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Patient Safety; Pennsylvania as the Tail or the Head

The Patient Safety Authority is in the process of preparing its 2014 Annual Report to the legislature, as required by law. The Patient Safety Authority was created when Governor Schweiker signed House Bill 1802 "Medical Malpractice Reform," March 20, 2002. "Patient Safety Authority" was the brainchild of the Institute of Medicine and was prominently touted in its 1999 report "To Err is Human, Building a Safer Health System." The Institute of Medicine published the shocking statistics that well over 100,000 people a year die in American hospitals as a result of preventable errors. Preventable deaths in the American healthcare system were one of the leading causes of death in the United States. Unfortunately this trend has only continued upward in the intervening years. However, Pennsylvania has attempted to make a dent in this national problem by the creation of its own Patient Safety Authority. I was an original appointee to the Patient Safety Authority where I continue to serve.

The Patient Safety Authority in Pennsylvania has grown from a small group of dedicated professionals to a major entity interacting with virtually every healthcare provider in the Commonwealth. The emphasis must be on "patients" and the question needs to be answered as to whether the Pennsylvania Patient Safety Authority has made a difference? The Pennsylvania Patient Safety Authority likes to say that it is "non-regulatory and non-punitive." However, one of the statutory responsibilities of the Patient Safety Authority in Pennsylvania is to coordinate with the Department of Health, to identify infrastructure failures for DOH and to be available to whistleblowers. While the Authority is not intended as a primary regulator in Pennsylvania, it is supposed to coordinate its responsibilities with the Pennsylvania Department of Health. The Authority has the ability, and in some cases, the obligation to report noncompliance, under the statute, to the Department of Health. Hospitals must report "incidents" and "serious events." So called "incidents" are those where there has been a failure but no harm. "Serious events" are to be reported not only to the Pennsylvania Patient Safety Authority but, unlike "incidents", also to the Department of Health and to the patients or their families. While all incident reports are confidential and not discoverable in litigation, serious events must be reported to the Department of Health and to patients or their families.

For the last several years I have presented an update on the Pennsylvania Patient Safety Authority to the Pennsylvania Bar Institute Health Law Consortium. Each year the highlight and focus of my presentation has been either the Executive Director of the Patient Safety Authority or prominent physician in the state. This year I talked with Dr. David Nash who introduced me to Dr. Rachel Sorokin. Both Nash and Sorokin are at Jefferson and are extraordinary talents.

Dr. Sorokin will be presenting at the Health Law Consortium on March 12th in Philadelphia. Recently I had the opportunity of reading Dr. Nash's book, Demand Better! Revive Our Broken Healthcare System. It is serious food for thought.

The doctor addressed a number of myths about the healthcare system. First and foremost, he said that doctors believe that they practice based on evidence and the problem lies elsewhere: "They blame it on medical liability; doctors reorder treatments and tests because they're worried about getting sued for malpractice." Dr. Nash found that there is good evidence that liability issues account for only 8 or 9% of the total cost to the healthcare system. Doctors find this hard to accept.

More healthcare does not necessarily mean better healthcare, concludes the doctor and his co-author, Sanjaya Kumar, MD, MSc, MPH. More care may actually cause more harm. The doctors conclude that we wrongly embrace a culture belief that more medicine is better, that scientifically backed reasoning drives more physician decision-making and that treatments physicians recommend are reliably effective. A mountain of evidence shows otherwise.

Perhaps most disturbing is the Myth, that our healthcare is safe. There is an epidemic of medical harm and error, conclude the physicians. Failure to use effective treatment such as beta-blockers and aspirin for heart-attack patients, for example, may mean that as many as 18,000 of these patients die each year in the United States. There are patient-safety lapses in physician offices as well, which often does not get much attention. When patients are discharged from the hospital, the records that summarize their care, medication and treatment plans are often missing or incomplete. "Two-thirds of the time, a patient's primary physician doesn't have the discharge summary and time for the patient's first visit out of the hospital." Medical records are indecipherable and sometimes impossible to use. Electronic medical records have made the system even worse. Discharge summaries lack significant information, and the system can only be described as "broken." Patients have been inadvertently injected with fatal doses of insulin because its bottle and label were nearly identical to Heparin, a blood thinner. Unfortunately, the doctors conclude that our healthcare system is poorly equipped to handle the aftermath because of its culture of silence. "The way in which our system treats family members whose loved ones have been harmed or killed by medical errors can be deplorable, marked by a culture of fear, blame and cover-up." Drs. Nash and Kumar say what every medical malpractice lawyer knows; most people call a lawyer because they simply want answers. Healthcare organizations need to make the transformation from denial and secrecy to honesty and openness when preventable errors harm patients.

The doctors also review information concerning our payment system and the absurd differences in the costs of providing healthcare. Preventative care is not rewarded, and patients fail to recognize that physicians and hospitals are in fundamentally different positions. Physicians work for hospitals. "Simply put, physicians and hospitals are in the disease business, not the wellness business."

It is claimed that medical schools are not doing a good job. While young doctors are willing and enthusiastic, their curriculum does not contribute to patient safety. Pure science is not necessarily the same as teaching prospective doctors how to make good decisions.

The book is accompanied by Part 2, Myth Busters. The doctors recommend greater patient engagement as a way to put pressure on moving doctors toward a better evidentiary basis for their practices. Patients, thanks to the internet, are bringing their doctors new information and doctors must use that information in an effective, organized and sincere way. The doctors seem to be in favor of tying reimbursement to effectiveness of treatment. Medicare should make coverage decisions based on effectiveness as a way to achieve cost control without limiting access to medical services. In Myth Buster 3, the doctors address the question of accountability. Pennsylvania has attempted to address the question of accountability through the Pennsylvania Patient Safety Authority, but the Authority posits itself strictly as non-punitive. What that means is that the Patient Safety Authority does not have much force except to point out to hospitals and doctors that there may be a particular problem at an institution because of the number of errors. Nevertheless, the authors do see Pennsylvania as pioneering a national effort to mandate health associated infection reporting. Infections have fallen in Pennsylvania as a result of the reporting, argue the physicians. Consumers do not and should not care about report cards, which really is nothing more than hospital advertising. Consumers need a different kind of report card: one that portrays risk, not benefit. If a patient goes to a particular hospital, the patient wants to know the hospital-acquired infection and error rates, not the severity adjusted morbidity and mortality for open-heart surgery. Pennsylvania's HAI report card is an example of what consumers care about. Nash and Kumar no doubt will shake up a lot of physicians. The authors believe that accountability mandates penalties. Accountability also means saying you are sorry. Successful formal apology systems work and discourage lawsuits rather than encourage them. Patients must be able to understand what hospitals and doctors are doing right and wrong, and there must be complete transparency.

Myth Buster 4 concerns paying for performance. Medicare is working hard to connect pay with performance, but has a long way to go. Patients can now be tracked after their hospital stay to determine whether the care provided actually prevented short and long-term complications and duplication of services. Bundled payment systems seem to work, although there is still much work to be done on that. The authors believe that we can learn to coordinate health care service and align the incentives of various providers, especially if the payment system is aligned. For anyone interested in patient safety and hospital/doctor effectiveness, Demand Better!, written by two notable and highly respected physicians is a must-read.

The Pennsylvania Patient Safety Authority has plenty of work ahead of it. The goals need to include the following:

1. Better attempts to understanding, report and address infrastructure failures;
2. Outreach to patients;
3. Serious problems in electronic medical records and making those records more usable, accessible and honest;

4. More reliable reporting of “serious events” both to PSA/DOH and patients;
5. A higher comfort level for potential whistleblowers so that they will actually blow the whistle;
6. Addressing the concerns of some physicians that we should as the PSA suggest legislation whereby reporting of individual hospitals will occur rather than by a mere regional reporting;
7. Addressing national trends to see where the PSA fits. We know that in 2014 there were increased concerns about preventable medical deaths in hospitals. The question is where does Pennsylvania stand in that universe? What are other states doings? What is driving those increased rates of death and is there a problem in Pennsylvania?

Is Pennsylvania the head of the lion or the tail on the fox? Are we leaders or followers? The Pennsylvania Patient Safety Authority has a big job to do in protecting the patients of Pennsylvania and the legal system must provide compensation to those injured victims of preventable medical errors.

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