



Why patient safety matters

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During the past decade, the ascension of the quality care movement into the national spotlight can be attributed to the publication of two Institute of Medicine (IOM) reports. The first, published in 2000 and entitled *To Err Is Human: Building a Safer Health System*,¹ was followed a year later by *Crossing the Quality Chasm: A New Health System for the 21st Century*.² The first report focused primarily on the high incidence of medical errors and examined some of the systemic institutional flaws that contribute to the problem. The second publication provided a broader framework for improving the health care delivery system, building on a foundation that emphasizes patient safety but extends to all aspects of service delivery. Both reports helped to catalyze a widespread dialogue among health professionals and their respective professional organizations on these important issues of patient safety, medical errors, and quality care.

Most providers believe that they provide high-quality care for all patients. However, the statistics do not seem to back up those claims. Each year, an estimated 44,000 to 98,000 patients die because of adverse events that occur during their interaction with the health care system.¹ Two of every 100 admissions to hospitals result in a preventable adverse drug event that produces higher costs, injury, and sometimes death.¹ And every time there is a medical error, patient trust in the health care system erodes—and future patient-provider interactions are adversely affected.

The Academy's work in quality care

Even before the IOM reports were published, the Academy's activities in this area were carried out through the Quality and Risk Management Committee. The focus of that committee was primarily on improving quality as a means of reducing professional risk. Most recently, the committee has looked more broadly at

quality care, prompting a name change to the "Quality Care Committee" (QCC) in 2003.

After the IOM reports were published, the committee worked with the AAPA Board of Directors and House of Delegates to redirect activities and focus more on patient safety. During the past two years, the QCC has worked diligently to promote this agenda to the membership through innovative communication techniques such as clinician-focused articles that provide user-friendly examples of safety improvement strategies, continuing education programs, and policy briefs to the House of Delegates. The committee monitors the quality care literature and publishes regular communiqués in *AAPA News*. Most recently, the committee worked with AAPA staff to submit a funding proposal to the Agency for Healthcare Research and Quality for CME lectures on patient safety. Funding for this initiative will be provided through the grant award, and plans are in place to launch the program at the upcoming annual PA conference in San Francisco.

The AAPA Quality Care Committee seeks to increase the knowledge, awareness, skills, and leadership capacity of the Academy membership in the patient safety movement. It is important to remember that most medical errors occur because of systemic flaws in health care delivery, not because of malicious intent or incompetence on the part of clinicians. PAs must be aware of how these flaws can be corrected and of the role they can play in helping to institutionalize these systemic improvements.

How we can improve care

In 2005, Dr. John Gosbee conducted a patient safety workshop sponsored by the QCC at the AAPA annual conference. The workshop introduced participants to the discipline of human factors engineering (HFE), which has been cited as an important institutional approach to improving patient safety and reducing medical errors. HFE examines human capabilities and limitations and applies the information gained to the design of safe, effective, and comfortable systems.³

During the workshop, Dr. Gosbee, who directs the National Center for Patient Safety *Continued on page 59*

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