Healthcare improvement based on learning from adverse outcomes

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Stellingen behorende bij het proefschrift

HEALTHCARE IMPROVEMENT BASED ON LEARNING FROM ADVERSE OUTCOMES

1. Our current approach to patient safety is analogous to researchers that seek to unravel the key to a succesful marriage by only looking at those that ended in divorce. *(this thesis)*

2. While learning at morbidity and mortality conferences is too focused on individuals rather than systems, the conference itself could benefit from focusing more on individual-level and social-level factors that influence its success. *(this thesis)*

3. Patient-level linkage of incident, adverse event and complaint data reveals valuable information on relations that otherwise remains obscured, such as incidents emerging in context of prior events or triggering seemingly unrelated events, and allows appreciating these events in the context of the patient perspective. *(this thesis)*

4. Although modern healthcare is increasingly multidisciplinary, our practices for learning and improvement lag behind in readiness to cross traditional boundaries between departments and disciplines. *(this thesis)*

5. We should not only learn from adverse events but also study our capacity to respond to harm once inflicted, preventing that (responses to) initial adverse events send patients 'out of the frying pan into the fire'. *(this thesis)*

6. The focus on incident data is also the source of many of our current problems with incident reporting: we collect too much and do too little. *(Carl Macrae. The problem with incident reporting. BMJ Qual Saf 2016;25:71-75)*

7. All too often, at morbidity and mortality conferences, the process ends after complications are identified and presented. A case is presented and discussed, learning points are highlighted, and the next case presentation begins — rinse and repeat. *(Greg Sacks. Morbidity and Mortality Conference 2.0. Ann Surg 2015;262:228-229)*

8. Wat is een betere manier van leren dan met elkaar kijken, luisteren en spreken over ons vak. *(Hans van Santen. Medisch Contact, 5 april 2018)*

9. Een begrip als kwaliteit kun je niet helder krijgen; het is niet transparant, niet te meten. Je kunt kwaliteit ook niet organiseren; je organiseert er altijd omheen. *(René ten Bos. Medisch Contact, 12 april 2018)*

10. Knowledge and error flow from the same mental source; only success can tell one from the other. *(Ernst Mach, 1838-1916).*

11. In theory, there is no difference between theory and practice. But, in practice, there is. *(Attributed to Yogi Berra, famous baseball player).*

12. You can use logic to justify almost anything. That is its power – and its flaw. *(Kathryn Janeway, captain of the USS Voyager).*

Marit S. de Vos, 18 december 2018