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Why Healthcare Needs a National Incident Investigation Agency

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Hospitals have become extremely complex, technology-intense environments where the use of intrinsically dangerous equipment and clinical procedures are routine. While the benefits associated with this complexity has been tremendous, they have come with an equally tremendous and horrific human cost; namely, the nearly unfathomable number of patients being accidentally killed in U.S. hospitals due to medical error. As concluded in the 2004 Health Grades report – *Patient Safety in American Hospitals* – "over 575,000 preventable deaths occurred as a direct result of the 2.5 million patient safety incidents that occurred in U.S. hospitals from 2000 through 2002" (1). At an estimated mortality rate of over 191,000 deaths per year, medical error has become the nation's third leading cause of death! (2). These estimates are nearly double the 98,000 annual deaths cited in the pivotal 1999 Institute of Medicine report *To Err is Human: Building a Safer Heath System* (3).

As these pioneering studies concluded, medical error tend to be a complex, multifaceted phenomena – caused more by faulty healthcare delivery systems as opposed to faulty humans simply making mistakes (3). As such, they desperately need a systems-related, multi-disciplinary approach for investigating and solving them. Just as it takes an interdisciplinary team of investigators from the National Transportation Safety Board (NTSB) to thoroughly investigate and reconstruct aviation mishaps and crashes, so too should it take some form of structured, team approach for investigating medical mistakes – especially those resulting in a patient's death. Until every wrongful death is investigated with the same tenacity and speed that the NSTB uses in its investigation of aircraft incidents, medical mistakes are likely to remain the largely hidden and hushed events that they are.

Unlike other high-risk, high-tech environments, healthcare has been much slower to learn from its mistakes. Not only is it extremely tragic when we injure or accidently kill patients, it becomes even more so when we fail to learn why these accidents happen – only then can we make the needed changes to prevent them from happening again. As an established multi-disciplinary, systems science, human factors offers healthcare the same safety-related benefits that has been embraced and used within the aviation industry.

Currently, only the U.S. Veteran's Administration (VA) hospitals have been – as a healthcare system – transitioning to an aviation-modeled, safety-focused organization. Their National Center for Patient Safety (NCPS) (http://www.patientsafety.gov/) offers VA hospitals a centralized, multi-disciplinary approach to improving patient safety through structured root cause analyses of adverse event. Formed in 1999, the NCPS includes the safety managers from each of the VA's 154 hospitals. It also offers the perfect model for a comparable organization needed for the nation's remaining 5,000+ hospitals.

Suggested here is the formation of an agency comparable to the NCPS, under the auspices of the Centers for Medicare and Medicaid Services. All hospitals that receive federal Medicare / Medicaid funding would be required to participate and be represented by regionally-located centers. These regional centers would have the same basic goals and functions as the NCPS; namely, to investigate and analyze the root cause of adverse patient injuries and deaths. The primary goals also being the same: identify what happened, why did it happen, and what to do to prevent it from happening again.

Only until healthcare gets sufficiently serious in its approach to effecting real change and improvements in patient safety, will its incidence of accidental patient deaths begin to decline. Just because someone dies in a hospital does not mean that they simply must have been sick – being accidently killed remains the other likely possibility.

References

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