Safety in Health Care: An Essential Pillar of Quality

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Each year, 40,000 to 98,000 deaths occur due to medical errors.[1] The Harvard Medical Practice Study (HMPS), published in 1991, found that 3.7% of hospitalized patients were harmed by adverse events and 1% were harmed by adverse events due to negligence.[2] The latest HMPS showed that, despite significant improvements in patient safety over the past 3 decades, patient safety challenges persist. This study found that inpatient care leads to harm in nearly a quarter of patients, and that 1 in 4 of these adverse events are preventable.[3]

Since the first HMPS study was published, efforts to improve patient safety have focused on identifying causes of medical error and the design and implementation of interventions to mitigate errors. Factors contributing to medical errors have been well documented: the complexity of care delivery from inpatient to outpatient settings, with transitions of care and extensive use of medications; multiple comorbidities; and the fragmentation of care across multiple systems and specialties. Although most errors are related to process or system failure, accountability of each practitioner and clinician is essential to promoting a culture of safety. Many medical errors are preventable through multifaceted approaches employed throughout the phases of the care,[4] with medication errors, both prescribing and administration, and diagnostic and treatment errors encompassing most risk prevention areas. Broadly, safety efforts should emphasize building a culture of safety where all safety events are reported, including near-miss events.

Two articles in this issue of *JCOM* address key elements of patient safety: building a safety culture and diagnostic error. Merchant et al[5] report on an initiative designed to promote a safety culture by recognizing and rewarding staff who identify and report near misses. The tiered awards program they designed led to significantly increased staff participation in the safety awards nomination process and was associated with increased reporting of actual and close-call events and greater attendance at monthly safety forums. Goyal et al,[6] noting that diagnostic error rates in hospitalized patients remain unacceptably high, provide a concise update on diagnostic error among inpatients, focusing on issues related to defining and measuring diagnostic errors and current strategies to improve diagnostic safety in hospitalized patients. In a third article, Sathi et al report on efforts to teach quality improvement (QI) methods to internal medicine trainees; their project increased residents' knowledge of their patient panels and comfort with QI approaches and led to improved patient outcomes.

Major progress has been made to improve health care safety since the first HMPS was published. However, the latest HMPS shows that patient safety efforts must continue, given the persistent risk for patient harm in the current health care delivery system. Safety, along with clear accountability for identifying, reporting, and addressing errors, should be a top priority for health care systems throughout the preventive, diagnostic, and therapeutic phases of care.

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