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Mistakes Chronicled on Medicare Patients

By DUFF WILSON

One of every seven Medicare beneficiaries who is hospitalized is harmed as a result of problems with the medical care there, according to a new study from the Office of Inspector General for the Department of Health and Human Services.

The study said unexpected adverse events added at least $4.4 billion a year to government health costs and contributed to the deaths of about 180,000 patients a year.

In a single month, October 2008, the report estimated that some 134,000 Medicare patients experienced at least one adverse event, ranging from a temporary health setback to death, during a hospital stay. It said 44 percent of them were “clearly or likely preventable.”

That study cited hospital infections as a major source of problems, but the inspector general’s report found other events to be more common. The most frequent problems classified as adverse events, it said, were those related to medication, like excessive bleeding, followed by those related to patient care, like intravenous fluid overload, and those related to surgery and to infection.

The most serious events, like surgery on the wrong patient, amounted to less than 1 percent of the events tallied, according to Ruth Ann Dorrill, a team leader for the inspector general’s study group. Those are known as “never events” — the National Quality Forum, a leading nonprofit group, said they “should never occur in a health care setting.”

An American Hospital Association official, Nancy Foster, said the study highlighted the importance of improving procedures to prevent the medication errors and other problems described in the report.

“Hospitals and doctors and nurses are focused on preventing harm,” Ms. Foster, the association’s vice president of quality and patient safety, said on Monday. “But as this report suggests, we do have a ways to go before we are where we want our performance to be.”

The study involved expert reviews of a representative sample of 780 patient files. It is

scheduled to be posted on the inspector general Web site on Tuesday.

In a written response contained in the report, Dr. Carolyn M. Clancy, director of the federal Agency for Healthcare Research and Quality, said the adverse events were affecting hospital patients at an “alarming rate” and promised to work to improve it.

Ms. Dorrill, a team leader for the study group, based in Dallas, said it was the seventh and most important of 10 reports on adverse events that the agency was doing in response to a health care law passed by Congress in 2006.

“There was a lot of momentum in the late ’70s, early ’80s when the patient safety movement started, and they wanted a progress check,” Ms. Dorrill said.

Kevin K. Golladay, the regional inspector general for evaluation and inspections, said: “We recommend a broader view of harm in a hospital.”

The report called for more oversight and financial incentives for hospitals to reduce errors. In its written response, Dr. Donald M. Berwick, administrator of the Centers for Medicare and Medicaid Services, said it would aggressively pursue recommendations to broaden the definition of adverse events, monitor and prevent them.

The problem had gained widespread attention with a 1999 report by the Institute of Medicine, titled “To Err is Human: Building a Safer Health System.” That report cited studies using different methodology to estimate 44,000 to 98,000 Americans die each year as a result of preventable medical errors in hospitals.

The inspector general’s study was the first to obtain a statistically valid national incidence rate for adverse events in a hospitalized population, the officials said. Previous estimates had extrapolated data from more limited studies.