# Who killed patient safety?

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The medical community's commitment to patient safety has withered to over the past 10–15 years after the original call to action in 2000 with the release of the IOM report, To Err is Human.[1] The tragedy of this decline in action around safety lies in the lives of the families like ours, who have lost loved ones, been harmed, and often permanently injured by medical error. What was once a motivating call to action, safety in hospitals and oversight by our government has been deprioritized, defunded, and devalued leaving patients like us to wonder: What happened to Patient Safety?

When the *To Err is Human* (IOM) report was released in 2000 it estimated that 44,000–98,000 people lose their lives every year from medical errors in U.S. hospitals. The medical community was appalled by the estimate of preventable death and injury from medical errors to patients as identified in the seminal report. More recent research published by John James, in 2013, and Marty Makary, in 2016, suggested the original estimates underrepresented the amount of harm to patients caused by medical care which amounted to 400,000 or more lives a year.[2,3]

In *To Err is Human*, the IOM called for a public-private partnership to reduce medical errors by ninety percent in 10 years. And as a follow up in its 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the IOM positioned patient safety as fundamental to healthcare transformation.[4] Twenty years later, other than infection control to anesthesia, the American hospitals have not progressed in systemically meeting patient safety goals, and the medical community seems to have lost its commitment to safety. Unsafe healthcare now vies with Covid-19 as the third largest cause of preventable death in the United States, and many of those who used to be champions for safety have moved on to other issues. Yet, we the patients and families, know safety is fundamental, not something that can ever fall off the list of priorities since it is a critical part of safe care every patient deserves.

Earlier this year a peer review committee of the National Academy of Sciences (NAS), which now houses the IOM, published a discouraging report on the current strategies to improve patient safety finding:

> *[We] believe the country is at a relative standstill in patient safety progress. Although the original To Err Is Human report commanded national attention more than two decades ago, the country has not achieved the level of safety in daily patient care that we have come to expect from other industries, such as when we board an airplane. Continuing on the current trajectory is not likely to produce substantial improvements in patient safety.*[5]

In 2019 the World Health Organization (WHO) re-intensified its concern for patient safety as a world health priority, adopting a new resolution urging every state to adopt specific initiatives proven to have merit, and establishing September 17th as World Patient Safety Day to raise awareness. In 2021, WHO launched the "Global Patient Safety Action Plan 2021–2030" which sets forth seven strategic objectives.[6] It calls upon government, providers, patients, and other stakeholders, as well as, WHO itself to advance those objectives. WHO will track progress in a series of report cards for the next 9 years.

## So, where is patient safety going in the USA?

While WHO and its member states are ramping up efforts, it appears to us that patient safety is adrift in the United States. The organizations who used to oversee, lead, and support safety have moved on to other priorities. Safety is no longer a critical part of their strategies, oversight, and programmatic funding. It is time those organizations: Institute for Healthcare Improvement, National quality Forum, Agency for Healthcare Research and Quality, Joint Commission, Centers for Medicare & Medicaid Services, American Hospital Association, state hospital associations, and others do a deeper pause on their work to contemplate if they are leading in safety or they are complicit in the decline of safety in the U.S.

As patient leaders and advocates, this decline in safety commitment is frightening and unacceptable. Dedication to the reduction of medical error is now diluted by Covid-19, workforce safety, racial injustice, and "value." All are crucially important, but it is tragic to see them positioned to compete with patient safety. These issues are linked and should energize transformation that makes healthcare safe, fair, and accessible for everyone whatever their color or ethnicity, gender, disability, rich or poor, gay or straight, patient or healthcare worker.

To compound the marginalization of patient safety in the U.S., the national "lingo" about patient safety has been watered down. Once raw, direct, and infused with a sense of urgency, now boards, leaders, funders, and others are discouraged to use terms "error," or "medical harm". "Unanticipated outcome" or "patient safety event" are advanced as more technically and politically correct.

We acknowledge that the U.S. also has a new 10-year patient safety plan, launched in 2020 by IHI and AHRQ as *Safer Together: A National Action plan to Advance Patient Safety.*[7] While the plan calls for improvements that dovetail with WHO recommendations, we respectfully suggest that the U.S. plan lacks urgency and commitment by the institutions who deliver care. This plan is relying on the same public-private partnership for the last 20 years, thus will keep the United States on the "same trajectory" that, per the NAS report, is "unlikely to produce substantial improvements in patient safety." The status quo of activity, oversight and commitment will not get our care of patients to the 21st Century transformation in safety, equity, efficiency, effectiveness, timeliness, and patient-centered care envisioned by *Crossing the Quality Chasm*.

## Moving forward with urgency

The first strategic objective set forth in the WHO Global Patient Safety Action Plan 2021–30 is to "Make zero avoidable harm to patients a state of mind and a rule of engagement in the planning and delivery of health care everywhere".[6] In the U.S., splintered oversight of safety preserves the status quo. As patient and family advocates who have lost our loved ones to medical error it is disappointing to observe the lacking coordination among oversight bodies to create accountability for ensuring safety and coordinating improvement. Many of the governmental affiliated bodies seem to prioritize revenue preservation and consulting opportunities and often acquiesce to hospitals as their "clients" to make safety less of a priority or make oversight rules easier, not following their civic calling to protect patients and reduce harm. Today, the great hopes for shared learning in safety have not come to fruition. It is widely acknowledged that harm from medical errors is underreported by healthcare facilities and that they may or may not decide to investigate the harm. If they do, what they learn is often not shared outside their facility, healthcare system or the Patient Safety Organization (PSOs) of which they are members.

Transparency is the hallmark of commitment to improvement and learning—yet is still missing in healthcare.[8] With a few notable exceptions among healthcare systems, when harm occurs the wall of silence, defensiveness, and buried lessons-learned is still the norm. The time has come to establish an entity at the federal level that coordinates, gathers information, and disseminates the learning to patients and providers across the nation like other high reliability organizations, specifically aviation. Patients and families deserve at least the same level of commitment to safety and trust in their care delivery as passengers receive upon boarding a plane.

## Activating patient engagement to pursue zero harm in the U.S.

The fourth strategic objective in the WHO plan is to "Engage and empower patients and families to help and support the journey to safer healthcare." In 2004, WHO established a global network of "champions" led by patients and their family members called Patients for Patient Safety (PFPS). As its charter, the London Declaration, states:

> *We, Patients for Patient Safety … are committed to spread the word from person to person, town to town, country to country. There is a right to safe healthcare, and we will not let the current culture of error and denial continue. We call for honesty, openness, and transparency. We will make the reduction of healthcare errors a basic human right that preserves life around the world.*[9]

Other countries have established robust, nation based PFPS branches. Motivated by the urgency of our own experiences of harm and the WHO call to action, we have established a PFPS-US to bring together U.S. leaders interested in collaborating with patients and families toward renewed and dramatic improvement in safety. We are activated to create greater accountability for safety, change the course of care in the U.S., and break the institutional silence that has led to a decline in commitment to safer care. We invite you to join us and evaluate what your role can and should be to change the course of safety.

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### ORCID iD

Carole Hemmelgarn https://orcid.org/0000-0002-4682-3024

### Supplemental material

Supplemental material for this article is available online.

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**Carole Hemmelgarn**
*MedStar Institute Quality and Safety, Washington, DC, USA*
*Email: c.l.hemmelgarn@hotmail.com*

**Martin Hatlie**
*MedStar Institute Quality and Safety, Washington, DC, USA*

**Susan Sheridan**
*Independent Scholar, Boise, USA*

**Beth Daley Ullem**
*Independent Scholar, San Juan Capistrano, USA*