular, such models almost always require determination of a required basket of health services to

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be provided by competing, or at least budget responsible, providers. Many health systems have encountered turbulence when reaching this point. For example, in the UK, NICE recommends coverage of health care treatments based on cost effectiveness analysis. However, items that pass the cost effectiveness threshold still must compete for funding with other treatments, and here NICE offers no guidance. The allocation among competing demands on the health care budget is decided upon by other stakeholders, such as Primary Care Trusts. There is a disconnect between the perceived scientific, evidence-based decisions of NICE and actual resource allocation at lower levels. How are these lower-level decisions made? What risks are there of medical and managerial errors? The system may be underpinned with a set of National Targets, but do these create undue incentives to focus on goals defined at the macro level at the undue expense of other important goals that have not been labeled as targets?

And, yet, because various forms of regulated competition have made a significant contribution to management of the difficult challenges posed by cost containment, the search for solutions to the problems created by the model tend to focus on further refinement of market models. More information to consumers, consumer driven health care, health savings accounts, increased regulation and more are being experimented with. But the bottom line is that at some point what is needed is understanding by the public and other stakeholders in the health system that not everything can be covered by targets, by contracts, and by choice. At some point there is a fuzzy line between the technical parameters of health systems, and reliance on human professionalism and discretion. Unfortunately, health policy analysts have been so invested in refining models of regulated competition that alternative models for organizing health care transactions are less developed. Such alternatives will be the hallmark of the fourth era.

The volumes discussed here suggest some ways forward. Perhaps first and foremost is to keep up measurement of health system performance as if it were a trusted science, all the while aware that it is only the first step in managing complex institutions. Ongoing reporting of hospital performance, including errors, even if incomplete and limited by manipulations of stakeholders, is essential. Incentives can be used to induce cooperation with such reporting efforts; for example, governments can publish lists of institutions providing data and those failing to do so. Alternatively, laws can be passed requiring reporting; but this immediately introduces a regulatory cat and mouse game, underpinned by legal sanctions which may reduce trust.

In addition, ongoing surveys of public knowledge and attitudes regarding the performance of the health system provide an infrastructure for public understanding. If such surveys are conducted frequently, and reported back to the public, this can serve to educate consumers and improve dialogue among stakeholders who tend to hold back in their own protective trenches. For example, physician awareness of typical levels of knowledge that patients have regarding the complexities of medical decision making, may facilitate explaining limitations on

https://doi.org/10.1017/S1744133107004240 Published online by Cambridge University Press

treatment possibilities to patients. If providers at the micro level feel that the manner in which they are being monitored is integrated with ongoing measurement of organizational context parameters influencing their performance, a culture of quality that is not based solely on blame and shame is encouraged.

The fourth era of health policy calls for coalescence of the various perspectives and accumulated experience provided by the previous eras. Somehow, the spirit of the era of expansion, that the frontiers of medical technology and treatment are endless has to co-exist with the economic insight that all resource allocations involve tradeoffs. The aspiration to ensure quality performance in situations seen as matters of life and death must live alongside the abiding knowledge that in complex systems things can go wrong in inexplicable ways, making assignment of responsibility challenging to the point of impossibility.

The two books reviewed here make a substantial contribution to raising the consciousness of health system stakeholders to these issues. As we enter an era of increased consumer responsibility for health care, of tailor made treatments based on genetic engineering, all the while subject to budget constraints, these perspectives are necessary to underpin the ability of societies to cope with the tradeoffs. It is the mature society that can recognize that the world is a dangerous place without becoming chaotic or, worse, paralyzed in attempting to go forward.

References

Chinitz, D. (2002), 'Good and Bad Health Sector Regulation: An Overview of Public Policy Dilemmas', in R.B. Saltman, R. Busse, and E. Mossialos (eds), *Regulating Entrepreneurial Behavior in European Health Care Systems*, Buckingham: Open University Press:

Chinitz, D. (2005), 'The art of qualitics: towards better regulation and management of health systems', *Bridges*, **1**(5): 4–7.

Elster, J. (1992), *Local Justice: How Institutions Allocate Scarce Goods and Necessary Burdens*, New York: Sage.

Mannion, R., Davies, H., and Marshall, M.N. (2005), *Cultures for Performance in Health Care*, Philadelphia: Open University Press.

North, D. (1993), 'The Sveriges Riksbank Prize in Economic Sciences in Memory of Alfred Nobel 1993 Prize Lecture', Lecture to the memory of Alfred Nobel, 9 December 1993, Nobel Prize.Org.

Scrivens, E. (2005), *Quality, Risk and Control in Health Care*, Philadelphia: Open University Press.

Simchen, E., Galai, N., and Chinitz, D. (1998), 'Interaction between the Ministry of Health and the cardiac surgeons in Israel, to improve quality of care in coronary artery bypass grafting (CABG)', in D. Chinitz and J. Cohen (eds), *Governments and Health Systems: Implications of Differing Involvements*, Chichester: Wiley.

Werner, R.M. and Asch, D.A. (2005), 'The unintended consequences of publicly reporting quality information', *Journal of the American Medical Association*, 9 March.

https://doi.org/10.1017/S1744133107004240 Published online by Cambridge University Press