



Special Article

FROM QCC, THE QUALITY CARE COMMITTEE OF THE AAPA

Apathy toward patient safety: Has 10 years made a difference?

Ten years ago, the Institute of Medicine (IOM) released the first of two pivotal reports that focused on various aspects of patient safety: *To Err is Human: Building a Safer Health System* (2000). A follow-up report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001), came out a year later (Figure 1).

In *To Err is Human*, some alarming statistics for health care in the United States were revealed. The report said that at least 44,000 patients, and perhaps as many as 98,000 patients, die in hospitals each year as a result of preventable medical errors. High pressure, fast-paced environments such as intensive care units, operating rooms, and emergency departments are areas where mistakes and threats to patient safety are more likely to occur. *To Err is Human* discussed mistakes such as adverse drug events, improper transfusions, wrong-site surgery, suicides, restraint-related injuries, falls, burns, pressure ulcers, and mistaken patient identities; the report said such errors in hospitals were estimated to exceed annual deaths from motor vehicle collisions, breast cancer, and AIDS combined.

To increase PA knowledge about important subjects related to quality of care, the AAPA Quality Care Committee (QCC) will publish quarterly articles in *JAAPA*. This article on patient safety is the first in that series. Topics for future articles include rapid response teams, disclosure of errors, and hand-offs. We hope that by educating fellow PAs in this way, we will increase your understanding of quality of care issues. If we improve our understanding, we can help, as a profession, to decrease apathy and improve patient care.

While preventable medical errors have an obvious economic cost (estimates between \$17 and \$29 billion per year), what is less appreciated is that they cause patients to lose trust in the health care system and they decrease satisfaction for both patients and medical providers. The IOM report noted that even though individual providers can sometimes be at fault for medical mistakes, errors are more likely to be caused by faulty systems, processes, and conditions that lead providers to make mistakes or fail to prevent them.

EFFORTS TO IMPROVE PATIENT SAFETY

To fix this national problem, the IOM report introduced a four-tiered approach: (1) establish a national focus on this subject; (2) develop a mandatory, nationwide public reporting system; (3) raise performance standards; and (4) implement safety systems in health care organizations. Following the release of the first IOM report, Congress appropriated funds to the Agency for Healthcare Research and Quality (AHRQ) that supported a variety of efforts targeted at reducing medical errors.

The second report from the IOM, *Crossing the Quality Chasm*, placed more of a focus on an inconsistent and less-than-high-quality US health care delivery system. The report highlighted that our current system has more than just small gaps in care; instead, there is a chasm of care. To

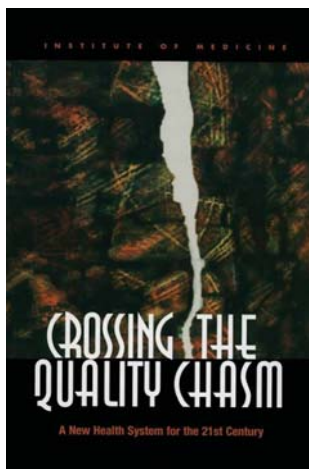
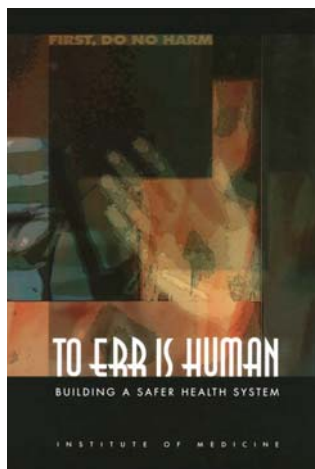


FIGURE 1. Pivotal IOM reports



close this chasm, the IOM introduced six aims for improvement, built around the core need for health care to be safe, effective, patient-centered, timely, efficient, and equitable. To help achieve these six aims, the IOM committee put forth 10 rules of health care redesign:

1. Care is based on continuous (through all available communication avenues) healing relationships.
2. Care is customized according to patient needs and values
3. The patient is the source of control
4. Knowledge (from systems to patients and their families) is shared, and information flows freely.
5. Decision making is evidence-based.
6. Safety is a system priority.
7. Transparency (from systems to patients and their families) is necessary.
8. Needs of the patient are anticipated.
9. Waste of the system is continuously decreased.
10. Cooperation among clinicians is a priority.

This report concluded that stronger leadership at the system level, unobstructed access to all forms of available information technology, the alignment of payment policies that focus on quality improvement, and preparing the health care workforce to make a smooth transition into an evolving and revamped health care system are all required next steps to go down the path of health care safety redesign.

CONFRONTING A WALL OF SILENCE

Rosemary Gibson's *Wall of Silence: The Untold Story of the Medical Mistakes that Kill and Injure Millions of Americans* (2003) casts yet more light on the subject of patient safety. This book highlights the disturbing fact that medical errors occur with alarming frequency, often with lethal results. Media reports of botched surgeries, medication mix-ups, and tragic misdiagnoses are more and more in the public eye. Gibson states that these errors have become increasingly more frequent as medical care becomes more complex, with miscommunication and systemic problems at the root of many failures.

Gibson further argues that the health care system has an inherent bias to cover up errors, which in turn allows and

even encourages medical providers to hide their mistakes. Like the IOM reports, her work places the blame where it should rest most—with the administrators and system designers who have failed to design the health care system for safety in the same way we have demanded safety in the aviation industry. As mentioned in the first IOM report, almost 100,000 Americans die each year of preventable

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medical mistakes—a number that is equivalent to a 747 jet crashing every day. Obviously, if the aviation industry was losing one large plane per day, a public outcry would result. Why is the same public reaction not occurring in response to the death toll from preventable medical errors?

LEARNING FROM OTHERS: AVIATION AND CAR MANUFACTURING

Health care can learn a great deal from both the aviation and car manufacturing industries. Pilots go through a standardized preflight check list with each and every flight, and if any aviation employee has a concern with a plane, that concern is investigated without that employee fearing retribution. Many investigations of hospital-based sentinel events have concluded that incidents could have been avoided if someone had spoken up or stopped an unsafe practice earlier. In car manufacturing, particularly at Toyota, constant effort is made to improve any and all processes and steps in the building of cars. In medicine, particularly in surgery, a “get it done and move on” attitude exists toward the implementation of new processes and projects. The common but incorrect thought is that once a new project is implemented, no follow-up work is necessary. “I learned it that way in my residency” and “I’ve been doing it this way for years” have been spoken in health care for decades.

These notions are barriers to making improvements. A health professional must be willing to review and redo process steps if they are deemed ineffective, wasteful, redundant, and/or unsafe. While patients are not planes or cars, the health care system can (and should) continue to learn from these two very successful, and safe, industries.

RESOURCES ARE ABUNDANT TO IMPROVE PATIENT SAFETY

Over the past 10 years, educational resources regarding patient safety have increased. As mentioned, the AHRQ

TAKE-HOME POINTS

- Hundreds of patients die every day in the United States from preventable medical errors, and thousands are harmed.
- In many cases, simple interventions and better education could greatly reduce these numbers.
- The estimated annual cost of preventable medical errors is between \$17 billion and \$29 billion.
- Reimbursement for certain medical services has become dependent on avoiding adverse outcomes.
- PAs play a critical role in preventing medical errors and promoting patient safety.



is an excellent educational resource. The Institute for Healthcare Improvement (IHI), founded in 1981, has grown a great deal over the past decade as a result of the success of its “100,000 Lives” and “5 Million Lives” campaigns to reduce medical errors and improve patient safety. In addition, the IHI offers an intense 10-month program, called the “Improvement Advisor Professional Development Program,” which trains medical providers to become improvement advisors within their own health care systems. The IHI offers many more programs, conferences, and collaboratives designed to take health care to a new level of performance.

In an effort to improve patient safety, the Joint Commission has implemented National Patient Safety Goals (NPSGs) for both outpatient and inpatient medical care, with focus on the following:

- Improving the accuracy of patient identification
- Improving the safety of using high-alert medications
- Accurately reconciling medications across the continuum of care
- Reducing the risk of patient harm resulting from falls
- Preventing health care-associated pressure ulcers
- Encouraging patients to have more involvement in their own care
- Improving handoff communication
- Using the Universal Protocol for preventing wrong site, wrong procedure, and wrong person surgery.

Through NPSGs, the Joint Commission gives health care systems detailed process steps to follow in order to better implement the above goals. The Joint Commission has developed additional NPSGs, and more are to follow.

“CMS has decided to eliminate payment for so-called *never events*, which are serious and costly errors that should never happen.”

Within the past 2 years, reimbursement for certain services has become dependent on the avoidance of adverse outcomes. The Centers for Medicare & Medicaid Services (CMS) decided to eliminate payment for so-called *never events*—serious and costly errors that should never happen. A few items on the initial list of *never events* include wrong site surgery, mismatched blood transfusion, and bacteremia from central line infections; and other *never events* have been released by CMS since they issued their initial list. As an example, bacteremia from a central line infection is considered a *never event* because by following evidence-based procedural checklists, using proper technique for central line insertion, and removing the lines promptly when not



IHI campaign to reduce medical errors

needed, health care systems can dramatically decrease and even eliminate central line infections.

THE NEXT STEP: FIGHTING APATHY

Despite volumes of information about patient safety from the IOM, the growth of resources like the AHRQ and the IHI, and the recent reality of a financial penalty for adverse events, frontline medical professionals still exhibit a great deal of apathy towards the subject of patient safety. While the causes of this apathy are varied, a few of the primary reasons are as follows:

- **Lack of universal health care.** The United States is the only industrialized nation that does not have some form of national health care for all of its citizens. Providers may thus wonder if our system will ever be able to meet all six of the IOM’s aims for improvement.
- **The hierarchical culture of medicine.** Unlike the aviation industry, medicine does not ensure that all voices are heard when adverse events are occurring or have taken place.
- **The “not me” phenomenon.** This common phenomenon in medicine, which is especially seen in surgery, is a barrier towards improving safety. In order to accept safety measures, providers have to first acknowledge that adverse events can and will happen to their patients.
- **New process steps.** The process steps to improve safety (medicine reconciliation, time outs, hand-offs, etc.) are performed by a generation of providers who still find these steps somewhat foreign. Younger PAs now coming into practice never knew life before these steps became mandatory. Therefore, they are more likely to accept them as common practice.
- **Lack of “frontline” education.** Articles on patient safety more commonly appear in patient safety and health care quality journals, rather than in medical journals commonly read by clinicians. Lack of awareness and knowledge may be a cause of apathetic attitudes.

PAs can play a critical role in fighting apathy and improving patient safety. It is our hope that articles such as this one will contribute toward that goal. [JAAPA](#)

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