IOM Report Examines Medical Errors

by Donald D. Asmonga

Estimates attribute between 44,000 to 98,000 deaths each year to medical errors in hospitals, while more than 7,000 deaths are the result of medication errors occurring in all healthcare settings. According to the Institute of Medicine (IOM) report "To Err is Human: Building a Safer Health System," even the lower estimate means that medical errors take the lives of more people annually than motor vehicle accidents, breast cancer, or AIDS. Further, medication errors kill more individuals than workplace injuries.

If you find these figures staggering, you have a lot of company. The IOM report and its recommendations illuminated the health quality issue and put the focus squarely on the subject of patient safety. The clamor to find answers and reduce patient deaths caused by medical errors has come from editorial pages, the healthcare industry, the Clinton administration, Congress, and the American public.

The report, drafted by the Committee on Quality Health Care in America, asserts that "good people are working in bad systems that need to be made safer." In other words, medical errors are systemic in nature. The report also notes that liability concerns discourage employees from reporting errors. The committee has set a goal to reduce medical errors by 50 percent over the next five years. To do so, the IOM offered a four-part plan that includes financial and regulatory incentives to reduce medical errors and make our healthcare system safer.

Steps Toward Safety

First, the report recommends establishing a National Center for Patient Safety within the Agency for Healthcare Research and Quality (AHRQ) of the Department of Health and Human Services (HHS). The Center would be responsible for:

- setting national safety goals
- tracking progress towards goals
- investing in research to prevent mistakes and medical errors
- acting as a clearinghouse for the latest information on patient safety

The IOM estimates that the set-up cost for the National Center for Patient Safety would be between $30 and $35 million and that funding would ultimately need to grow to $100 million.

Second, the report recommends creating mandatory and voluntary reporting systems, such as a nationwide state-based mandatory public reporting system to "collect information on the most serious errors that result in death or permanent harm, and to use this information to better understand the factors that contribute to error, to encourage healthcare organizations to take the necessary steps to prevent future errors, and to keep the public informed of safety issues."[1]

The IOM also recommends that Congress pass legislation to protect the confidentiality of the information on medical errors that do not result in serious consequences. Without confidentiality protections, error information could be used in court and thus discourage voluntary reporting. The IOM hopes that confidentiality protections will encourage voluntary reporting systems at the local level so that errors can be corrected within the healthcare facility or practice.

Third, the report calls on consumers, professionals, and accreditation groups to strengthen the standards and expectations for improvements in patient safety. For example, the report recommends a periodic reexamination of healthcare providers based on their "competence and knowledge of safety practices." In addition, the report encourages the FDA to increase its attention to public safety by taking steps to eliminate similar-sounding drug names, confusing labels, and packaging methods that induce mistakes.

Finally, the report urges the healthcare industry to create a "culture of safety." This culture does not blame individuals but implements safety systems "to prevent, detect and minimize hazards and the likelihood of error." A culture of safety must start at the top of an organization where funding commitments are made to encourage, promote, and monitor safety. The primary intention of changing an organization's culture is to create an open environment so errors can be discussed.

Designing an Error Reporting System

Since the publication of the report and its recommendations in November 1999, Congress has held a number of hearings on this issue. So far, the focus is on the following questions:

- Should medical error reporting be mandatory, voluntary, or a combination of systems?
- Should a reporting system be controlled by the federal government or state-based?
- What role should liability play?
- What information should be made available to patients?

The answers to these questions will be the basis for creating an error reporting system that lends itself to reducing and stopping deaths from medical errors and identifying the errors before they occur.

At press time, only two bills have been introduced in Congress that address medical errors:

1. HR 3672, the Medication Error Prevention Act of 2000, was introduced by Rep. Constance Morella (R-MD). The bill would amend the Public Health Service Act to provide for voluntary reporting by healthcare providers of medication error information. The information would be used to assist appropriate public and nonprofit private entities in developing and disseminating recommendations and information with respect to preventing medication errors. The bill sets up a voluntary error reporting system based on the U.S. Pharmacopeia's MedMARx system.
2. The Medical Error Reduction Act of 2000, introduced by Sen. Arlen Specter (R-PA) and Sen. Tom Harkin (D-IA), would fund 15 demonstration projects to determine the best course of action for medical errors. Five projects would research the feasibility of voluntary reporting systems with confidential information. Another five projects would fund and study five mandatory reporting systems with confidentiality. The final five projects would fund and assess a mandatory reporting system with a requirement that the error be disclosed to the patient and the family.

HIM's Role in Error Reduction

Although numerous healthcare organizations have increased their efforts to monitor and reduce medical errors, there are strong indications that many in Congress believe this is too little, too late. It's likely that the medical errors issue will be addressed through legislation. If there is a strong bipartisan consensus on language, there is a remote possibility that provisions could be added to the Patients' Bill of Rights Act, which is currently being addressed in a House/Senate conference committee.

President Clinton has also taken an active approach to addressing the findings of the IOM report by including a call for $33 million in the fiscal year 2001 budget for the FDA to reduce errors related to proprietary drug names and packaging. Additionally, the budget includes $20 million to create a Center for Quality Improvement and Patient Safety to research medical errors. Finally, the president announced his support for a nationwide, state-based mandatory error reporting system, which would make aggregate information public without identifying patients or medical professionals. HCFA will also publish a regulation requiring Medicare participating hospitals to implement patient safety programs.

This issue will continue to be one of primary importance to AHIMA, because the resolution will affect HIM professionals working in quality improvement, risk management, data reporting, and information systems. As healthcare systems become more automated, HIM professionals will need to be involved in assessing the positives and negatives of various computer software programs. How well does a specific program reduce errors? Although a program may reduce errors, what type of new errors can it cause?

As Congress and other policy makers continue to research medical errors, education will continue for those in the healthcare system. The central tenet to maintain is that the patient must be at the forefront of any policy that is ultimately devised. To

improve patient safety, a medical error reporting system must be able to identify the common error-producing factors so institutions can establish prevention measures.

This process may offer insights into new ways to improve the health information management process. As one quality management expert notes, "What we benefit from patient safety may be transferable in improving efficiency and processes in the health information management department."[2]

Notes

1. Cassell, Christine K. Testimony to the House Ways and Means Health Subcommittee, February 10, 2000.
2. Spath, Patrice L., ed. *Error Reduction in Health Care: A Systems Analysis Approach to Improving Patient Safety*. San Francisco: Jossey-Bass Publishers, 1999.

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