A BRIEF HISTORY OF THE PATIENT SAFETY MOVEMENT

1905: A case came before the Supreme Court, involving a female epileptic who sued her surgeon for removing her uterus and ovaries without telling her his intentions in advance. The surgeon argued that he had deceived the patient so that she would not resist having the "needed" procedure. The court ruled in favor of the patient, asserting that even the most "eminent" physician or surgeon cannot violate a patient's body without prior consent.

1943: A nationwide epidemic of diarrhea among newborns killed close to two-thirds of all afflicted babies. A medical researcher investigating the problem discovered that hospital administrators elected not to seek help from the local health department because they feared bad publicity.

1950s: Loyal Davis, a regent of the American College of Surgeons, was nearly expelled from Chicago's medical society for dishonoring the profession's good name because he honestly answered a reporter's question about the prevalence of fee splitting.

Mid 1950s: Researchers began reporting the problem of patient safety in the medical literature. Various reports revealed the regular deaths and injuries that occurred following treatment.

1954: A prominent forensic medical specialist stated that 50 to 80 percent of malpractice suits could be eliminated if physicians would stop criticizing one another's "unavoidable" errors.

1955: A shocking article on medical errors concluded that errors were merely the price to be paid for "the inestimable benefits of modern medicine."

1958: Journalist Richard Carter's *The Doctor Business* exposed the excesses of "commercial medicine."

1965: Because of poor care by a doctor who had not set a fracture in three years, an 18-year-old Illinois boy had to have his leg amputated. Since the boy was treated at a non-profit hospital (typically viewed as "charities" in those times and immune to malpractice suits), the hospital argued that it only "provided the setting" for doctors to practice. The Illinois Supreme Court, however, ruled that patients who "avail themselves to 'hospital facilities' expect that the hospital will attempt to cure them, not that the nurses and others 'will act on their own responsibility.' "

1966: Journalist Martin Gross', *The Doctors*, estimated that two million unnecessary operations were performed annually.

Early 1970s: The courts began forcing doctors to disclose to their patients not only the procedures to be performed, but also the benefits and possible negative effects.

1970: Sociologist Eliot Freidson argued in his book, *Profession of Medicine: A Study of Sociology of*

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Applied Knowledge, that even obvious preventable errors were not enough to prompt collegial correction. When Freidson asked physicians what they would do if confronted with a colleague whose behavior violated acceptable norms of conduct, most replied, "Nothing."

1971: Surgeon "Lawrence Williams" (writing under a pseudonym to protect himself from collegial retaliation) published an "insider"s guide" to shoddy medical practices entitled, *Unnecessary Surgery*.

1974: An estimate that as many as 30,000 to 140,000 hospital patients suffered fatal drug reactions every year became big news.

1978: Physician-attorney Don Harper Mills studied whether a surge in judgments for patients in malpractice cases was due to poor quality of care or excessive litigation. His study, "Medical Insurance Feasibility Study – A Technical Summary," which appeared in the *Western Journal of Medicine*, surveyed medical charts at 23 California hospitals. Mills concluded that one patient in 20 was harmed by medical error and four out of a 100 of these "events" caused major, permanent disability. The "good news," however, was that few of these errors resulted in lawsuits or legal judgments against physicans.

1979: Robert Mendelsohn asserted that an attitude of "see no evil" was still persistent in the medical profession. In his book, *Confessions of a Medical Heretic*, Mendelsohn wrote, "If you're in the operating room and somebody finds a sponge in the belly left from a previous operation, traditional ethics would make sure that somebody in the family found out about it. Medical ethics will tell you to keep your mouth shut about it."

1980s: A television expose of anesthesia accidents led the American Society of Anesthesiologists to form a patient safety committee.

1991: The Harvard Medical Practice Study used medical chart review of New York State hospitals to document a level of error similar to what Mills had found a decade before. Researchers concluded that four out of ten errors in administering a drug could be prevented.

December 21, 1994: A pair of articles concerning medical errors appeared in the *Journal of the American Medical Association (JAMA)* challenging the prevailing paradigm of medical practice. These articles caught the attention of a National Public Radio reporter, who highlighted one author's characterization of the death toll due to error as equivalent to "two 747s crashing every three days." The NPR story prompted *The Washington Post* to write an article about the problem, which, in turn, drew national news coverage.

Early 1995: An epidemic of errors erupted in the nation's hospitals. In Grand Rapids, Mich., a surgeon operating on a 69-year-old woman mastectomy patient removed the wrong breast, and a New York woman died when a doctor mistook her dialysis catheter for a feeding tube and

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ordered food pumped into her abdomen. These mistakes received intense coverage by the news media, ranging from tabloid shows to the editorial pages of *The Wall Street Journal*.

March 23, 1995: Richard Knox's page-one article for the *Boston Globe*, "Doctor's Orders Killed Cancer Patient," detailed the death of Betsy Lehman, a health columnist for the *Boston Globe*, from a massive overdose of an anti-cancer drug. Following Lehman's death, the CBS news show, *48 Hours*, aired a special report about seven cases in which patients had accidentally been given cisplatin instead of a less toxic chemotherapy drug.

1996: Prompted by public concern over errors, hospitals and others in Massachusetts formed a Coalition for the Prevention of Medical Errors. The American Medical Association and the American Hospital Association began talking more openly about medical mistakes. The AMA also set up a National Patient Safety Foundation which funds research on error prevention.

1997: A study in a Chicago teaching hospital found 18 percent of patients suffered a serious adverse event, yet only one percent of patients filed a claim for compensation – not far different from the absence of effective litigation found by Mills 25 years before

Late 1997: A freelance journalist wrote an account in the financial magazine, *Worth,* of his pregnant wife's and newborn son's deaths due to poor care by a well-known New York obstetrician.

October 1998: A cover story in *USA Today,* "Aviation's Safety Prescriptions Land in Operating Rooms," explored the health care system's approach to preventing medical errors

February 1999: *The New Yorker* ran a piece by a physician detailing his own unintended errors.

March 1999: *Boston Globe* reporter Larry Tye received a tip about a suburban Boston hospital that had failed to follow a Massachusetts law requiring errors to be reported to the state. This led to a four-part series on medical errors. Those stories led to hearings in the state legislature.

September 1999: The *Philadelphia Inquirer* ran a four-part series on medical errors by reporter Andrea Gerlin. The bankruptcy of the Allegheny Health System's Philadelphia hospitals in 1998 had provided Gerlin with a detailed account of incidents, claims and lawsuits at Philadelphia's MCP Hospital from January 1989 through June 1998. This series was reprinted by more than 20 newspapers, often with sidebars detailing medical errors in local communities.

November 29, 1999: The Institute of Medicine released *To Err is Human*, a report which asserted 48,000 to 98,000 Americans died in hospitals every year due to preventable medical errors. This report unleashed a flurry of news stories. A few weeks later, a poll by the Kaiser Family Foundation showed 51 percent of the public knew of the report's conclusions.

Early 2000: A group of prominent chief executive officers of major corporations in Pittsburgh

persuaded local hospitals, doctors and health care workers to pledge to eliminate all preventable drug errors and nosocomial infections.

2000: The U.S. General Accounting Office produced a report on adverse drug events. Legislation to require medical error reporting was introduced in Congress, and eight state legislatures passed error-related laws. Following the IOM report, executives at General Motors and DaimlerChrysler applied the figures from this report to their own work population and produced their own estimates, such as: "One death of a DaimlerChrysler employee, dependent or retiree every other day."

May 2000: St. Louis' Gateway Purchasers for Health organized a seminar designed to call "urgent" attention to the "human and dollar costs of medical errors," indicating that employers on a regional basis were beginning to realize lives and money can be saved by combating medical errors.

November 2000: The Leapfrog Group, a coalition of Fortune 500 employers, began pushing hospitals to install computerized physician order entry systems to prevent medication errors; to use intensivists to reduce the death rate; and to refrain from doing a low volume of surgeries in certain instances.

Late 2000: A four-part documentary "Why Doctors Make Mistakes," aired on British television.

Late 2001: Fifteen states had mandatory adverse event reporting laws. Five states and the District of Columbia had voluntary reporting systems.

July 1, 2001: The Joint Commission began requiring hospitals to notify patients if they are harmed by a medical error.

SOURCES:

Millenson, Michael L. "The Patient's View of Medical Error." *Medical Mistakes: What Do We Know*. Edited by Marilynn Rosenthal and Kathleen Sutcliffe. San Francisco: Jossey-Bass, In Press, Summer, 2002 and Millenson, Michael L. "Patient Safety: How the Press Has Led the Profession," *Quality and Safety in Health Care*. In Press, Spring, 2002.

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