Prologue

Five Years Later—Are We Any Safer?

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The Institute of Medicine (IOM) released *To Err Is Human: Building a Safer Health System*,[1] its seminal summary of preventable patient injuries suffered within American hospitals, on November 29, 1999. This report was unique in one important way: it was the first IOM report directed as much to the general American public as at the U.S. government, the health care industry, members of the healing professions, and health policy experts. While evidence documenting high rates of treatment-associated injury and mortality have appeared in the peer-reviewed medical literature since the 1950s, neither the health professions nor the health care industry have ever prioritized patient safety as a critical imperative. The IOM's Committee on the Quality of Health Care in America, which produced *To Err Is Human*, sought—through its new public relations direction—to force patient safety to the pinnacle of the policy and care delivery improvement agendas. The committee set a goal of reducing fatalities associated with hospital-based care delivery by 50 percent within 5 years.

Five years have passed. A few institutions have reached the initial IOM goal for some injury sources (for example, Brigham & Women's Hospital in Boston for adverse drug events [ADEs]; Intermountain Health Care's LDS Hospital in Salt Lake City for ADEs and for postoperative wound infections; and Johns Hopkins University Hospital in Baltimore and Vanderbilt Hospital in Nashville for central venous catheter-associated infections). However, as a country, progress has fallen far short of the IOM's ambitious goal. Some members of the original IOM committee have publicly decried the lack of substantial progress,[2, 3] citing a continuing inability by the United States to hold patient safety at the center of a national health care reform agenda. For example, even though more than 30 percent of a random sample of physicians responding to a survey reported that they or a member of their immediate family had experienced significant injuries when receiving care, physicians still see patient safety as a low priority.[4]

Donald M. Berwick summarized efforts to improve patient safety in terms of *will*, *ideas*, and *execution*.[5] He focused on the execution of patient safety efforts, and catalogued four major barriers at that level:

1. Most clinicians remain blind to care-associated deaths, injuries, and near misses, because of difficulties in recognizing, tracking, and summarizing these events.
2. A lack of appreciation of the true incidence and nature of patient injuries leads to "unscientific theories," which result in "counterproductive responses to the problem."
3. There is a lack of a business case for safety, to justify and offset the large investments that may be necessary to make care safe.

4. Patient safety represents a difficult and complex problem.

Dr. Carolyn Clancy, director of the Agency for Healthcare Research and Quality (AHRQ), has put forward a much more positive view.[3] She points to growing interest in patient safety within the healing professions and health care delivery organizations, representing the *will* to change. The contents of this volume, summarizing AHRQ- and other government-sponsored patient safety research over the past 5 years, demonstrates solid, broad, and rapid progress in the other key element upon which successful execution will rest: *ideas*. Here you will find every dimension of safe patient care delivery, ranging from state-of-the-art detection and tracking systems (concurrent and retrospective clinical trigger systems), to successful interventions that addressed specific, single injury sources (e.g., adverse drug events), to organizational structures (e.g., building a culture of safety; nursing roles; teamwork), to safety features within and among care delivery locales (e.g., rural versus urban care; ambulatory versus inpatient care; patient transitions), to core theory (e.g., human factors; cognitive factors; work load; transitory work assignments), to the role of technology (decision-support systems for safe care; methods to safely deploy new technologies), to the role of national and State-level policy.

We all hold the future of patient safety in our hands. The problems are urgent, yet the pursuit is lifelong. Indeed, it is difficult to overemphasize the complexity of the problem, given the fragmented nature of health care in the United States. We are learning that safety is an emergent property of systems, not a problem that can be easily and uniformly reduced by a certain percentage in a fixed period of time. While impressive in its own right, the contents of the present volume is but a down payment—the first few steps of a lifelong journey—for new levels of understanding and effective execution. Building on this foundation, the next 5 years should be even more challenging and productive than the past 5 years have been.

References

1. Kohn LT, Corrigan JM, Donaldson MS, editors. To err is human: building a safer health system. A report of the Committee on Quality of Health Care in America, Institute of Medicine. Washington, DC: National Academy Press; 2000.
2. Berwick DM. Invisible injuries. (Op-ed column) The Washington Post 2003 July 29; p. A17.
3. Morrissey J. Patient safety proves elusive. Mod Healthc 2004 Nov 1;pp. 6–7, 24–5, 30, 32.
4. Blendon RJ. Views of practicing physicians and the public on medical errors. NEJM 2002;347(24):1,933–40.
5. Berwick DM. Errors today and errors tomorrow. NEJM 2003;348(25):2,570–2.