

## EDITOR'S PAGE

# Patient Safety: A(nother) Call for Action

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Editors like to believe that nearly all important medical findings appear first in peer-reviewed medical journals. However, I was reminded that this is not the case earlier this month (July) by a report from Health Grades Inc., a private company that provides healthcare quality ratings of physicians and hospitals as well as consulting services to consumers, hospitals, employers, and insurers. The study, entitled "Patient Safety in American Hospitals," examined the patient safety events occurring in the Medicare population across all U.S. hospitals for the three-year period from 2000 to 2002. The study found that the number of patient safety incidents in hospitalized Medicare beneficiaries was substantial and resulted in injury, death, and excess costs.

The attention of the medical and non-medical communities was first focused upon patient safety by a landmark publication of the Institute of Medicine (IOM), "To Err Is Human." Extrapolating data from Colorado, Utah, and New York, the IOM report indicated that 44,000 to 90,000 hospitalized patients per year were dying because of medical errors. Even the lower estimate would render medical error the eighth leading cause of death of Americans, exceeding automobile accidents, AIDS, and breast cancer. The IOM committee that authored the report estimated the cost of such errors to be between \$17 billion and \$29 billion a year. These incidents not only have an effect upon patients, but also demoralize doctors and nurses and reduce trust in the healthcare system. The report made a large number of specific recommendations to Congress and others for a comprehensive program to increase patient safety.

The IOM committee speculated upon the reasons that medical errors had received what appeared to be so little attention from the profession. They opined that the public generally believed that medical errors were rare and controlled by licensure and accreditation. Physicians tended to avoid the topic for fear of punitive measures and in view of malpractice litigation. In fact, medicine was and still is one of the most self-examining and policing disciplines in society. Others have indicated that hospitals lack the resources to invest in the large and costly technology that is thought to be required to solve the problem. These considerations argued for an inertia that might slow the resolution of issues compromising patient safety.

This month's Health Grades study, as well as the March release of a report by the Medicare Payment Advisory Commission (MedPAC), provides a status report on the state of patient safety incidents. The data indicate that there

is little evidence that patient safety has improved in the past five years. In fact, the MedPAC report suggests that adverse events have actually increased. The Health Grades report indicates that more Americans die of patient safety incidents every six months than perished in the Vietnam War, and that medical errors would be the sixth leading cause of death in the U.S. Among the more striking data, 1.14 million patient safety incidents occurred among the 37 million hospitalizations, 81% of the deaths of patients who experienced one or more adverse patient safety indicators were potentially attributable to the error, teaching and larger hospitals had more safety incidents than others, and the 16 patient safety indicators studied accounted for \$8.5 billion in costs annually. The authors concluded that their findings supported the contention that medical errors and injuries are epidemic in the U.S.

Attempts to resolve the issue of medical error have been stymied by uncertainty as to how to define and catalogue the problem. The Agency for Healthcare Research and Quality (AHRQ) addressed this need by developing a list of 20 patient safety indicators to be derived from hospital administrative data. The Health Grades study applied these indicators to Medicare patients in virtually all hospitals. Clearly, examination of only a small number of indicators may not be representative of the universe of medical conditions. However, the study represents the most systematic approach to examining the patient safety issue thus far.

As is true of virtually all new data, the foregoing findings are neither perfect nor without limitations. The absolute incidence of serious injury for any individual patient safety indicator remains quite low at about 1%. In addition, total mortality in hospitalized patients is decreasing. Perhaps of greatest significance, nearly all the data regarding medical errors have been derived from administrative databases, which are very susceptible to coding errors and poor documentation. Thus, although the current data may represent the best estimate we can get, they cannot be said to represent the true number or severity of patient safety incidents with certainty.

It is also worthy of note that a great many patient safety issues are related to systems problems. The lack of information available on site when patients see multiple physicians is a prime example. Therefore, the solution to much of the current problem is out of the hands of individual physicians.

In light of the foregoing, what should be the response of the medical community? To begin with, I think we should acknowledge that there are a number of problems with our current medical systems. Although it may be true that attention is being focused on a very small number of adverse events rather than upon the large number of excellent outcomes, we cannot deny that errors do occur. We should not only embrace the solutions proposed for the patient safety problems, but devise solutions ourselves. Confronted with the data that safety issues have not changed much since the initial IOM report, we as physicians must assume some responsibility for this failure and for finding effective remedies as soon as possible. Perhaps more attention would be directed to this effort if the data regarding medical errors appeared in medical journals rather than in reports from government agencies or private think tanks.

I suspect that I am typical of most physicians in thinking that quality control is greater in medicine than in any other discipline. When speaking of medical error, I immediately think of licensing, credentialing, Morbidity and Mortality and Tissue Conferences, and the nearly continuous case

presentations that go on in most hospitals. Very few services of any kind come to mind that are scrutinized more closely or are of more uniformly high quality than those in medicine. Nevertheless, the expectations for the healing arts are much higher. Our patients, and I believe most of us, expect us to be perfect, or nearly so. As can be seen from the reports cited, the consequences of our errors are significant and obvious. In many ways, we are analogous to the aviation industry; we just cannot afford to make errors. In fact, we could probably learn a great deal about safety from aviation. Therefore, I believe we should embrace these expectations and take the lead, as we have done so consistently in the past, in identifying our flaws and eliminating them. A patient entering the hospital should have at least as great a chance of an error-free encounter as a passenger boarding a plane.

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