

## **Balancing “No Blame” with Accountability in Patient Safety**

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## Balancing “No Blame” with Accountability in Patient Safety

**TO THE EDITOR:** Wachter and Pronovost (Oct. 1 issue)<sup>1</sup> question the “no-blame” paradigm in patient-safety improvement and suggest the adoption of explicit punitive approaches to poorly performing physicians. We counsel caution. In a longitudinal study over a 2-year period in a large facility,<sup>2</sup> we found that penalties did not deter undesirable behavior. Rather, penalties drove evidence of non-compliance underground, encouraging people to conceal it and thus perversely reducing accountability.

Drawing the line between blameworthy and blameless acts was difficult and involved subjective judgments of observers about the foreseeability of harm, reasonable care, and prudence. The question was: Who was permitted to draw that line?<sup>3</sup> And who reported “violations”? In the example of hand hygiene described in the article, those difficulties are compounded by uncertainties in the evidence base about when and how hands should be washed.<sup>4</sup>

In our study, peer intervention was more effective in generating accountability and desired change than punitive administrative action; less blame led to more accountability. Our research clearly suggests that by demanding penalties, we might stifle accountability rather than enhance it.

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**TO THE EDITOR:** With regard to the criteria listed in Table 1 of the article by Wachter and Pronovost, who gets to decide what is a critical “patient-safety practice”? The Institute for Healthcare Improvement and others in the patient-safety indus-

try made a very big point of maintaining blood glucose target ranges of 80 to 110 mg per deciliter (4.4 to 6.1 mmol per liter) in patients in critical care units. Many clinicians who opposed this recommendation were told that they were simply not keeping up with evidence-based medicine. The Normoglycemia in Intensive Care Evaluation–Survival Using Glucose Algorithm Regulation study (ClinicalTrials.gov number, NCT00220987) proved quite definitively that this goal not only did not help, but actually caused excess deaths as compared with looser glucose control. The flip-flop by the Centers for Medicare and Medicaid Services on beta-blocker use immediately after myocardial infarction is another example in which what was advertised as beneficial was actually harmful. A very clear definition of what is truly a patient-safety practice, scientific criteria, and certainty of the evidence are needed to mandate a clinical practice. If not, we will continue to violate the ancient creed of “do no harm” in misguided safety efforts.

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**THE AUTHORS REPLY:** We agree that we need to proceed cautiously and err on the side of parsimony in choosing practices that are suitable for an accountability approach. Candidate practices should be relatively easy to follow, have a strong and enduring evidence base, and be ones in which other approaches have been tried and not succeeded. We believe that infection-control practices such as hand hygiene easily meet these criteria and are ideal practices to start with. However, at this point, clinical care standards such as tight glucose control and the use of certain medications at appropriate times seem more suitable for approaches that use education, traditional audit and feedback, and computerized decision support.

Our auditing methods will also need to mature. Although some auditing can and should be done by colleagues (promoted by team training and a shared ethic of patient protection), it is human nature for colleagues to avoid “ratting out” each other, particularly when there are penalties at