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BURDA ON HEALTHCARE

Forgetting — Or Ignoring — An Important Patient Safety Anniversary

By David Burda
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Last month marked an important healthcare anniversary. It was the 25th anniversary of To Err Is Human: Building a Safer Health System. Published by the Institute of Medicine (today the National Academy of Medicine) on Nov. 29, 1999, the report sparked the modern patient safety movement after estimating that nearly 100,000 people die each year from medical mistakes.

I remember the report's release like it was yesterday because it marked one of the biggest mistakes I made in my 41-year journalism career. I was news editor of Modern Healthcare at the time. We got an embargoed copy of the report on Friday, Nov. 26, 1999, with a release date of Monday, Nov. 29, 1999. Our weekly print edition came out on Mondays.

I asked our patient safety reporter whether he thought the report was big news. He said he read it, and he said it wasn't because it was based on secondary, not original, research. I believed him, and after the report exploded into national news three days later, we had egg on our face as the healthcare industry's leading publication. I don't remember if we had ignored the story completely or wrote a two- or three-sentence brief on our News at Deadline page.

Either way, the reporter outsmarted himself and I was stupid. From that point forward, if a reporter told me a story that I thought was newsworthy wasn't, I immediately assigned the story to another reporter. Trust your own news judgment and own the consequences.

Well, a lot of too-smart-for-their-own-good healthcare reporters must have told their stupid editors that the 25th anniversary of To Err Is Human wasn't worth reporting on this year. I expected a slew of pieces asking the question: Are we safer now than we were 25 years ago? I don't recall seeing any last month. If you did, please send them to me for a follow-up piece to this column.

So, I will take it upon myself to answer the question via some secondary research. Below is my lit review.

MORE SECURE MESSAGING, MORE WRONG PATIENT ORDERS

JAMA Network Open published a study on Dec. 4, 2024, that looked at the correlation between the use of secure messaging by physicians and accuracy of patient orders made through secure messaging. The study pool consisted of more than 3,200 physicians, medical residents, medical fellows and advanced practice practitioners at 14 hospitals affiliated with the BJC HealthCare system and who use the system's secure messing apps embedded in its Epic EHR system to send patient orders to one another. The study found a positive correlation between volume of messages and order mistakes. The more messages sent, the higher the number of mistakes. "These findings may have implications for patient safety" as secure messaging apps proliferate in hospitals and health systems, the researcher said. Ya think.

AI TOPS LIST OF HEALTHCARE TECH HAZARDS FOR 2025

ECRI, the Plymouth Meeting, Pa.-based patient safety organization, released its annual ranking on Dec. 4, 2024, of the top 10 healthcare technology hazards for the upcoming year. Topping the list of what to watch out for in 2025 was AI-enabled health technologies. Citing data bias, AI hallucinations, data drift and the brittleness of many AI models, ECRI said, "Placing too much trust in an AI model — and failing to appropriately scrutinize its output — may lead to inappropriate patient care decisions." The list wasn't all high tech. (FWIW, secure messaging didn't make it.) Low tech made the list, including medical adhesive products that can injure patients' skin. Ouch.

MORE THAN 1 IN 3 SURGERY PATIENTS EXPERIENCE ADVERSE EVENTS

The BJM (British Medical Journal) published a study on Nov. 14, 2024, that looked at the frequency of adverse events for patients undergoing surgery. The study pool was a random sample of 1,009 patients who had surgery at 11 Massachusetts hospitals in 2018. Overall, 383 patients, or 38%, experienced one or more adverse events. One hundred and sixty patients, or 15.9%, experienced one or more "major" adverse events. The researchers defined "major" as serious, life-threatening or fatal. There was a total of 593 adverse events of which 225, or 37.9%, were major. Of those, 63.2% were potentially, probably or definitely preventable. "These findings emphasize the critical need for ongoing improvement in patient safety, involving all health professionals, throughout perioperative care," said the researchers, who, to their credit, mentioned To Err Is Human in the introduction to their study. Someone remembered.

NEARLY ONE IN FOUR HOSPITALIZED PATIENTS EXPERIENCE DIAGNOSTIC ERRORS

The journal BMJ Quality and Safety published a study on Oct. 2, 204, that examined the frequency of diagnostic errors experienced by patients in the hospital. A random sample of 675 patients hospitalized between July 2019 and September 2021 made up the study pool. Overall, 154 patients, or 22.8% of the total, experienced 160 diagnostic errors. An unlucky few experienced more than one error. Eighty-two patients, or 12.1% of the total, experienced what the researchers called "harmful diagnostic errors," or mistakes that led to another clinical problem, extended hospital stay, visit to the intensive care unit or a one-way trip to the hospital morgue. The researchers said 85% of the harmful diagnostic errors were preventable. And you think AI is going to solve this problem?

DIAGNOSTIC ERRORS CAUSE MORE THAN ONE-THIRD OF ADVERSE PATIENT EVENTS

Speaking of diagnostic errors, ECRI, the aforementioned patient safety organization, released an analysis on Sept. 5, 2024, of more than 3,000 adverse patient safety events that happened in 2023. ECRI's deep dive found that 34% of the adverse events were related to diagnostic errors. Of those diagnostic errors, nearly 70% occurred during the testing phase, i.e., ordering, processing, getting test results or communicating test results. Of those that happened during the testing phase, more than 23% were technical or processing errors, and 20% were things like mixed-up samples, mislabeled specimens and tests done on the wrong patient. Sounds like a lot of secure messaging is going on.

DEATH TOLL FROM ANTIBIOTIC-RESISTANT BACTERIA IS RISING DRAMATICALLY

The journal Lancet published a study on Sept. 28, 2024, on the "global burden" of antibiotic-resistant bacteria. Researchers pored through more than 500 million patient records from 204 countries to find out how many deaths were associated (correlated) with or caused by antibiotic-resistant bacteria. Our collective failure to be good antibiotic stewards has led to this mess. Here's what they found. Some 4.7 million deaths worldwide were associated with antimicrobial resistance in 2021. They projected that the number of deaths will nearly double to 8.2 million a year by 2050. That means 169 million people will die cumulatively over the next 25 years from antibiotic-resistant bacteria. That's a lot of preventable deaths.

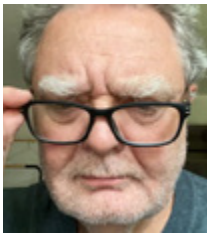
NUMBER OF REPORTED HOSPITAL INFECTIONS DROPPED LAST YEAR

Let's end with some good news, shall we? And I use the word "good" guardedly. The Centers for Disease Control and Prevention (CDC) released its latest annual report on healthcare-associated infections, or HAIs, on Nov. 6, 2024. The National and State Healthcare-Associated Infections Progress Report tracks six types of infections acquired by patients in acute-care hospitals, critical access hospitals, inpatient rehabilitation facilities and long-term acute care hospitals. Nearly 4,000 acute-care hospitals reported data to the CDC. Actual versus expected cases dropped for five of the six HAIs last year. The actual versus expected cases rose for one. Translated into numbers, total HAI cases dropped 13.1% last year to 124,385 from 143,142 in 2022. That was great news for the 18,757 patients who the CDC expected to get an infection in the hospital last year but didn't. Huzzah. No so great news for the nearly 125,000 patients who did and got sicker or died after they went to the hospital to get better.

So, are we safer now than we were 25 years ago?

No.

AUTHOR



David Burda began covering healthcare in 1983 and hasn't stopped since. Dave writes this monthly column "Burda on Healthcare," contributes weekly blog posts, manages our weekly newsletter 4sight Friday, and hosts our weekly Roundup podcast. Dave believes that healthcare is a business like any other business, and customers — patients — are king. If you do what's right for patients, good business results will follow.

Dave's personnel experiences with the healthcare system both as a patient and family caregiver have shaped his point of view. It's also been shaped by covering the industry for 40 years as a reporter and editor. He worked at Modern Healthcare for 25 years, the last 11 as editor.

Prior to Modern Healthcare, he did stints at the American Medical Record Association (now AHIMA) and the American Hospital Association. After Modern Healthcare, he wrote a monthly column for Twin Cities Business explaining healthcare trends to a business audience, and he developed and executed content marketing plans for leading healthcare corporations as the editorial director for healthcare strategies at MSP Communications.

When he's not reading and writing about healthcare, Dave spends his time riding the trails of DuPage County, IL, on his bike, tending his vegetable garden and daydreaming about being a lobster fisherman in Maine. He lives in Wheaton, IL, with his lovely wife of 40 years and his three children, none of whom want to be journalists or lobster fishermen.

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