

The Oregonian

Results not for the squeamish

The first report on hospital errors shows improvement is a matter of life and death

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Recently, the Oregon Patient Safety Commission issued its first draft report on hospital errors. It had a brisk yet kindly bedside manner, concise and numerical, with a gentle touch of euphemism about "adverse events." Even so, the report was not for the squeamish. It was absolutely terrifying.

Between May and December last year, Oregon hospitals reported 53 preventable errors, including 18 that resulted in patient deaths. The 18 fatal errors included perforations during surgery, infections, falls, diagnostic or treatment delays and communication tangles among different medical providers.

Eight times, surgeons did the wrong surgery, operated on the wrong body part or in some way bungled the administration of anesthesia. Ten times, a surgical team left objects in a patient.

"It is an eye-opener," said Jim Dameron, administrator of the Oregon Patient Safety Commission. "It speaks in its own humble way about the complexity of providing medical care." Surgical teams, in vigilantly tracking a patient's vital signs, may lose track of something that doesn't seem as vital, like a sponge.

Many hospitals already have protocols to help them avoid such errors, but the Oregon Patient Safety Commission will take the data it has collected, hone in, and try to design even more effective approaches.

All in all, this report is every bit as painful and awkward as hospitals knew it would be. And chances are, the report barely skims the surface. Fifty-two of Oregon's 57 hospitals participated in this voluntary reporting program, but a safe guess is that dozens of "adverse events" went unreported. Eight years ago, a report that galvanized the nation estimated hospital errors cause somewhere between 44,000 and 100,000 deaths a year.

The whole idea behind the Oregon Patient Safety Commission is to encourage hospitals to report errors and learn from them, instead of covering them up. But it takes time to create such an atmosphere. In some ways, the whole idea goes against self-protective human nature. Even with anonymity and with hospitals backing the concept, it's hard to convince doctors and nurses to admit their imperfections.

But already, hospitals have learned that they can prevent hospital-caused infections. They used to be considered inevitable, just the price of taking care of people in institutions. And soon, by the way, hospitals won't be the only ones feeling the push to improve. The Oregon Patient Safety Commission will also be looking at ways to prevent errors in nursing homes, pharmacies and ambulatory surgery centers.

For those critics who say (or think it, even if they don't say it), oh well, mistakes are inevitable, Dameron has a question: "Do you mean to suggest that we'll never reduce medical errors to zero, and that, as a result, we'll lose credibility by trying?"

"Perfection might not be possible, but the research says that 50 to 70 percent of adverse events can be avoided. . . . That's a lot of lives saved, a lot of harm prevented."

This new report shows why constant improvement should be every hospital's goal. Some minimal discomfort is involved for hospitals, but it's worth it to maximize the comfort and safety of patients.