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Medical Quality

Why We Still Kill Patients

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A sensitive question has troubled me since I started researching, writing, and speaking about patient safety some 3 decades ago. It is this: Given the grim toll of preventable medical harm, why have so many good people in health care—colleagues, friends, and family—done so little to eliminate it compared to what could be done?

Here is how I bluntly phrased my answer to that question in a 2010 *Health Affairs Forefront* article: "Why we still kill patients: Invisibility, inertia and income."[1] A decade and a half later, and by a conservative estimate, well over one million preventable patient deaths later, this unsettling dynamic remains frustratingly relevant.

When it comes to invisibility, the aviation analogy we have heard innumerable times is that plane crashes are public, but medical errors occur in private. That is true, but other factors have played an important role.

For instance, although every patient harmed in the hospital has at least one diagnosis (correct or not), the patient safety community has never involved prominent disease groups like the American Heart Association and American Cancer Society in the fight against error. To these influential organizations, whose voice on behalf of patient safety would resonate with clinicians, the public, and policymakers, the extent of their constituents' harm remains largely invisible.

Similarly, the powerful stories told by patient activists generally fail to identify specific institutions where a loved one was harmed. Although sometimes that is because of legal constraint, often it is just an attempt to draw general lessons. The lack of specifics, however, allows professionals and the public alike to avoid confronting the personally uncomfortable reality that being a middle-class, educated patient at a high-reputation institution confers no immunity from harm.

Finally, one time-tested way to hide a problem is to obscure it in unintelligible language. For instance, a 1980 article provocatively entitled, "Iatrogenesis: Just What the Doctor Ordered," concluded: "We are awash in iatrogenesis."[2] That could have been a sensational soundbite years before the *To Err is Human* report—if, that is, the public recognized "iatrogenesis" as a Greek term meaning "the production of disease by the manner, diagnosis, or treatment of a physician." In other words "what the doctor ordered."

Since then, we have gone from Greek to geek, with technical jargon like HACs and HAIs, acronyms without individual accountability, referring to "health care-*acquired* conditions" and "health care-*associated* infections."

The invisibility of the scope of and responsibility for patient harm has led inevitably to inertia. David L. Katz, a physician who lost a loved one to medical error, came closest to explaining why good people allow bad things to happen. The problem, he wrote, is "a system populated mostly by genuinely caring and often highly expert people that nonetheless devolves into routine and dangerous dysfunction."[3]

Or as one journal commentary put it: "Clinicians have labeled virtually all harm as inevitable for decades."[4]

Many health system leaders adopt a similar attitude. In the *2022 AHRQ Survey of Patient Safety Culture*, 52% of respondents said hospital management seems interested "only after an adverse event happens."[5] Separately, an American Hospital Association survey found that just 50% of hospital boards listed quality among their priorities.[6]

A last note on enabling inertia. As the COVID-19 pandemic waned in 2021, the Joint Commission required hospitals to set a goal for hand hygiene compliance and show progress toward meeting it. But a closer examination revealed the new rule was essentially toothless. It stated: "There is no specific numerical target for this goal…and no requirement for organization-wide surveillance."[7]

Finally, there is income, the touchiest topic. For years, we have seen articles attempting to make the "business case" for patient safety. It is, frankly, infuriating. Were it any other life-and-death health issue, this kind of calculation would be condemned as morally beyond the pale.

Certainly, health systems must balance competing financial priorities. However, major expenditures are not the issue here. For instance, one article examined

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the business case for reducing central-line-associated bloodstream infections (CLABSIs) in the pediatric intensive care unit.[8] A similar study focused on the "attributable costs" of preventing CLABSIs in children hospitalized with blood cancer in order to "inform decisions regarding the value of investing in efforts to prevent CLABSIs in this vulnerable population."[9] In other words, does protecting seriously ill kids from being injured or killed boost the bottom line?

Not to overlook harm to adults, a recent journal article presented a "cost-benefit analysis" of implementing an evidence-based program for preventing falls, characterized as a "leading source of non-reimbursable adverse events." Even without reimbursement, the authors noted, a fall prevention program could cost just 88 cents per hospital bed.[10] A bargain! (My word, not theirs.)

These are just a few examples from the literature, and, to be clear, the articles' authors are not at fault. They are only holding up a mirror, and attempting to positively influence, the decisions by "genuinely caring" people, to echo Katz's phrase. In private, how many of us, like these authors, have seen patient safety actions axed due to an inadequate financial return?

If all this seems discouraging, the first step to solving a problem is facing it honestly. In this case, what must happen next is recognizing, encouraging, and strengthening efforts to break down barriers to change.

For instance, Leapfrog Group scores have illuminated heretofore-invisible individual hospital safety performance, incentivizing an end to inertia. As important, the scores also recognize high-performing institutions. The patient safety community should systematically highlight those examples to health system leaders and boards, as well as to policymakers and the media. What can be done to protect patients should be done, and done with a sense of urgency.

On the income front, Medicare has announced it will link hospital payment to public reporting on 5 domains of patient safety culture as part of its effort to promote value-based care.[11] This is a significant step we need to support.

Even if it is not always obvious—no lights flashing or monitors urgently beeping—we in the patient safety community are saving lives. But not enough, and not rapidly enough. We need to purposefully make invisible harm visible, replace inertia with accountability, and ensure that a catchy mantra about money and mission stops being a morally acceptable excuse for good people tolerating their patients suffering eminently preventable harm.

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Conflicts of Interest

The author has no conflicts of interest to disclose.

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