

First, Do No Harm

The Institute of Medicine in 1999 issued a landmark report, *To Err Is Human*, recommending measures to reduce medical errors and increase the quality of health care in the U.S. The Patient Safety and Quality Improvement Act of 2005 resulted from the IOM report. Darrell “Skip” Campbell, M.D. (Residency 1978), professor of surgery and chief of clinical affairs, updates us on progress, at Michigan and nationally.

Q: How did medical errors become such a serious concern?

A: The IOM report was a wake-up call. The number of deaths each year due to medical errors was staggering — estimates ranged from 44,000 to 98,000. That got everybody’s attention. Nobody had recognized the scope.

Q: What are the costs?

A: There’s a huge impact on the total bill for health care — hundreds of millions of dollars. But there’s another major cost. We depend upon the trust of the public. The report detailing so many errors and potential deaths made the public somewhat distrustful of the medical profession. It’s also demoralizing to health care professionals to see that a mistake has been made. These are good-hearted people, and when they think they’ve done something that’s hurt a person, it gets directly at the heart of our mission.

Q: What are the biggest hurdles in creating a culture of patient safety?

A: Transparency and blamelessness. Getting caregivers to embrace those concepts has been difficult but very important. We want people to talk about errors in an open way so we can learn

from them and do something about them. We try to not point the finger, but instead say, what in the system allowed this error to happen?

Q: How does this relate to our shift in malpractice thinking — to openly acknowledge and disclose errors?

A: People thought the sky would fall in terms of malpractice exposure. In fact, our policy of being forthright and honest has caused a substantial reduction in our malpractice expense over time. That’s something the whole country has taken notice of. Everybody had been in a ‘defend and deny’ mindset. That, we think, is a great problem in advancing patient safety. How can you learn anything if you’re denying the problem exists?

Q: In what ways are we involved in patient safety at the state and national levels?

A: We’ve been active in the state to improve quality across a broad spectrum of efforts, such as the Michigan Surgical Quality Collaborative — a group of 34 hospitals that use the same reporting system for quality and safety, so we have a common database for evaluating best practices. The Health

System administers six similar collaborative projects, all funded by Blue Cross Blue Shield of Michigan. The National Surgical Quality Improvement Program is something I’ve had a role in distributing to more than 200 hospitals nationally — the goal is 2,000.

The U-M’s philosophy and experience also formed the basis for an important paper by Senators Clinton and Obama in the *New England Journal of Medicine*, “Making Patient Safety the Centerpiece for Malpractice Reform.” Legislation based on the philosophy of transparency and blamelessness was introduced to Congress by Obama and Clinton, but died in committee. Clinton plans to reintroduce the legislation, and our top risk management executive, Rick Boothman, has met several times with Clinton’s office to talk about the basics of this bill.

Q: What work remains to be done?

A: The big work is to create a reliable national registry with a standardized taxonomy of what patient safety is, so that we can get a more accurate idea of where the problems are and how to address them.

Interview by Rick Krupinski

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