

# CU Report: U.S. Health Care System Fails To Protect Patients From Deadly Medical Errors

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### Consumers Union Assesses Lack of Progress Ten Years After Institute of Medicine Found Up To 98,000 Die From Preventable Errors

Ten years ago, the Institute of Medicine (IOM) sounded the alarm about the widespread toll of medical errors in a groundbreaking report call "To Err is Human." The report prompted a rush of congressional hearings and promises of reform. But in the decade since the report was published, little progress has been made implementing key reforms recommended by the IOM to improve patient safety, according to Consumers Union, the nonprofit publisher of *Consumer Reports*.

In a new report issued today, "**To Err is Human – To Delay is Deadly**," Consumers Union detailed the lack of progress since the IOM estimated in 1999 that as many as 98,000 Americans die every year from preventable medical errors. **Consumers Union's report** was released as lawmakers in Congress are working on legislation to address the rising cost of health care and expand access to coverage. Consumers Union maintains that reducing medical harm -- including hospital-acquired infections and medication errors -- would not only improve patient care but also provide significant costs savings to help make expanded access to health coverage possible.

"There is little evidence to suggest that the number of people dying from medical harm has dropped since the IOM first warned about these deadly mistakes a decade ago," said Lisa McGiffert, Director of Consumers Union's Safe Patient Project ([www.SafePatientProject.org](http://www.SafePatientProject.org)). "That means a million lives and billions of dollars have been lost over the past ten years because our health care system failed to adopt key reforms recommended by the IOM to protect patients. As the debate over health care heats up in Washington, Congress should make sure that improving patient safety is a central part of any reform legislation it adopts."

The IOM's 1999 *To Err is Human* report estimated that medical errors cost the U.S. \$17-29 billion a year, and recommended sweeping changes to the health care system to improve patient safety. The IOM called for a measurable improvement in patient safety, stating it would be "irresponsible to expect anything less than a 50 percent reduction in errors over five years." The report prompted a flurry of activity in Washington, including seven high profile hearings in Congress and the introduction of five medical error bills. But none of those bills were adopted and progress in implementing a number of the IOM's key recommendations has been frustratingly slow.

"One decade later, we can't say whether we are any better off today than when the IOM first sounded the alarm about medical errors in 1999," said Arthur Levin, Director of the Center for Medical Consumers and member of the IOM's Committee on the Quality of Health Care in America, which issued the landmark *To Err is Human* report. "We can't wait another decade to take the steps needed to protect patients from deadly and costly medical errors. The time to act is now. Too many lives and health care dollars are at stake." Levin assisted Consumers Union with its report.

Consumers Union's report reviewed four key IOM recommendations to make health care safer:

**Implement safe medication practices:** According to the IOM, at least 1.5 million preventable medication errors cause harm in the U.S. and cost \$3.5 billion each year. Medication errors include administering or prescribing the wrong drug, providing the wrong dose, or using the wrong route to administer drugs to patients. The IOM recommended stronger oversight by the Food and Drug Administration (FDA) to address safety issues connected with drug packaging and labeling, similar name drugs, and post marketing

surveillance by doctors and pharmacists. Unfortunately, progress on reducing medication errors has fallen short of the IOM's vision. The FDA reviews new drug names for potential confusion that could lead to mistakes, but few existing names are changed. In addition, a 2008 American Hospital Association survey revealed that only 17 percent of hospitals were using Computerized Physician Order Entry (CPOE) systems, which could help reduce medication errors significantly. The survey found that 45 percent had no plans to implement CPOE systems. Finally, no reliable national medication error system that publicly discloses errors by facility is in place.

**Create Accountability Through Transparency:** The IOM recommended two national reporting systems to help reduce errors: a mandatory and public reporting system designed to encourage accountability, and a voluntary and confidential reporting system to help health care providers learn from their mistakes. Progress on reporting since 1999 has been made mostly on voluntary, confidential systems that do not create external pressure for change. Twenty four states do not have any medical error reporting requirements in place and most states that require error reporting do not disclose facility-specific information to the public about mistakes, a key incentive for improving patient safety. The federal Patient Safety and Quality Improvement Act of 2005 followed the same pattern of keeping all medical error reports gathered by Patient Safety Organizations confidential. While a network of hospital infection reporting systems is emerging, 24 states do not require infection reporting. Consumers Union recommends facility-specific reporting of medical harm that is mandatory, validated, and public.

**Measure the Problem:** In its 1999 report, the IOM noted that there was no cohesive effort to improve health care and called for the creation of a Center for Patient Safety within the federal Agency for Healthcare Research and Quality (AHRQ) to coordinate and monitor improvements. Ten years later, we still have no national entity comprehensively tracking patient safety and are unable to tell if we are any better off than we were a decade ago. AHRQ is attempting to do this, but its efforts are hamstrung by the lack of reliable medical error reporting. In its May 2009 report, the AHRQ noted that patient safety actually declined by almost one percent a year over the six years after the IOM report was issued in 1999 and stated that “[d]ata remain incomplete for a comprehensive national assessment on patient safety.” The AHRQ still points to the IOM's 1999 report as the best estimate of the magnitude of medical errors.

**Raise Standards for Competency in Patient Safety:** The IOM recommended a greater focus on patient safety by regulators, accreditors, and purchasers and called for periodic examinations of doctors and nurses to assess “both competence and knowledge of safety practices.” Over the past ten years, many initiatives to improve competency in patient safety standards have come from the private sector. While these efforts are laudable, the results have been fragmented and no process exists to promote and measure national improvement. The Joint Commission has attempted to use the accreditation process to ensure competency and adoption of its National Patient Safety Goals at hospitals. The Commission provides limited information regarding the performance of individual hospitals, however its efforts to monitor patient safety often have been criticized.\* There is scant evidence that physicians, nurses, and other health care providers are any more competent in patient safety practices than ten years ago.

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\*Revised 05/22/09