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To Err Is Human, But This Is Something Else

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In November 1999, the Institute of Medicine (IOM), a branch of the National Academy of Sciences, published a study declaring that a threshold improvement in the quality of health care was urgently needed because medical negligence committed in hospitals in the United States was killing more people annually than motor vehicle accidents, breast cancer and AIDS. Kohn LT, et al., To Err Is Human: Building a Safer Health System, National Academy Press pg. 26 (1999). (Hereafter "To Err Is Human"). The impact of that study, and its "jarring" analogy that the annual number of deaths from hospital negligence would be equal to the downing of a jumbo jet every single day, "galvanized the public and health professionals and led to congressional hearings, media exposes, and millions of anxious patients." Robert M. Wachter, M.D., The End of the Beginning: Patient Safety Five Years After "To Err Is Human," W4 Health Aff. (Millwood) Web Exclusives 534 (2004). (Hereafter "The End of the Beginning").

It is not an overstatement to say that as a result of the IOM study, in 1999 the United States came to the realization that medical mistakes were a problem of epidemic proportions. *Id.*

A Call for Change

To Err Is Human declared that the health care industry needed to take the following steps to make health care safer:

- Create leadership roles, research patient safety issues and develop tools and protocols to enhance knowledge of safety issues that exist;
- Create nationwide mandatory and voluntary error reporting systems so that it could identify and learn from medical errors;
- Raise safety standards through the use of oversight organizations, professional groups and health care purchasers; and
- Implement safety systems that enhanced safe practice at the health care delivery level.

Howard Larkin, 10 Years, 5 Voices, 1 Challenge. To Err Is Human Jump-Started a Movement to Improve Patient Safety. How Far Have We Come? Where Do We Go From Here? 83 *Hosp. Health Netw.* 24 (2009). (hereafter "10 Years, 5 Voices 1 Challenge").

There was an initial flurry of activity following the IOM report in 1999. Five years after the study was released, the federal government, private foundations, health plans, hospitals and clinics were all investing more in patient

safety then they had been in 1999. The End of the Beginning *supra*, at 543. Notwithstanding this fact, as early as 2004, there was recognition that efforts to advance patient safety were not moving forward comprehensively enough to be responsive to the problem. *Id.* Studies of specific hospital systems revealed that while some areas of patient safety systems were improving, other were declining due to changing hospital priorities, budgets and philosophies. Daniel R. Longo, OblSb, ScD, The Long Road to Patient Safety: A Status Report on Patient Safety Systems 294 *JAMA* 2858, 2863 (2005). (hereafter "The Long Road to Patient Safety").

In To Err Is Human, the IOM called for a 50% reduction in medical errors in five years, but 10 years later it was clear that progress in the area of patient safety was still far short of that goal. Lucian Leape, et al., Transforming Healthcare, a Safety Imperative, 18 *Qual. Saf. Health Care* 424 (2009). Indeed, one commentator observed that "[s]hockingly modest progress has been made given the impact of the problem, how many people were made aware of it and how many efforts have been made to address it." 10 Years, 5 Voices 1 Challenge, *supra*, at 28. "The current status of hospital safety systems is not close to meeting IOM recommendations." The Long Road to Patient Safety, *supra*, at 2858. Data from recent studies measuring safety progress suggests that "patient safety progress is slow, and cause for great concern." *Id.*

Why the Loss of Momentum?

Various reasons have been given for loss of momentum in the patient safety movement over the last 10 years. First, there was no organization set up to implement and oversee the plans set forth in To Err Is Human. 10 Years, 5 Voices 1 Challenge, *supra*, at 28. Additionally, the health care industry has displayed a reluctance to engage in recommended error reporting systems. *Id.* Although we are beginning to see changes, for the most part, payment systems throughout the last 10 years generally did not reward patient safety or penalize unsafe practices. *Id.* at 27. Finally, "Some of this lack of progress may be attributable to the persistence of a medical ethos, institutionalized in the hierarchal structure of academic medicine and healthcare organizations, that discourages teamwork and transparency and undermines the establishment of clear systems of accountability for safe care." Transforming Healthcare, a Safety Imperative, *supra*, at 424.

A Scathing Review

On Nov. 18, 2010, the *New England Journal of Medicine* published a study that attempted to quantify the impact of patient safety measures on in-patient hospital admissions. Christopher P. Landrigan, M.D. et al., Temporal Trends in Rates of Patient Harm Resulting from Medical Care, 363 *New Eng. J. Med.* 2124 (2010). (Hereafter Trends in Rates of Patient Harm). *The New York Times* identified Trends in Rates of Patient Harm as "one of the most rigorous efforts to collect data about patient safety" since the publication of To Err Is Human. Denise Grady, Study Finds No Progress in Safety at Hospitals, *N.Y. Times*, Nov. 24, 2010 at A1.

Trends in Rates of Patient Harm examined hospital admissions in a stratified random selection of hospitals in North Carolina between 2002 and 2007. Trends in Rates of Patient Harm, *supra*, 2124-2125. The study was restricted to adult patients. The authors specifically chose to evaluate the impact of patient safety efforts in North Carolina because that state showed a high level of engagement in efforts to improve patient safety. In spite of this, the study revealed that "harm resulting from medical care was common, with little evidence that the rate of harm had decreased substantially over a 6-year period ending in December 2007." *Id.* at 2130. The review revealed that 25.1% of the patients receiving medical care in the hospitals surveyed suffered from medically induced harm. *Id.* at 2124-2125. Sixty-three percent of these were entirely preventable. *Id.* at 2127.

Proposed Law Changes May Further Patient Pain

On Dec. 1, 2010, The National Commission on Fiscal Responsibility (NCFR) published a report with suggestions to be pursued by Congress and the Senate to deal with the federal deficit. NCFR, The Moment of Truth, Dec. 1, 2010, http://www.fiscalcommission.govsites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf. Several recommendations of the NCFR seek to restrict the rights of redress of patients harmed by medical malpractice, in the name of reducing the federal deficit. There appears to be bipartisan support for creating "safe-haven" rules for health care providers who follow best practices of care, for creating a more restrictive federal statute of limitations for all medical malpractice cases, and creating specialized "health courts" to replace the jury system. *Id.* at 29. Some members of the NCFR recommended that the legislature consider the imposition of a federal statutory cap on damages. *Id.*

More of the Same?

Ten years ago, To Err Is Human announced that the health care industry was "a decade or more behind other high-risk industries in its attention to ensuring basic safety." To Err Is Human, *supra*, at 5. The report was so shocking in part because "silence surrounds" the issue of medical malpractice. *Id.* The goal of To Err Is Human was noble: to break the cycle of inaction in the health care industry. *Id.* at 3. Action was urged 10 years ago because doctors (not lawyers) finally declared that the status quo was not acceptable and could no longer be tolerated.

Conclusion

It is difficult to imagine the last 10 years' history of the patient safety movement occurring in any other industry. If 10 years ago jumbo jets were falling from the sky every day and we learned from a study (conducted by the airline industry itself) that the resulting individual tragedies were avoidable if air carriers followed safe practices, citizens would demand change and there would be bipartisan support for government intervention to stop preventable deaths. The idea that thousands of deaths already occurred because of air carriers' failure to follow safety standards would be considered utterly scandalous. You certainly would not expect people to stand idly by while the planes continued to fall from the sky every day for ten more years.

And one more thing: If the planes did keep falling, nobody would dream of suggesting that we should reduce airline accountability to the victims who were dying because of preventable errors.

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