A Manufacturing Industry Outsider’s Journey into the Healthcare Culture

By Robert J. Latino
CEO, Reliability Center, Inc.

Abstract

My role as a Root Cause Analysis (RCA) practitioner, educator, author and software designer in the heavy manufacturing industries for the past 32 years played an important part of my perspective when researching the applicability of RCA in the healthcare field. I began my journey into the exploration of the healthcare culture nearly 20 years ago, and it has been an enlightening experience to say the least. In this paper I will seek to draw many parallels between the manufacturing/process and healthcare cultures, with an emphasis on dramatically increasing patient safety in the short-term. Keeping in mind the entire time my primary experience in healthcare has been as a patient!

Background Information

Let me start this paper off with a comment about healthcare – “Based on my past experiences, I believe that people who work in the healthcare field are one of the most committed groups to their profession that I have had the privilege to work with”. I make this statement up front, because many of the observations that I will outline in this paper, make give the misperception the above statement is not true.

I come from a field in the manufacturing industries called Reliability Engineering (RE). This field of engineering was pioneered in chemical manufacturing by Charles J. Latino while he was the founder and Director of the Reliability Center for AlliedSignal Corporation (Now Honeywell) in 1972. Reliability Engineering is a field that focuses on equipment, process and human reliability of any ‘system’ (input, transformation, and output). One of the many methods and tools that we developed while in this group was the application of Root Cause Analysis (RCA) and Opportunity Analysis (OA) to manufacturing systems and processes.

The Signals Were Stacking Up in Healthcare

In 1998, it came to our attention that some studies that were coming out in the healthcare sector, would not be endearing to their ability to increase patient safety. We also followed pending legislation that showed a trend towards efforts to reduce medical error. In short, the writing was on the wall that the healthcare industry would soon become “under the microscope” for excessive medical errors and hence increase the patient’s risk of unnecessary harm. This tension in healthcare, at the time, peaked with the release of the IOM report in 1999 indicating that between 44,000 – 98,000 people are killed a year by medical error. Now the public uproar would ensue and would expose a worldwide epidemic of medical error. Since that iconic report in 1999, numerous subsequent reports have indicated the number of annual deaths due to medical error in the U.S. has exceeded 440,000.

As an ‘outsider’ to this healthcare sector, such numbers are appalling. Deaths by medical error are now the third leading cause of death for all Americans behind heart disease and cancer. I was even more frustrated, bordering on...
angry, when I found out in the fine print, the IOM report only considered “errors of commission”. Errors of commission are when someone takes an inappropriate action in handling a patient’s care and the patient ends up worse than they were before as a result of the error. My point here is that ‘errors of omission’ were not in the report. Errors of omission are where someone should have taken action and did not. For instance, a patient comes into the emergency with some symptoms that are not assessed/prioritized properly by triage. As a result, they wait in the waiting room for an extended period of time and suffer a heart attack, a seizure, or any other consequence of not being seen in a timely manner. I would personally see the number of deaths by errors of omission as being a significant multiple of those deaths by acts of commission. I have not met anyone in the healthcare profession who does not believe the IOM report on deaths was grossly conservative.

The Paradigm of Patient Safety
This is the point where my ‘outsider’s view’ of the hospital being a safe haven, turned to my paradigm about healthcare to ‘avoid getting hurt at all costs so that I do not have to run the risk of being admitted to a hospital’. I suspect that most Americans are like I was, they see going to the hospital as a place they can entrust their health and welfare in the professionals’ hands. Many healthcare professionals I have met throughout the last twenty years, indicated they would never leave a loved one alone for a minute in a hospital. They said everything must be watched and questioned regarding their loved one’s care... to be vigilant.

I have been attending numerous healthcare conferences over the years and the undeniable focus is on Patient Safety. I listen to very talented and esteemed speakers tell of their efforts to increase Patient Safety at their respective hospitals. During this time, I am thinking to myself, “If Patient Safety is only becoming the focus now, what was the focus before?” From my perspective as a patient, I would have thought Patient Safety was always the focus in healthcare.

I started to reflect on my own background in the manufacturing industry and seeing if I could draw a parallel. In industry, every facility will have a safety department. It may be called something else like Plant Protection or Environmental, Health & Safety (EH&S), but nonetheless they are charged with ensuring compliance with governmental safety regulations (i.e. – EPA, OSHA, etc.) and making the workplace as safe as possible. However, while this group exists for their charted purpose, very few who work in the plant believe that their safety is totally dependent on the Safety Department’s effectiveness. It is well known in the manufacturing and process industries that YOU are the one most responsible for your own safety!!

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Current Healthcare Paradigm #1
Patients rely solely on their caregivers to protect them.

New Healthcare Paradigm #1
Patients must accept responsibility for their own safety in a hospital and realize they are a part of their treatment plan.

As I have learned, this is certainly the way that most healthcare workers would prefer it. Oftentimes people perceive if they ask questions about what is going on with their care, it is rude, inappropriate or condescending to the care giver. One thing I have learned is that patients should speak up and take control of their own care. After all it is their lives that are at stake.

Error Rates and Technology
I kept thinking to myself, why would the healthcare field be prone to so high an error rate?

Again, I start to reflect on the history of Reliability in the manufacturing industries over the past century. Around the turn of the century we found ourselves in the Industrial Age. This was time where machines were evolving to help man accomplish work of various types. However, much of the work was still based on the brawn and physical stature or the worker (which at the time was mostly men in the industrial

continued on p. 3
workforce). At this time, industry was very labor intensive and required much man-to-man interfacing. I have not been able to find error rates for industry during this time period, but when looking at the injury rates then as compared to now, you will see a dramatic improvement. (Accessed 12.1.16)

As we moved more towards the information age, where the equipment became very sophisticated (i.e. – automation and robotics), it took less and less muscle, and more and more brainpower. This saw the era of the influx of more women into the workplace.

Given this evolution, there is a heavy human-machine interface in the manufacturing and process industries today. As compared with the industrial revolution era, today in industry, three times more output is achieved with one third the manpower. As robotics become more sophisticated, the human will serve in a support role to the technology.

Now I revert to healthcare and my curiosity about why error rates would be so high in such an industry. Again, another paradigm about healthcare from an outsider’s perspective, is that the technology used is of “star wars” caliber. I have found this to be a half-truth. High technology in healthcare is employed on the sharp end or the medical diagnostics end, but not typically in the administrative end (i.e. – communications infrastructure). Remember, I am speaking in generalities.

The administrative infrastructure of a hospital reminds me of 15-20 years ago in manufacturing. The information and communication infrastructure in healthcare today is archaic compared to the technologies that are available on the market today. Why?

So here we have a very labor-intensive industry like healthcare, where lives depend and rely on communication between caregivers, and an archaic information infrastructure is in place that is an obstacle to effective communication and knowledge management.

This is perplexing to someone who has spent a career in industries that produce widgets. The ‘widget’ industries typically have more advanced information and communication infrastructures than the healthcare industry, whose ‘product’ is quality of life (which is way more important that widgets).

Anytime that we have very labor-intensive industries that require massive human-to-human interfacing, we increase the risk of human error. The risk of human error is reduced when we enter industries where man interfaces with machines, and error is virtually eliminated when machines talk to machines. We must remember that we are human and with that comes human fallacy.

 Outsider, cont. from p. 2

Figure 1: Nonfatal occupational injury and illness incident rates

[Graph showing incident rates from 2003 to 2015]

continued on p. 4
Current Healthcare Paradigm #2
Healthcare today must be safe as we are using all of this fancy technology.

New Healthcare Paradigm #2
Medical diagnostic technologies are state-of-the-art in the world today. However, the technology employed to help caregivers effectively communicate with each other to ensure patient safety is substandard at best, and a ‘silo’ culture still exists.

Putting Complexity into Perspective
We just discussed that errors rates for labor-intensive industries are prone to be higher primarily due to poor communication systems. The Joint Commission (TJC) update above further supports this in healthcare, where they estimate that ~70% of the root causes in reportable sentinel events concluded human factors, leadership and communication problems. (Accessed 12.1.17)

Look at the characteristics of a healthcare environment: unpredictable case load, variable need for specific services, millions of transactions a year, rotating staff, greater need to meet regulations imposed, growing focus on costs and value, and much more. When in the thick of things in a hospital, successful outcomes seem impossible with the chaotic conditions being the normal. These conditions are the antithesis of a High Reliability Organization (HRO). With Reliability comes consistency of operations. When we have consistency, outcomes are more predictable. When outcomes are more predictable, human error rates are significantly reduced.

However, look at some other environments with similar characteristics in industry. A large chemical plant or oil refinery for instance may make hundreds of different kinds of chemicals or types of gasoline. They flow product through miles and miles of piping, having to make sure that exact temperatures, pressures and flows are employed to make product to exact customer specs. Their demand, distribution and pricing changes daily on the spot markets, and they must adapt accordingly.

Figure 2: TJC 2015 Root Cause Statistics

<table>
<thead>
<tr>
<th>Identified Root Causes</th>
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<tbody>
<tr>
<td>Human factors (such as competency assessment and staff supervision)—</td>
<td>999</td>
</tr>
<tr>
<td>Leadership (related to issues such as priority setting and complaint resolution)</td>
<td>849</td>
</tr>
<tr>
<td>Communication (among staff, administration, and/or patients and families)</td>
<td>744</td>
</tr>
<tr>
<td>Assessment (includes patient observations and care decisions)</td>
<td>545</td>
</tr>
<tr>
<td>Physical environment (such as emergency management and fire safety)</td>
<td>202</td>
</tr>
<tr>
<td>Health information technology related (refers to issues such as incompatibility between devices and hardware failure)</td>
<td>125</td>
</tr>
<tr>
<td>Care planning (planning and/or collaboration issues)—</td>
<td>75</td>
</tr>
<tr>
<td>Operative care (includes blood use and/or patient monitoring)</td>
<td>62</td>
</tr>
<tr>
<td>Medication use (includes labeling and preparing medications)</td>
<td>60</td>
</tr>
<tr>
<td>Information management (having to do with, for example, the aggregation of data)</td>
<td>52</td>
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continued on p. 5
Look at a casino. Millions of transactions a day occur with millions of dollars at stake. Yet they know where every penny is at every moment. If you have ever been in a casino book room, you will liken it to being in the NYSE. Again they will have horse races from around the country going on in real time, and taking in bets from around the world. All the time, a lapse in time of a few seconds in delay of transmission, can cost millions of dollars.

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**Current Healthcare Paradigm #3**
We are not like other industries. We are a complex system and require complex solutions.

**New Healthcare Paradigm #3**
We are not alone with our unique characteristics. Technologies are available from other industries to help manage our perceived chaos.

I do not seek to trivialize the nature of the work done in healthcare, but when we look at the hospital as a system (inputs, transformation, outputs), we recognize that other models do exist and use technologies to help manage the chaos. During my speaking engagements at manufacturing conferences, I encourage the engineering fields to support their local hospitals. I actually ask them to engage the Risk, Quality and Performance Improvement departments and offer their assistance as a gesture of community goodwill. After all, the engineers who live in the community have vested interest in the success of their local hospital as they will be using their services as some time in their lives.

**The Data Dilemma**
I have been amazed to observe in healthcare, the general reluctance in the need to collect data relative to errors that occur in the hospitals, especially when no one is harmed as a result of the error.

Let me give you some background on why this concept is so foreign to someone from the progressive side of the manufacturing industries. In manufacturing, it is very commonplace for Production and Maintenance departments to utilize Computerized Maintenance Management Systems (CMMS) and Asset Performance Management (APM) Systems. These systems vary in their complexity and effectiveness, but that is not the point I want to make. The point is the majority in manufacturing understand the critical need to collect failure data in order to control the reliability of their production processes. How can you control production if you don’t understand what’s causing the gap between a system’s potential versus what they are actually producing?

It is ironic that Six Sigma is not effectively catching on in healthcare, because it requires an immense amount of time and resources in collecting data. Time and resources are exactly what healthcare claims to not have for such tasks. While Six Sigma has been re-packaged recently, it is merely a collection of very common tools from the past.

**Statistical Process Control/Statistical Quality Control (SPC/SQC)** is a Quality-era, basic tool set, developed nearly 50 years ago and is a fundamental source of information in any manufacturing operation today. Basically these systems are hardwired into a manufacturing process, and a series of instruments and sensors provide an array of real-time process data back to a control panel. Process data may include temperatures, pressures, flows, vibration levels, etc.

I have been truly amazed to see the contrast between how intensive, failure data collection is in manufacturing and how resistant healthcare is to collect such data. It is certainly a cultural issue in healthcare. However, this cultural barrier will have to be overcome in time, if healthcare is ever going to truly achieve their patient safety objectives.

In my travels in healthcare, trying to impress upon my audiences the existing technologies for conducting RCA and OA, I am running into the same barriers over-and-over again. Here is a listing of common objections I hear to using such methodologies and technologies in today’s current healthcare atmosphere:

1. We are too busy trying to address all of these problems on a daily basis, therefore we don’t have time to collect this information much less enter it into a software program.
2. I am a caregiver, not a failure analyst. This is not my job to collect such data.
3. The software systems we enter such information into,

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is cumbersome at best. I don’t have the time to deal with inefficient software systems.

4. Even if I entered the data, I don’t believe anyone would effectively use it. This is just another ‘flavor of the month’ program, I will wait for it to pass like the others.

5. Collection of failure data is not viewed as value-added by my organization to collect, so why bother.

These are just a few of the common paradigms I have run across in the past. Imagine if our legal system adopted these paradigms. Imagine if we went to court and relied on hearsay when someone’s life was at stake. Imagine us telling a judge or jury that someone is guilty because somebody ‘told me so’. We would be laughed out of a courtroom with this approach. If we did not have a solid case based on facts, we would not prevail.

In healthcare, the Risk Managers (RM) are very familiar with this approach as they are often the entity dealing with helping prepare their counsel’s case for any claims against the hospital. How come we only do such preparation after the fact? How come we do not address issues when they are at a ‘near miss’ or ‘unacceptable risk’ stage (proaction)? Isn’t it logical to deduce that ‘near misses’ are precursors to sentinel events? However, these near misses are often unrecorded because people are simply too busy to log them in somewhere and there is no sound, regulatory requirement to do so. When this culture prevails, the near misses become viewed as a cost of doing business and an acceptable risk. To me, a near miss simply means ‘we got lucky that day’. The roots that led to that close encounter are still buried within our flawed systems and will surface somewhere else at another time. We won’t be ‘lucky’ every time.

We often see this in our culture as well. For instance, when the NTSB investigates an airline incident/accident, they merely make recommendations to the FAA. It is up to the FAA to mandate these recommendations to the airlines, or not. Usually, the greatest chance of getting the recommendations implemented is unfortunately right after a catastrophic airline accident when the incident is fresh in the public’s mind. The same goes for failures in a hospital. The ones that get the most attention are the singular events that result in claims. What about all the chronic failures, near misses and unacceptable risks? They do not get the same attention because they are proactive and there is no sense of immediate urgency. However, to start to move towards a proactive or Reliability culture, we have to start attacking failure at the risk stage, not simply chasing their consequences and reacting (Accessed on 12.1.16).

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Current Healthcare Paradigm #4
Data collection of failure information is too cumbersome and we do not have time to collect it.

New Healthcare Paradigm #4
Without proper data collection practices, healthcare’s Patient Safety initiatives will never succeed.

Determining How to Drastically Reduce Error Rates – Root Cause Analysis
We have explored the possibility that parallels do exist between the manufacturing industries and healthcare, but how come the healthcare error rate is so high as compared to industry? Think about the common denominator in any industry that experiences error – it is the human being. This is another fallacy in prevalent thinking; that methods like Root Cause Analysis (RCA) are only tools that engineers from industry use to solve very complex issues.

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Current Healthcare Paradigm #5
Root Cause Analysis is something that engineers use in industry to solve complex and costly problems.

New Healthcare Paradigm #5
Root Cause Analysis is specific to the human being and how we use our human reasoning skills to solve ANY undesirable outcomes.

Based on my observations, TJC is headed in the right direction as far as forcing (and enforcing) the use of RCA in healthcare (particularly their latest RCA initiative). However, the TJC RCA and FMEA requirements have many deficiencies. While most hospitals in the U.S. are accredited, the medical error rates continue to rise. How can most everyone be compliant, yet the patient is not any safer? This tells continued on p. 7
me there is a disconnect between the regulations/requirements and their measure of effectiveness. At the hospital level, I see people doing RCA only superficially to comply with their TJC guidelines for an impending audit. There is a difference between Root Cause Analysis and ‘Shallow Cause Analysis’ (Accessed 12.1.16).

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Current Healthcare Paradigm #6
We do RCA in order to comply with regulatory requirements to ensure the flow of CMS funds to the hospital.

New Healthcare Paradigm #6
We do RCA to quantifiably and measurably improve patient safety – period!

Put aside the industry you work in and follow along from the standpoint of the human being. In order to understand why we have undesirable outcomes, we must understand the mechanics of failure. Most undesirable outcomes are the result of human errors of omission or commission. In my decades of RCA experience, any undesirable outcome will have a series of 10-14 cause-and-effect relationships that queue up in a particular pattern for that event to occur.

This dispels the commonly held myth that one error causes the ultimate undesirable outcome. All such events will have roots embedded in the physical, human and latent areas.

Physical roots are the typically found soon after decision errors of commission or omission. They are the first physical consequences of the human decision error.

Human roots are decision errors. These are the actions (or inactions) that trigger the observable physical consequences to surface.

Latent roots are the organizational or management systems that are flawed. These are the support systems (i.e. – procedures, training, incentive systems, purchasing habits, management oversight, etc.) that are typically put in place to help our workforce make better decisions. Latent roots are the rationale for our decisions at the time. Latent roots also include sociotechnical factors that influence decision making such as new regulations, laws, technological advances, etc).

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Current Healthcare Paradigm #7
Undesirable outcomes occur because of one root cause.

New Healthcare Paradigm #7
On average it takes 10 to 14 cause-and-effect relationships to queue up in a particular pattern for an undesirable outcome to occur. There are normally a multiplicity of root causes.

To illustrate this point, here is a logic tree diagram (a graphical depiction of cause-and-effect relationships) of an undesirable outcome in healthcare. The event is an ‘Unavailability of MRI System for Neurovascular Scans’. Follow each level of the logic tree asking yourself “HOW COULD?” the previous event have occurred?

Here is a sample case study.

In the end of this analysis we find that housekeeping was removed from the MRI suite for well-intentioned reasons (danger of introducing ferrous housekeeping materials into MRI room). However this decision had unintended consequences as it was not thought out

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well enough in advance. Here are some of the latent factors affecting the decision-making:

1. Housekeeping needs in the MRI room were not thought of as a high priority by Radiology staff.
2. There was a lack of understanding by the staff of the possible infection control effects of the decision to remove housekeeping staff.
3. There was no Quality Control review of upstream or downstream effects of removing housekeeping from the MRI room.
4. There were no regulations that required housekeeping practices inside the MRI suite.

As a result of these factors, they led to failure of the MRI head coils due to the creation of static electricity generated by the dirt on the floor and flowing through the staff, to the MRI equipment. This was costing tens of thousands of dollars in non-reimbursable MRI repairs.

Use of such disciplined approaches to RCA are evidenced-based and clearly depict the effect of certain behaviors in an organization and how upper level decision-making contributes to undesirable outcomes. Organizations are not doing true RCA if they are not validating their hypotheses with sound evidence and/or if they are stopping short of understanding the latent root causes that contributed to the decision errors.

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Current Healthcare Paradigm #8
Brainstorming, troubleshooting and other ‘Shallow Cause’ approaches are considered valid RCA methods.

New Healthcare Paradigm #8
True RCA involves the identification of physical, human and latent root causes fully supported with hard evidence.

News ‘n Notes

Sheridan Ryan Wins 2017 MBA Messenger Award

WSHRM Past President Sheridan Ryan was recently honored by the Milwaukee Bar Association with the Messenger Award for journalistic excellence. She received the award for her article titled “‘Zero Tolerance’ for Violence and Violent Patients: Sound Policy or Sound Bite?” The article appearing in the Fall 2016 issue of the MBA’s newsletter.

Judges noted that, “The article describes the uneasy fit of the workplace violence ‘zero tolerance’ OSHA guideline in the context of hospital settings. The ‘zero tolerance’ guideline presupposes that an individual understands the consequences of his actions and has an ability to control his behavior. Using stories of people who, while suffering from medication errors, undiagnosed brain disease, or Alzheimer’s, engaged in discrete acts of violence in a health care setting, the author questioned whether those acts truly were within the person’s control.

“The author then suggested that state and national legislation should require more targeted training for healthcare workers to anticipate and prevent violence by persons who might not be able to control their own behavior. Zero tolerance, in the author’s opinion, puts the onus on the ill person and unduly relieves healthcare workers from any duty to protect or prevent.

“This article merits an award because it broaches a topic affecting all Messenger readers as consumers and citizens, and not simply one particular practice group. The article is effective, as is good legislation, because it illustrates its policy position with compelling human stories of difficult situations.

“Thanks to Sheridan Ryan for provoking us to think beyond the ‘sound bite.’”
There is no doubt that investigations and analyses take time to properly conduct. However, we are doomed to repeat the failures unless our RCAs are effective. If we are just doing RCAs to be compliant, we will not be successful. Since the TJC RCA requirements have been in effect since 1996, I am not aware of any valid study demonstrating their effectiveness on patient safety. The fact that deaths due to medical error are increasing over this time period tells me the opposite.

We should be doing RCA because it is the right thing to do, not because someone is making us do it. This makes a HUGE difference. If we do RCA for the right reasons, we would be focusing on chronic failures, near misses and high risks. We would be focusing on the potentials of failure instead of simply becoming better responders. This is a mark of a true HRO. RELIABILITY = PROACTION = NO SURPRISES.

We all need to band together and defeat this paradigm:

“We NEVER seem to have the time and budget to do things right, but we ALWAYS seem to have the time and budget to do them again!”

Think about that for a while and see if your organization is trapped in this paradigm.

### Appendix 1: Paradigm Shift Summary

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By Sheridan Ryan  
*Medical College of Wisconsin*  
*Clinical Risk Management*

Unlike other industries, in healthcare, some potential victims have treating relationships with those who threaten them. This by itself creates a unique challenge, but healthcare has still more hurdles to offer the healthcare threat manager.

**Street vs. Suite Violence**

In John Monahan’s seminal 1981 book *The Clinical Prediction of Violent Behavior*, he begins, quite logically, with a discussion of the definition of violence. “Corporate violence” he described as deliberate decision-making by corporate executives that results in unreasonable risk of physical harm.

Recent examples of “corporate violence” include General Motors’ ignition switch litigation, in which GM admitted it knew about ignition switch problems for more than a decade before issuing a recall. Reportedly for decades, Remington denied a trigger problem in its model 700 rifle. In 2015, a peanut company owner was sentenced to 28 years behind bars for salmonella poisoning linked to 9 deaths and about 300 hospitalizations. Toyota ultimately agreed to pay $1.2 billion for hiding its “unintended acceleration” problem ultimately linked to 89 deaths.

Monahan wrote that corporate violence “is responsible for more deaths and injuries than the more mundane forms of crime” and suggested that the “preoccupation of the law and the behavioral sciences with ‘street’ rather than ‘suite’ violence reflects, in part, political and economic biases operating in American society.”

Nearly 40 years after the publication of Monahan’s book, it’s still street, not suite, violence that dominates workplace violence prevention efforts.

Broadly, threat assessment is the process of gathering information to make a decision regarding the potential for violence. Threat management refers to actions taken to gain control over a situation and threat management to “the actions that can be, should be, or have been taken to prevent violence.” Healthcare threat management strategies to prevent incidents of “street” violence range from least intrusive (e.g., actively monitoring a situation to detect change) to most intrusive (e.g., arrest, prosecution, involuntary commitment for treatment). In between are options such as behavioral contracts, physical environment modifications, security enhancements, warnings, dismissals (from a physician’s practice, a clinic, or an organization), “no trespass” directives, and restraining orders. Threat management experts typically advise beginning with the least intrusive option available while still ensuring safety.

While threat assessment does not differ in healthcare from other industries, threat management strategies do have some unique considerations.

**Patients Who Threaten Providers**

When a patient threatens a provider, the “knee-jerk” reaction may be to dismiss the patient. Of course, in any industry, whether or not such an action will promote safety should be considered: “[I]t is contrary to the practice of threat assessment to actually be responsible for further escalating a situation.” But in healthcare, there are additional concerns. Only in healthcare is there risk that the termination of the professional relationship with the threatening
individual could result in harm and claims of medical abandonment.

Indeed, a full threat investigation may reveal the threatening behavior to be indicative of a new or undertreated medical or psychiatric problem that the provider or other providers in the organization are actually in a position to address. Maintaining a treating relationship with the patient can offer the ability to monitor for safety and intervene as warranted. Also, a thoughtful approach reduces concerns for claims of abandonment, and ensures strategies implemented are neither over- nor under-reactive, both of which can undermine the credibility of the healthcare threat manager. However, in healthcare there can be strong organizational influence reluctant not to dismiss patients who have acted in intimidating or threatening ways.

Healthcare Organizational Policies
OSHA’s healthcare workplace violence (WPV) prevention recommendations aim to prevent all forms of WPV, including verbal and non-verbal threats. In keeping with OSHA’s unending commitment to “zero tolerance for violence” policies, healthcare facilities may adopt organizational dismissal policies supportive of dismissing patients who have expressed threats. While the intent is to support staff, promote a safe workplace, and comply with OSHA recommendations, the organization may fail to recognize that dismissing such a patient may not enhance safety and in fact could worsen the potential for a violent outcome. Dismissal may also result in harm to the patient (unintended “suite violence”) that far outweighs the patient’s actions.

Adhering to “zero tolerance” policies is generally not advised by threat management experts who avoid such language because it implies harsh justice without thorough investigation and carries with it baggage from the failed war on drugs; “by transferring a largely discredited brand name to violence prevention, the employer risks seeming more interested in appearances than in effectiveness.”

Another organizational consideration is the healthcare facility’s mission or vision statement, which may espouse commitment to the health of the community it serves. Our own does, and so did those of nine out of ten other facilities that we randomly selected for review. Policies supporting the practice of dismissing patients from medical management do not seem consistent with efforts to promote community health. Moreover, in our experience, dismissal is simply not an effective violence prevention management tool. A significant percentage of dismissals end up being reversed, and patients can always return for care through our emergency department.

Unlike what might be expected of other industries, healthcare should recognize that mental health can fluctuate just as physical health does, and healthcare often presents frustrations sufficient to test even the most resilient among us. While most patients behave within generally accepted social norms despite what may be very stressful conditions, it should not be a surprise that some people - those in a mentally fragile state for whatever reason – who are in the midst of a health crisis, navigating healthcare system obstacles, and experiencing concurrent social stressors (e.g., divorce, job loss, mortgage foreclosure), are pushed beyond their limits and act out. OSHA, as anyone working in healthcare arguably should, recognizes the high stress atmosphere healthcare can be: “Pain, devastating prognoses, unfamiliar surroundings, mind- and mood-altering medications, drugs, and disease progression can all cause agitation and violent behaviors.”

Such awareness is necessary to direct WPV prevention efforts where they are likely to have greatest effect.

Healthcare Workplace Violence Statistics
“Every year, OSHA staffers are ‘shocked’ by the number of workplace injuries and fatalities in [healthcare].” And almost every year, healthcare organizations receive annual reports showing a rise in violence. The threat manager can benefit from

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understanding what makes up the violence statistics because for many in healthcare, what comes to mind is an increase in instances of the “street” type of violence – intentional assaults, batteries, and homicides committed by aggrieved patients or their angry family members against healthcare providers. In reality, the reason healthcare is consistently at the top of the WPV statistics is because we’re where violent patients are brought for care.xii

Ever since WPV statistics began being tracked by the Society for Human Resource Management in 1996xiii, workplace violence has been a concern for both employees and employers. For research and data reporting purposes, OSHA has adopted the California Division of Occupational Safety and Health’s description of four workplace violence categories, which are based on the relationship of the perpetrator to the victim—employee’s workplacexiv.

In type 1 violence, there is no relationship between the perpetrator and the workplace (e.g., a healthcare provider injured during a burglary at a hospital); in type 2, the perpetrator of violence is a customer/client of the employer business; type 3 involves employee on employee violence, and type 4 is domestic violence brought into the workplace. Violence by patients or their family members directed toward healthcare staff is type 2 violence, which is typically not further divided between acts of intentional (targeted) violence and spontaneous (unintended, affective, or reactive) violence.

Thus, for statistics purposes, the aggrieved patient who makes a decision to take a violent action against a provider is grouped along with the geriatric patient with dementia who grabs at her caregiver’s hair while being helped with bathing.

This broad grouping of Type II violence accounts for healthcare consistently being at the top of the statistics. When Type II violence statistics are reported to have risen, it can be helpful to know if the rising violence is of an intentional or unintentional type, as well as whether or not the increase reflects an increase in reporting or instead is truly reflective of rising incidents, not just reporting. Many reports on WPV to healthcare facilities rely on voluntary reporting and do not account for increased reporting efforts that have been undertaken.

Recognizing potential contributing factors for violence as well as the basis for reported statistics can aid healthcare WPV prevention policymaking as well as threat management decision-making.

**Sheridan Ryan, JD, PT, CPHRM, CTM is Associate Director of Clinical Risk Management at the Medical College of Wisconsin.**

**Sheridan and Jonathan Wertz, JD, RN, Director of Clinical Risk Management at the Medical College of Wisconsin, will join threat assessment and management experts Dr. James Cawood*, William Zimmerman and Dr. Matt Logan to present the 4th annual in-depth seminar focusing on threat assessment and management of targeted violence in the healthcare setting. Details at www.mcw.edu/MCW-Risk-Management.htm.**

*Many thanks to Marquette University Law School students and MCW risk management legal interns Scott Hale and Craig Leckie for their research contributions to this article.*

*Referenced in endnotes iv and ix.


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Proposed Bylaws Change

In accordance with WSHRM’s bylaws which require that proposed changes to WSHRM’s bylaws be either emailed or posted to the WSHRM website fifteen (15) days in advance of a vote by the membership, WSHRM is hereby informing members that it intends to hold a vote at the 2018 Annual Member Meeting to change the bylaws to allow for a tiebreaker drawing to be held in the event of a tie for a mid-term vacancy to determine who will fill the position. The proposed change to the bylaws is noted in red below.

ARTICLE VII
BOARD OF DIRECTORS
Section 6. Vacancies
The Board shall have authority to fill any mid-term vacancy, other than a vacancy in the Office of the President or President-Elect (which shall be filled in accordance with Section 7 of Article VIII), that may occur on the Board by appointment of an eligible member of the Society for the unexpired term. In the event of a tie for a mid-term vacancy, a tiebreaker drawing will be held that will include the names of the candidates tied for the vacant position. The President, or their designee, will draw a name. The candidate whose name is drawn will fill the mid-term vacancy. Filling of a vacated office by appointment of the Board shall not be deemed to constitute a term of office.

Email Reminder
Organizational firewalls may block communications from being received in your inbox. Make sure to check your spam folder or junk email for WSHRM information.

WSHRM Conferences: Save the Dates
We have an exciting year ahead in 2018 for WSHRM! Make sure to mark your calendar to be at the Spring and Fall Conference!

Spring 2018 Conference – Friday, April 27 2018
Fall 2018 Conference – Friday, September 14 2018

Check out www.WSHRM.org for more information about upcoming conferences, including hotel room reservation information. WSHRM conferences are a great way to learn and network, while growing professionally! We look forward to seeing all of you!

Happy Birthday to Us
WSHRM turns 30 in 2019 and wow we look good! We are looking for memories to share from the past 30 years. Please send stories and photos from past WSHRM events to Sharon Rateike. Let’s get ready to celebrate in 2019!!

Have any news to share for the next edition of Risky Business? We’d love to hear from you! Please e-mail to Sharon Rateike.
Thanks to WSHRM’s sponsors, speakers, planning committee, and attendees, the 2017 Fall Conference, Diversity & Inclusion in Healthcare, was a very successful event. What a great compilation of sessions on this important topic affecting all who work in healthcare!

2017 Fall Conference Sponsors
WSHRM’s affordable conferences would not be possible without our generous sponsors. Our Fall conference sponsors were Wisconsin Medical Society, ProAssurance, RL Solutions, Corneille Law Group, LLC, CNA, Leib Knott Gaynor, LLC, Hinshaw & Culbertson, LLP, Otjen, Gendelman, Zitzer, Johnson & Weir, SC, and Nash, Spindler, Grimstad, & McCracken, LLP, and Coverys. Thank you to all!

2017 Fall Conference & Annual Meeting Recap
For the first time, we held a conference at the beautiful Grand Geneva resort in Lake Geneva. We began with breakfast, sponsored by the Wisconsin Medical Society, which was then followed by our first presenter, Erikajoy Daniels, who leads Aurora Healthcare’s system-side diversity and inclusion program. Ms. Daniels kicked off the day with a dynamic session exploring the evolution of, and benefits of, embracing D&I in healthcare.

David Hunt, President of Critical Measures, a company that advises on diversity-related matters in law, business and medicine, addressed patient considerations in cultural competency and then, after a break sponsored by Nash, Spindler, Grimstad & McCracken, LLP, focused on the corresponding employment considerations. How interesting to learn that in the U.S., what formerly was regarded as employment law is now diversity law.

Next, Paul Greve of Willis Towers Watson admirably took on the challenging topic of Maternal Refusals of Care and led an excellent discussion on the moral dilemmas that providers can find themselves faced with, and shared with us ACOG’s position statement (posted online for attendees to access).

The Annual Meeting was held just before a lunch sponsored by Leib Knott Gaynor, LLC. President-Elect and outgoing Treasurer Monica Marton did extensive work to review WSHRM’s financial practices, and along with WSHRM incoming Treasurer Cheryl Paasch and Past-President Nancy Duran, brought forward a proposal passed by the WSHRM board of directors to hire, for an initial trial period of one year, a CPA consultant who specializes in small businesses. The WSHRM board expects this action to better align WSHRM’s practices with today’s security expectations for business regarding external controls to minimize the risk of fraud and identify theft. Additionally, this move meant that the “Assistant Treasurer/Internal Auditor” role could be eliminated, and would make the role of Treasurer more appealing to potential WSHRM volunteers. Great work, Monica, Cheryl and Nancy!

Another topic shared at the annual meeting was that of future fall conferences, which will now be one day in length (as the spring conferences are), rather than 1 ½ days. This cost-reducing change will allow continued low WSHRM membership and conference registration rates, and will help offset the new CPA consultant-associated costs.

Next discussed was the proposal to amend BOD Article VII Section 6 which will be emailed to WSHRM members for a vote. This proposed amendment is to address any tie among the Board of Directors wherein a board member resigns prior to completing their term, leaving 10 board members to vote to fill the vacated position. In case of a 5:5 tie, a tiebreaker drawing.
Finally, the 2018 Directors, Officers, and Committee Chairs were presented. A full list appears on page 16 of this newsletter.

It has been my great pleasure to serve the WSHRM membership in 2017 as President. I would like to thank those board members who are continuing their service, transitioning to new board roles, or joining for the first time. The Board was joined by new members Sue Courtney and Sharon Rateike at the September 20th board meeting – welcome Sue and Sharon!

Sharon filled the board vacancy created when long-time WSHRM member Patti Erickson decided to accept a new position. It was hard to say good-bye to Patti, but we wish her well in her new endeavors and are grateful for her steady guidance serving on the WSHRM Board of Directors, including serving as President in 2015.

With 2017 coming to a close, a warm welcome is extended to incoming President Monica Marton! As President-Elect in 2017, Monica was responsible for planning the 2017 fall conference, and as incoming President, will be responsible for planning the 2018 spring conference. The program planning will soon be underway, aided by several WSHRM members who we are fortunate to have volunteer on the program planning committee.

The fall conference afternoon sessions resumed after the annual meeting/lunch with Arthur Salazar of the Office of Civil Rights presenting on the ADA and the OCR’s regulatory perspective of civil rights laws, followed by a knowledgeable D&I panel: Debra Endean (AIDS Resource Center), Kisa Gant (Minority Health Program), and Mitch Hagopian (Disability Rights WI). What a great group to respond to our questions!

Recognizing that in the U.S. we reside in a culture of guns, Friday morning began with Pennsylvania psychiatrist Jack Rozel discussing risk management of armed law enforcement in the ED. Then, departing from our D&I theme, we shifted to legislative updates, first with an informative update on Wisconsin’s recent changes to worker’s comp laws presented by Dan Zitzer of sponsoring firm Otjen, Gendelman, Zitzer, Johnson & Weir, SC, and followed by our annual Fund update (Terri Carlson and Diane Konsella) and Legislative update (John Rather of sponsor WI Medical Society).

Ideas for conference speakers and sessions come from suggestions made on conference evaluations, as well as by attendance at ASHRM’s annual conference which offers many sessions on a broad array of topics. One of the benefits of volunteering for the WSHRM Board is that the President and President-Elect have the option of attending ASHRM’s conference. This year, I attended, and board members Karen Whyms and Sharon Graves, through CHW, also attended. The conference was in Seattle on October 15-18, 2017, and ideas will be brought back to WSHRM’s program planning committee.

WSHRM Upcoming Conferences
• April 27, 2018: Spring Conference (Delafield Hotel)
• September 14, 2018: Fall Conference (Holiday Inn – Pewaukee)
• May 3, 2019: Spring Conference (Delafield Hotel)
• September 13, 2019: Fall Conference (Holiday Inn – Pewaukee)

See the WSHRM website for conference details, including room rates. All conferences are held on Friday and are preceded by a board of directors’ meeting the Thursday evening before, which WSHRM members are welcome to attend. On January 1, 2019, one board position will become available, and on January 1, 2020, three board positions will become available.

Attending a BOD meeting can provide insight regarding the nature of the work involved and the extent of the commitment. Meetings that coincide with conferences are always included in the conference brochures, and the next one will be held September 13, 2018, at Holiday Inn-Pewaukee.
Wisconsin Society for Healthcare Risk Management

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Risky Business is a publication of the Wisconsin Society for Healthcare Risk Management (WSHRM), a chapter of the American Society of Healthcare Risk Management. It is distributed to WSHRM members with information pertinent to the field of healthcare risk management.

Information contained in this publication is obtained from sources considered to be reliable; however accuracy and completeness cannot be guaranteed. Articles should not be construed as legal advice.

Address all questions and comments to the Editor:
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Board Notes

Board Meeting Schedule
WSHRM Members are encouraged to attend board meetings. If you have an agenda item, please contact a Board member. Check the WSHRM website for the current meeting schedule.

Interested in a Board Position?
Anyone with questions about volunteering for a position with the WSHRM Board, please contact Patti Erickson at patti.erickson@wfhc.com.

Newsletter Volunteers
If you are interested in contributing to Risky Business, please contact Sharon Rateike at Sharon.Rateike@SSMHealth.com.

Planning Committee Volunteers
If you are interested in serving on the WSHRM Conference Planning Committee, contact Sheridan Ryan at sryan@mcw.edu.

Remember to “like” WSHRM on Facebook, if you have not yet done so. It provides a wealth of information and keeps you informed of current events related to risk management, conferences and many more things.

Make sure to check out the WSHRM website also!