Reducing the Rate of Medical Errors in the United States

Medical errors cost tens of thousands of lives in US hospitals each year—more than deaths from highway accidents, breast cancer, and AIDS combined. Studies have put the numbers of deaths anywhere from 44,000 to 98,000 annually in hospitals. However, these numbers could go much higher if the numbers of people who die as a result of errors in day-surgery and outpatient clinics, retail pharmacies, nursing homes, and home care were counted, said the Institute of Medicine (IOM) in its landmark report “To Err is Human,” which was released in November.

“These stunningly high rates of medical errors—resulting in deaths, permanent disability, and unnecessary suffering—are simply unacceptable in a medical system that promises first to ‘do no harm,’” said William Richardson, chair of the committee that wrote the report and president and chief executive officer of the W.K. Kellogg Foundation in Battle Creek, Mich. “Our recommendations are intended to encourage the healthcare system to take the actions necessary to improve safety. We must have a healthcare system that makes it easy to do things right and hard to do them wrong... The status quo is not acceptable and cannot be tolerated any more.”

Preventing such mistakes requires system-wide changes, the IOM committee said in its report. They noted that although many such errors could be avoided, the will to change practices and systems does not yet exist. They set as a goal a 50% reduction in medical errors by the year 2004. “We believe that with adequate leadership, attention, and resources, improvements can be made,” said Richardson. “As we say in the report, ‘It may be part of human nature to err, but it is also part of human nature to create solutions, find better alternatives, and meet the challenges ahead.’”

The problem is pervasive, noted the committee. “One recent study conducted at 2 prestigious teaching hospitals found that about 2 of every 100 admissions experienced a preventable adverse drug event, resulting in average increased hospital costs of $4700 per admission, or about $2.8 million annually for a 700-bed teaching hospital. If these findings are generalizable, the increased hospital costs alone of preventable adverse drug events affecting inpatients are about $2 billion for the nation as a whole.”

Such errors contribute to a general loss of trust in the healthcare system by patients and “diminished satisfaction by both patients and healthcare providers,” the committee wrote. “Yet silence surrounds this issue.” Most consumers believe they are protected, and licensure and accreditation give the appearance that healthcare institutions are above reproach. “Yet, licensing and accreditation processes have focused only limited attention on the issue,” the report stated, “and even these minimal efforts have confronted some resistance from healthcare organizations and providers. Providers also perceive the medical liability system as a serious impediment to systematic efforts to uncover and learn from errors.”

The system itself contributes to medical errors and the lack of response to them, the report said. “When patients see multiple providers in different settings, none of whom have access to complete information, it is easier for something to go wrong than when care is better coordinated. Unsafe care is one of the prices we pay for not having organized systems of care with clear lines of accountability.”

The very system of purchasing care contributes to the problem, Richardson said. Group purchasers of care have made few demands that safety in hospitals and other healthcare settings be improved.

Yet, analyzing errors is the beginning of determining how to prevent them, the committee noted. “All adverse events resulting in serious injury or death should be evaluated to assess whether improvements in the delivery system can be made to reduce the likelihood of similar events occurring in the future. Errors that do not result in harm also represent an important opportunity to identify system improvements having the potential to prevent adverse events.”

Among the recommendations for dealing with the problem are the following proposals:

- Congress should create a Center for Patient Safety within the Agency for Health Care Policy and Research that would set national goals for patient safety, track progress in meeting these goals, and issue an annual report on patient safety, as well as developing knowledge and understanding of errors.
- A nationwide mandatory reporting system should be set up to provide for the collection of standardized information about adverse events that result in death or serious harm. At the same time, voluntary reporting should be encouraged.
- Data related to patient safety and quality improvement should be protected in the same way that peer review information is protected.
- Groups that accredit or oversee healthcare facilities and groups should be more focused on patient safety. Public and private health care purchasers should provide incentives to healthcare organizations that can prove that they have improved patient safety. The US Food and Drug Administration should develop standards for drug labeling and packaging to avoid sound-alike and look-alike confusion between existing drug names and work with the various divisions of the healthcare sector to identify problems that threaten patient safety.
Healthcare organizations and providers should make patient safety a declared and serious aim by providing clear and visible attention to safety, putting in systems that allow the reporting of analyses of efforts. Organizations should put into practice proven methods of ensuring medication safety.

The IOM report received applause from the National Patient Safety Foundation (NPSF), an independent nonprofit education organization formed by the American Medical Association, CAN Health Pro, and 3M. Nancy Dickey, MD, the former president of the American Medical Association and past chair of the NPSF’s Board of Directors said, “In general, medicine is very safe, but medicine is also very complex and is not without risk. Any error that harms a patient is one error too many. While we may never achieve perfection, we must continue to strive for it. The NPSF will continue to lead the effort to improve patient safety.”

Henri R. Manasse, Jr, PhD, ScD, the current chair of the NPSF Board of Directors, said, “The findings of this report are very important to the issue of improving patient safety and working toward the goal of fail-safe care processes. The IOM information is very supportive of earlier learning and should help raise awareness and establish patient safety as a national priority.”

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