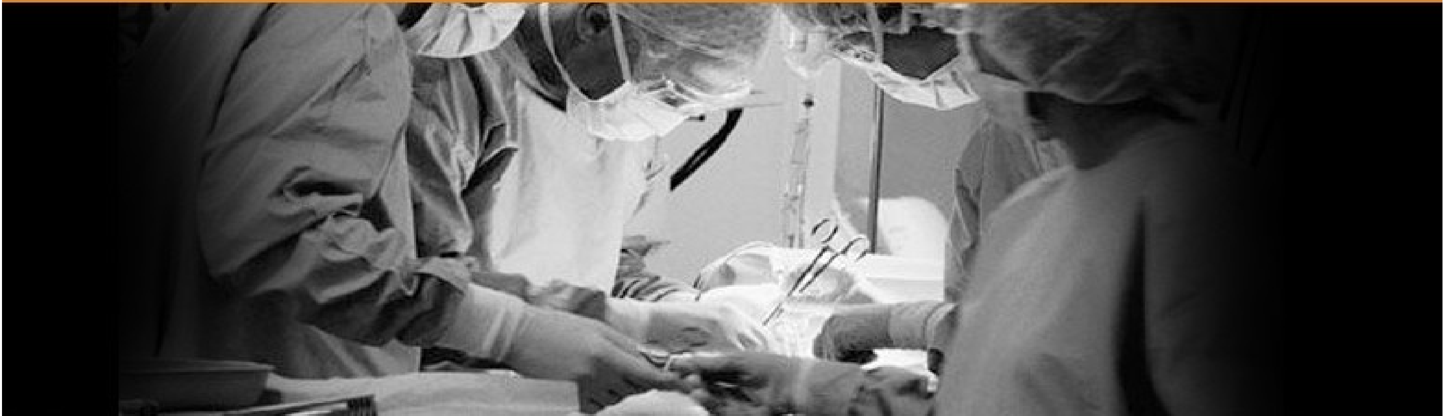

Posted On: **December 22, 2010** by Patrick A. Malone

Why Malpractice Still Hurts and Kills So Many Patients

Invisibility, inertia and income. That's the answer from one health care expert.

I'm borrowing this guest column from the blog of the prestigious Health Affairs journal. It's by Michael Millenson, an expert consultant and author in patient safety.

You can read comments from readers and his original article here.

A recent front-page article in the New York Times conveyed grim news about patient safety. The first large-scale study of hospital safety in a decade concluded that care

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has not gotten significantly safer since the Institute of Medicine's 1999 estimate of up to 98,000 preventable deaths and 1 million preventable injuries annually.

What for me struck a particularly jarring note was not just the absence of improvement, but the reluctance of the health care leaders interviewed to speak candidly about why progress has been so slow. Instead, they offered nostrums about the need to "do more" or opined that "openness" or better "coordination" would somehow turn the tide.

But tucked in the actual study's conclusions section, between bland boilerplate about "further study" and a "refocusing of resources," some carefully worded candor cautiously peeked through: "[T]he absence of large-scale improvement is not evidence that current efforts to improve safety are futile," wrote Christopher Landrigan and colleagues in the Nov. 25 New England Journal of Medicine. "On the contrary, data have shown that focused efforts to reduce discrete harms, such as nosocomial infections and surgical complications, can significantly improve safety."

In plain language, we know how to prevent many of these patient deaths, but we don't. That makes, "Why?" a lot tougher question.

It is a question that has haunted me since I discovered that clear descriptions of the medical error problem, its human cost and the corrective actions needed began appearing in the medical literature in the 1950s. The first large-scale study of hospital safety, by Don Harper Mills in California, was published in 1978. My extrapolation of its findings showed a preventable national death rate of about 120,000 patients annually. That's roughly the same as the numbers from the oft-quoted Harvard Medical Practice Study published in 1991 that the IOM relied upon in its 1999 To Err is Human report. In human terms it means that 2.5 million men, women, and children died preventable

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deaths in U.S. hospitals during the 21 years between 1978 and 1999. A staggering seven to 17 million suffered preventable injuries.

The Silence Continues

I laid out those numbers in a March, 2003 Health Affairs article that challenged the profession to break a silence of deed — failing to take corrective actions — and a silence of word — failing to discuss openly the consequences of that failure. This pervasive silence, I wrote:

continually distorts the public policy debate [and] gives individuals and institutions that must undergo difficult changes a license to postpone them. Most seriously of all, it allows tens of thousands of preventable patient deaths and injuries to continue to accumulate while the industry only gradually starts to fix a problem that is both long-standing and urgent.

Nearly eight years later, medical professionals now talk freely about the existence of error and loudly about the need for combating it, but silence about the extent of professional inaction and its causes remains the norm. You can see it in this latest study, which decries the continuing "patient-safety epidemic" while failing to do next what any public health professional would instinctually do: tally up the toll. Instead, we get dry language about the IOM's goal of a 50 percent error reduction over five years not being met.

Let's fill in the blanks: If this unchecked "epidemic" were influenza and not iatrogenesis, then from 1999 to date it would have killed the equivalent of every man, woman and child in the cities of Raleigh (this study took place in North Carolina) and Washington,

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D.C. Does a disaster of that magnitude really suggest that “further study” and a “refocusing of resources” are what’s needed?

Why are we still killing so many patients? Call it the “three I’s”: invisibility, inertia and income.

The invisibility issue is commonly articulated this way: while airplane crashes kill a lot of people at once in a very public manner, medical error kills a few people at a time in private, spread out among thousands of hospitals. Moreover, most deaths occur among those who were already very sick, and only a small proportion represent negligence. This is inadvertent harm; there are no villains here. In any event, medical care is complicated. As a result, as a 2009 JAMA commentary pointedly noted, “Clinicians have labeled virtually all harm as inevitable for decades.”

That conviction is conveyed to and largely believed by patients. Why else would the advocacy groups for the sickest patients, such as the American Cancer Society or American Diabetes Association, pay so little attention to treatment-caused harm? Absent public or peer pressure, doctors and hospitals are reluctant to adopt interventions whose efficacy they mistrust to prevent an epidemic they really don’t see and which is profoundly discomfiting to confront.

Letting Children Die Unnecessarily

There are many examples of the inertia these beliefs produce, but one I cannot get out of my mind concerns sick children. At the 2009 AcademyHealth meeting, Dr. Richard Brilli of Nationwide Children’s Hospital presented data showing how a collaborative backed by some of the most respected organizations in pediatric care had slashed the rate of catheter-associated bloodstream infections (CA-BSIs). CA-BSIs are relatively

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common, very expensive and can be quite deadly (up to one quarter of victims die). Brilli said his collaborative had tried to recruit 330 pediatric intensive care units to join the initial participants, but after three years, just sixty had accepted. The reasons Brilli said he's been given indicated to me that few had taken the time to examine the collaborative's methodology or results. Instead, respondents asserted that their patients were sicker, their hospital was busier than the others in the study, that joining would make them look bad to others, or that the mortality reduction didn't apply because "I am in a world famous center."

Now fast-forward to the February, 2010 issue of Pediatrics, in which the collaborative concluded: "CA-BSIs are a preventable cause of patient harm to critically ill children." What you can't see in the peer-reviewed literature is this context: at literally scores of hospitals which declined to participate in the collaborative, hundreds of sick children likely were injured or killed who probably would not have been harmed had the hospital been a collaborative member. Those harmed were tended to by dedicated staff who thought they were doing everything they could to help the kids in their care. They were dead wrong, but even today they may not know it. Certainly, their patients and the public do not.

I'll cite just two other examples of inertia and invisibility interacting to impede change. When the Institute for Healthcare Improvement launched its "Save 100,000 Lives" Campaign on the fifth anniversary of the IOM report (the delay speaks for itself), four out of 10 U.S. hospitals still declined to participate. No policymakers or commentators questioned why 40 percent of hospitals would sit out this opportunity to improve care.

Another example: the Centers for Disease Control and Prevention published its first hand-washing guidelines in 1975. Yet nearly 35 years later, when the Joint

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Commission launched an improving hand hygiene project, the eight hospitals that volunteered had a baseline hand hygiene rate typical of hospitals nationwide: 48 percent. That's worse than the worst rate at the worst big public men's room in the United States, according to one recent survey. But rather than giving providers an ultimatum, we launch campaigns to ask patients to ask providers to please wash up.

Most lethal of all is when invisibility and inertia interact with income. Ironically, the modern patient safety movement owes its foundational data to providers' belief that malpractice insurance premiums were too high. The landmark studies of medical error published in 1978 and 1991 were backed by physician groups which hypothesized that unjustified lawsuits, not actual medical problems, were driving up premiums. In the event, research demonstrated that only a small percentage of errors resulted in lawsuits and an even smaller percentage in judgments. By that yardstick, the most recent study represents progress, since it was motivated by care improvement rather than income protection. Still, provider fear of being unjustly sued no doubt obstructs needed sharing of information and argues for malpractice reform.

Confronting The Belief That Complications Bring Extra Income

But there's another elephant in the room that makes providers squirm even more. Put bluntly, many hospital executives believe they make money from complications. (Not from deaths, of course, because those shorten length of stay). Frustrated clinicians have personally told me this many times over the years, and as recently as a few weeks ago. The evidence has even made its way into the medical literature.

To cite just one example, let's go back to those expensive bloodstream infections that affect the most vulnerable of patients, critically ill children, being cared for at the most eleemosynary of institutions, children's hospitals. Even here, clinicians find themselves

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forced to argue that there is a “business case” for reducing CA-BSI’s in the pediatric intensive care unit.

In a recent journal article, the authors framed their case this way: Yes, infections increased the hospital stay by an average of nine days, and yes, insurers saved more money than hospitals by eliminating them. However, if a hospital filled the beds vacated by non-injured patients, it actually made more money because new patients provided more revenue in the first few days than tacking on those days to the hospital stay of patients already in the ICU. A clinical and financial win-win!

The Unknown Success Story Of Ascension Health

The ultimate irony about the silence surrounding patient safety is that one of the most extraordinary success stories in preventing harm has largely gone unheard. Ascension Health looks like most of the U.S. health care system, operating 65 community hospitals with independent medical staffs. Yet its program to eliminate all preventable injuries or deaths has been highly effective. They have carefully documented how they reduced infections, falls, complications of childbirth and a host of other common causes of patient harm to a fraction of national norms and saved more than 2,000 lives every year.

The clinical and administrative leaders of Ascension Health, one of the nation’s largest Catholic health systems, made the invisible visible, and found that errors were far more prevalent than they thought. They declared that inertia would not be tolerated; all their affiliated hospitals had to participate. And they were willing to risk hospital income to prove that they were serious about change.

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It is a story that so far seems to have excited only a few conference goers and regular readers of theJoint Commission Journal, which has been publishing articles about Ascension's results since 2006.

As a society, we know what combination of social pressure, economic incentives and provision of tools to enable new behavior lead to transformational change. In patient safety we are using all of them, including various public and private programs to refuse payment for preventable error and publicize hospitals' safety records. But at the front lines of patient care, it is all too clear that these efforts have yet to make much of a difference, as well-intentioned professionals silently turn away from the preventable harm we are still inflicting on those we are working so hard to help.

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