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Front-page news

The media finally realizes patient safety is an important story

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I remember when I first started pitching stories about healthcare quality to news editors. There would be a moment of dead silence, followed by the question, "Anything else going on?" Sometimes I'd try showing them a story in the *New York Times* about big employers paying more attention to quality as their healthcare costs rose. Mention of the Old Gray Lady usually bought me a few more minutes of discussion. But frankly, to most editors, reporting on healthcare quality seemed about as interesting as an academic treatise, even though they were eager to cover what other industries were doing to improve their products and services.

Then, at some point in the 1990s, patients came into view--patients who were harmed, even killed, because of poor quality. The tried and true explanation that these were isolated "mistakes" and that individual doctors were to blame was confronted with a growing body of research arguing that bad systems--defects in the processes of care--were to blame far more than bad physicians.

The full magnitude of these underlying flaws and how endemic they are to the day-to-day workings of healthcare really hit home in 1999 with the publication of the Institute of Medicine's report, *To Err Is Human: Building a Safer Healthcare System*. Its nearly 300 pages came down to one disturbing fact--as many as 98,000 people die each year in U.S. hospitals as a result of avoidable medical errors. Subsequent studies have announced equally alarming statistics, such as the fact that 2 million patients develop nosocomial infections each year and 90,000 die as a result.

Suddenly, the movement to make quality the watchword of healthcare--a movement that had been respectfully plodding along--gained new momentum. The hard facts about medical errors were like manna from heaven, from a galvanizing point of view. The public had been warned and so had the people who paid healthcare's bills. The big story was what was the system going to do to erase this black eye?

Five years after *To Err Is Human* was published, I went to work for the Institute for Healthcare Improvement, an organization founded by pediatrician Donald Berwick to carry out his goal of reinventing the healthcare system. My job is to identify stories that will encourage the media to cover the issues surrounding that transformation. The terms used to describe the work haven't gotten any jazzier than when I was attempting to cover this story. The difference now is that concepts such as root-cause analysis and failure modes and effects analysis are critical to something every editor is coming to understand: Healthcare has gotten serious about fixing defects in order to deliver the right care to the right patient, at the right time, every time.

Promoting stories on quality has also gotten easier because there is growing evidence that process improvement yields huge results in things readers can easily relate to, such as fewer hospital-acquired infections, shorter waiting periods for doctor appointments, better surgical outcomes, and faster and better treatment in emergency departments.

The satisfaction we get working at the IHI is enhanced when we see with data what hospitals can achieve, and that the public attention drawn to these issues by the media may finally be reversing decades of healthcare provider intransigence: It's no longer acceptable to have average or below-average performance.

More than 2,800 hospitals have decided to join an IHI campaign to avoid 100,000 unnecessary patient deaths by June 2006. Some speculate that the 100K Lives Campaign is riding the wave of healthcare's resurgence as a top political issue; others believe that the handwriting is on the wall in terms of providers having to pay the piper--and answer to accreditation bodies--for poor quality and that healthcare leaders now know that improvement has everything to do with the bottom line.

However, it's not just brass tacks. Anyone who's been around a healthcare leader or front-line staff member smitten by the possibility of better patient care and more satisfying work days knows what I'm talking about. At a minimum, people rediscover why they went into medicine or work in the industry in the first place--so much so, they now want to learn anything and everything about patient safety and practically inhale the information that can be applied.

The momentum behind quality improvement is reflected in increased media coverage. According to a Kaiser Family Foundation study published in late 2001, coverage of big health policy issues increased 34% in the four years prior. It's not clear if that trend has continued, but there's evidence more reporters are catching onto the once eye-glazing "quality story" and realizing it's worth the time and effort to figure out what's going on. The irony of course is that this fundamental embedding of quality improvement into day-to-day healthcare practice isn't the stuff of screaming headlines--indeed it's the antidote that promises to gradually strip the front page of stories about patients being harmed or dying tragically due to medical errors.

Reinvention of this magnitude can of course become the huge new story about healthcare if reporters are willing to suspend their disbelief and abandon the view that broken systems never really change; the truth appears to be just the opposite.

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