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U.S. HEALTH CARE SYSTEM EARNS C+ FOR PATIENT SAFETY

Analysis in Health Affairs Says Health System Has Made Insufficient Progress Since IOM Issued Landmark Medical Errors Report in 1999

New York, NY–In 1999, the U.S. Institute of Medicine (IOM) reported that 44,000-to-98,000 people die each year from avoidable medical errors, the equivalent of a jumbo jet crashing daily. A new report appearing on the 5th anniversary of that landmark study says the U.S. has made "insufficient" progress to improve the safety of patients in hospitals.

This report card, supported by the Commonwealth Fund and published in today's Web-exclusive edition of *Health Affairs,* gives the U.S. health system an overall grade of C+ on patient safety, noting some improvement but considerable deficiencies in key categories.

"Although there are striking areas of progress, we still have a ways to go," says report author Robert Wachter, MD, associate chairman, Department of Medicine, University of California at San Francisco. He says the lack of funding, training, organizational structure, and culture have created barriers to meeting the goals of the 1999 report, which called for halving the number of medical errors by 2004.

Wachter, editor of an online patient safety journal and author of a recent best-selling book, *Internal Bleeding: The Truth Behind America's Terrifying Epidemic of Medical Mistakes,* gives high marks to the effects of strong regulation and broader use of information technology (IT). But he says error reporting systems have had little impact on fostering patient safety and there has been virtually no progress on making clinicians or health care systems more accountable for their actions over the past five years.

Wachter's patient safety report card comes amid heightened consumer concerns about the quality of care. Another survey released this month by the Kaiser Family Foundation, U.S. Agency for Healthcare Research and Quality (AHRQ), and the Harvard School of Public Health to commemorate the anniversary of the IOM report showed that nearly half of Americans worry about the safety of their medical care, with one in four saying that the quality of care has worsened since 1999.

Commonwealth Fund President Karen Davis agrees that there are signs of progress in improving patient safety but that much more needs to be done. "For example," she notes, "the number of states with adverse event reporting systems has increased from 15 to 22; 64 percent of the U.S. population now lives in states with mandatory reporting of such events. The challenge is to expand this practice to all states and to use the information reported in a proactive way to identify and spread safer practices."

Wachter's report analyzes and grades five major areas of activities and initiatives related to patient safety that marked the last five years; regulation, error reporting systems, IT, the malpractice system and other vehicles for accountability, and workforce training issues. Regulation received the highest grade, while the malpractice system and other vehicles for accountability scored the lowest. His grades follow:

Regulation: A^-. Regulatory solutions have "arguably been the most important early step" in reducing errors in hospitals, says Wachter, particularly for creating safer systems, standardizing procedures, and cross-checks in hospitals. He cites the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which accredits hospitals, as "the most important driver of progress in patient safety" to date. One of the biggest steps has been JCAHO's requirement that clinicians read back patient names and oral orders to avoid errors. He notes that virtually no American hospital had such a policy before 1999. Also, JCAHO now requires physicians to mark the intended site on patients before a surgery. Unfortunately, Wachter notes, regulation tends to pick the "low-hanging fruit" and is unlikely to spark the creation of a safety culture and the widespread implementation of IT, the two biggest issues going forward.

Error Reporting Systems: C. Error reporting systems can be powerful tools when used to improve systems or educate providers, says Wachter. But, this isn't happening enough. Instead, he notes, many hospitals and policymakers have embraced the flawed notion, which he calls "the Achilles heel of error reporting systems," that reporting alone is sufficient evidence that safety is improving. While there are certainly pockets of success, including the federally supported Web-based journal of provider-reported errors that Wachter edits (www.webmm.ahrq.gov), he says much work remains to create a system that effectively translates error reporting into meaningful solutions.

Information Technology: B^-. IT holds the most promise for addressing medical mistakes. Wachter says a strong IT backbone will increasingly become an essential tool for hospitals and clinicians if they want to be perceived as providers of safe, high quality care. The national commitment to IT has been stepped up recently, with new research dollars and the appointment of a health care IT "czar." The biggest worry, though, is that institutions that have invested heavily in IT may feel they have spent all they can on safety. There also have been high-profile IT miscues, ranging from prolonged system crashes to physician revolts against unwieldy systems. However, as IT gets its sea legs, Wachter says the benefits should become more tangible.

Malpractice System and Accountability: D^+. This category presents some of the most complex issues in patient safety. The effect of the malpractice system on patient safety is overemphasized, Wachter says. But a bigger problem is the lack of accountability for poor performance. Wachter says essentially no progress has been made in developing ways to

promote a no blame culture for providers who make innocent slips or mistakes while holding persistent rule violators or incompetent providers accountable; how to hold institutions accountable for allowing unsafe conditions to persist; and how to compensate patients for harm without invoking the heavy hand of tort law.

Workforce and Training Issues: B. Wachter sees much progress here due to increased awareness by providers, policymakers, and the public of the effects that nursing shortages, resident fatigue and a disjointed team environment have on patients. This has led to advancements and policies to improve patient safety, including the creation of hospitalists and intensivists (new inpatient generalists who help coordinate care of patients with complex treatment requirements), and enforcement of workload standards for residents and nurses. Additional work needs to be done to implement these standards and to increase teamwork and communication training for all health care providers.

Outlook

Although institutions are investing much more on patient safety today than in 1999, Wachter says the investment still falls well short of what is needed. For example, he says, AHRQ has been producing important research but its volume and impact have been limited by substantial underfunding compared with overall investment in medical progress. He also says that few hospitals have made major investments in patient safety initiatives, outside of IT. This underinvestment demonstrates "that the business case for safety remains inadequate to the task," he says. The biggest challenge for the next five years, Wachter says, is finding the "right mix of financial, educational, research, regulatory, organizational, and cultural activities and forces to catalyze the far-greater investment that will be needed to make health care significantly safer."

Health Affairs, published by Project HOPE, is a bimonthly multidisciplinary journal devoted to publishing leading edge health policy thought and research. Copies of this Web-exclusive article: *The End of the Beginning: Patient Safety Five Years After To Err is Human*, can be obtained at www.healthaffairs.org. Address inquiries to Jon Gardner, *Health Affairs,* at 301-347-3930 or via e-mail, jgardner@projecthope.org.

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