Management Mistakes in Healthcare

This book defines management mistakes and offers a variety of models to classify and interpret them. It describes the evolution of management mistakes, techniques for identifying and disclosing mistakes, the relationship between management and medical mistakes, and steps to prevent and correct them. Seven case studies, drawn from a real set of events in healthcare organizations, describe management mistakes and are followed by commentaries by experts in the field of healthcare management, indicating measures that might have produced more positive outcomes.

Ultimately, managers will not be completely successful in making healthcare better and more cost-effective without viewing mistakes as learning opportunities. This book is written for healthcare managers throughout the world and for the benefit of their patients, staff, and communities.

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Foreword

Dick Davidson
President, American Hospital Association

Reading for the first time the hard-hitting case studies in this important book took me back to my days as a young school teacher in Delaware. On Monday nights, I'd watch the hospital drama "Ben Casey." As the show opened, a wise old voice would intone "man, woman, birth, death, infinity." On screen, an anonymous right hand holding a stubby piece of chalk drew the universal symbol for each word on a classroom blackboard. Shot in black and white, the show was gritty and real, and it made Ben Casey's County General Hospital seem like a metaphor for the world the rest of us lived in.

In fact, hospitals once were perceived as a much more integral part of the community than they are today. And this image has been reinforced for decades by our popular culture. In the 1970s, we had kindly Marcus Welby, MD, treating patients at, appropriately, Hope Memorial. In the 1980s, hard-luck patients were warmly welcomed at city-owned St. Elsewhere.

These dramas showed hometown American hospitals as the public saw them – life-saving, compassionate and participating partners in their community. Week after week, the familiar characters showed us how the life and death consequences of healthcare bind us in a very special relationship to the people and institutions that care for us. The shows were huge hits because they validated the real-world experiences of ordinary people when they went to the hospital.

But, as we neared the twenty-first century, forces shaping how the public sees hospitals were changing. Public opinion research showed that more and more Americans felt that our healthcare system wasn't meeting their needs. A stream of negative news reports played up worst-case medical errors, billing inequities, and the immense problems of a system becoming more expensive and complex. On TV, the doctors and nurses on "ER" still seemed heroic, but the hospital seemed like a bureaucratic barrier that got in the way of good people trying to help people.

What had changed? Was art really imitating life? Research told us that the public was experiencing a widening healthcare *confidence chasm*. The public worried about quality, safety, and their ability to afford the care they might need if they

lost precious health insurance. The public clearly wanted a more personal, less business-focused healthcare system.

Not surprisingly, out of the spotlight, policy makers, lawmakers and the dedicated men and women who run our hospitals and health systems have wrestled with these same issues. But their successful efforts to address these concerns have received little attention. After all, why kill a good story line? There is little tension or drama in the often slow and careful path of change.

The uncovered good news is that successful change is radically reducing clinical errors and producing better clinical outcomes. The words "patient safety" are more than a mere term of clinical art; they are rallying cry for the nationwide movement to transform healthcare itself. Hospitals have committed enormous human and financial resources to the cause.

But overlooked and understudied – until this book – is a lesser-known and seldom examined area in which quality improvement can make all the difference – the kind of *executive* errors and *management* mistakes that can also devastate a hospital's performance, reputation, and public standing. Also overlooked and understudied – until this book – is what we can do to correct and prevent them. And the bottom line? This, too, needs to be a cause.

"Executive error" often occurs out of the media's line of sight. It's easy to pass by, especially when the public spotlight shines so brightly on our national effort to reduce medical errors. Unfortunately, some organizational cultures prefer it that way, shortsightedly choosing plausible deniability to honest and transparent accountability. And similar to clinical error, the world of management error is often characterized by a dysfunctional culture of blame, shame, and punishment.

Now, thanks to editors Paul Hofmann and Frankie Perry and an outstanding assembly of contributing authors, a sharply focused and bright new spotlight is illuminating this long-ignored subject. Hofmann and Perry, experts on healthcare management practices and ethics, teach us here about the up-close forces and factors that trigger executive errors in the first place. They set up the challenges that confront healthcare leaders who need to understand the landscape as it appears from 30,000 feet. The lessons to be learned from the seven cases they present are urgent and vital for all hospital and health systems executives and their management teams, employees, and patients.

As you'll see in the pages that follow, this is a tough area to investigate. In an atmosphere of blame and shame, the old rules impose zero tolerance for errors and zero tolerance for the humans who err. When a mistake occurs, the shame system contracts in self-defense, and there are scapegoats and punishment, typically with demotion or dismissal. The system, thus "fixed," resumes business as usual. But it remains blind to its inherent failings and in denial over its fatal flaws – until someone errs again.

Internally, the damage can be lethal and lasting. The culture can turn mean and threatening. Teamwork, critical to preventing or fixing management error, crumbles under the weight of self-protection.

Externally, the chain of public trust, tremendously difficult to forge over time, is ever more stressed. The most successful hospital executives and managers take this on faith. Clinical errors? Correct them, learn from them, and move on. Management mistakes? Same thing. Correct them, learn from them, and move on, as well.

Many hospitals are already models for how to succeed in a post-blame and shame era. They know that you don't need to go to business school to apply some common sense. We tell our kids that we learn from our mistakes. We need to practice the same principle in healthcare management. Other important principles you'll take away from this book include:

- Realizing mistakes are not a "people" problem, but a "systems" problem.
- Benefiting from the experience of the patient safety movement.
- Emulating the best practices of hospitals that are "winners."
- Instilling a new culture of teamwork, self-examination and public accountability.
- Improving the quality and diversity of the workforce.
- Capitalizing on the changing demographics of management ranks.
- Balancing an internal business model with a commitment to the community.
- Maintaining good relations with various publics.
- Sharing important information with the community.
- Understanding that hospitals are agents for social change in their communities.

If we follow these principles, we will identify, correct, and prevent management mistakes with the same relentless honesty, vigor, and staying power that we already bring to reducing medical errors.

In the chapters that follow, you'll be reminded that the trust of the public is a precious asset; it accumulates slowly as the public realizes it is safe to invest its faith and good will. Securing and retaining the trust of the public is as high a priority as any hospital can set. Lose this trust through avoidable mistakes and miscalculations, and the price to be paid is more than our system can bear. For this reason alone, even if a hospital's connection to the community already is strong, it must be bolstered. If it is weak, it must be strengthened. If it is broken, it must be fixed.

The world of healthcare is much more complex and intimidating than in the old days of TV's Hope Memorial and St. Elsewhere. The leaders, executives, and management teams running America's healthcare organizations need to remind themselves, their communities, and the entire nation of the true character of America's hospitals, of what we believe, and how we live those beliefs. This is

the real value of this book. If we are, indeed, who we say we are, the public's trust fully will be ours. It had better be – Ben Casey's grandkids are counting on it.

Dick Davidson
Washington, DC
August 2004

Preface

Acknowledging and examining mistakes in healthcare management is not a pleasant or popular activity. Although clinical errors have received increasing attention, executive errors have been largely ignored.

Our book is intended as a first step to address this lamentable gap in both the healthcare literature and professional consciousness. By recognizing and reducing clinical errors, healthcare organizations have improved not only the quality of care but also clinical outcomes. Additional benefits can be achieved from similar scrutiny on the administrative side if we are candid about management mistakes and become much more diligent in correcting and preventing them. Through a combination of chapters and cases, along with commentaries, we want to stimulate current managers in hospitals and other healthcare organizations to learn from their previous mistakes and to become more systematic in avoiding their recurrence.

We begin by admitting that a management mistake is not always easy to recognize and define, and that some mistakes are unavoidable. The sources and causes of errors are, however, very clear. Furthermore, as in medicine, mistakes can be the result of acts of omission as well as commission. Disclosing mistakes and developing effective coping techniques are emphasized as essential prerequisites to improving management performance.

John Abbott Worthley (chapter 2) explores the context of management mistakes by distinguishing eight major aspects: legal, organizational, financial, political, professional, ethical, social, and psychological. He provides a robust conceptual framework for understanding and addressing mistakes.

In chapter 3, Wanda J. Jones focuses on a number of critical factors involved in identifying and classifying mistakes, dissecting and divulging them, and dealing with the fear of retribution. Throughout her discussion, she provides vivid examples of management mistakes and their consequences.

Because medical and executive errors usually occur within a complex organizational setting, Carol Bayley (chapter 4) suggests that management can benefit by

drawing on the insights produced by the longer history and more extensive experience of clinicians in dealing with their mistakes. Contrasting the "blame and shame" approach with a newer understanding of responsibility for error reduction, she explains why and how cultural issues can play such a critical role.

John A. Russell and Benn Greenspan (chapter 5) draw on their respective backgrounds in managing large and diverse healthcare organizations to provide the reader with an effective framework to deal with the inevitability of executive errors. Their approach is based on lessons learned from personal and career examples of management mistakes, and they offer recommendations designed to correct and avoid mistakes, and to reduce their impact.

Ultimately, according to Emily Friedman (chapter 6), confronting management mistakes is a matter of accepting accountability. She explores the psychology of accountability, discusses the implications of various scandals in both the healthcare and non-healthcare industries, and proposes specific steps for producing accountable leaders and establishing accountable organizations.

These six chapters provide a comprehensive overview of the problems created by management mistakes in healthcare and how they can be identified, corrected, and prevented. Each chapter includes brief descriptions of various mistakes, small and large.

Circumstances associated with a particular situation are almost always complicated by a host of political and other considerations, and the mistakes are rarely the result of only one decision. Consequently, to illustrate these complexities, seven cases (prepared by Frankie Perry and based upon actual events but in fictitious institutions) are presented, followed by commentaries from leaders in the field (chapters 7–13). These leaders were asked to answer the following questions: (1) What management mistakes occurred in this case? (2) How could they have been avoided? (3) What steps could be taken within this organization to prevent these kinds of mistakes in the future? To determine whether the cases and their analyses were relevant to healthcare executives in the United Kingdom, we also asked two distinguished UK experts to provide their perspective (chapter 14).

In our concluding chapter 15, we highlight common themes, offer some admonitions, and suggest why and how examining management mistakes can make a significant difference in the delivery of healthcare. Given the absence of research and the paucity of publications concerning this important issue, we hope others will be motivated to pursue the topic further.

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We are grateful for this opportunity to address a topic that has not received the attention it deserves. In addition to thanking our colleagues who generously agreed to serve as contributing authors, we want to convey our sincere appreciation for the time and candor of others who were willing to describe management mistakes that formed the basis of our case studies. We are also thankful for the invaluable assistance of Pauline Graham, Commissioning Editor, Science, Technology and Medicine, and Barbara Docherty, our copy-editor, at Cambridge University Press.