MEDICAL NEGLIGENCE: MEDICAL ERRORS

A 2013 study found that 440,000 Americans die from preventable medical errors in U.S. hospitals every year. At that rate, preventable medical errors would be the third leading cause of death in the U.S. behind heart disease and cancer.

440,000 deaths from preventable medical errors every year, 20 times as many serious injuries.
The study, published in the *Journal of Patient Safety*, found that, in addition to the 440,000 deaths, there were 10-20 times as many serious injuries.[1]

For all the attention paid to patient safety, there has recently been "a lessening intensity of focus in the issue."
The National Patient Safety Foundation's 2015 follow-up to the Institute of Medicine's landmark To Err is Human report on medical errors concluded:

"Despite demonstrated improvement in specific problem areas, such as hospital-acquired infections, the scale of improvement in patient safety has been limited. Though many interventions have proven effective, many more have been ineffective, and some promising interventions have important questions still unresolved. The health care system continues to operate with a low degree of reliability, meaning that patients frequently experience harms that could have been prevented or mitigated."[2]

One in three hospital admissions experience a medical error.
A 2011 study from the Institute for Healthcare Improvement found that one in three patients admitted to hospital experienced a medical error.[3] The top three errors the researchers found were:

- Medication errors
- Errors in procedures
- Infections

18 percent of patients harmed during care.
Researchers from the Harvard School of Medicine found that about 18 percent of hospital patients are harmed during the course of their care. Of these injuries:

- 2.9 percent were permanent
- 8.5 percent were life-threatening

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- 2.4 percent caused or contributed to a patient's death.[4]

"Never events" happen as much as 40 times a week. Recent studies of wrong site, wrong surgery, and wrong patient procedures show that these "never events" are happening at an alarming rate of up to 40 times per week in U.S. hospitals.[5]

Medical errors add billions to health care costs. Diagnostic errors are clinically and financially more costly than ever before.[6] An actuarial review of medical records found that injuries caused by medical errors add billions to health care costs.[7] Pressure ulcers (bed sores) and postoperative infections are the most common yet most expensive errors to treat. In 2008, medical errors caused:

- 374,964 pressure ulcers at a cost of $3.27 billion
- 252,695 postoperative infections at a cost of $3.36 billion.
- more than 400,000 "never events" costing $3.7 billion.

The majority of medical errors go unreported. A 2014 study in the *Journal of Patient Safety* found that providers rarely voluntarily disclose errors to patients. Only 9.3 percent of respondents reported that a medical facility voluntarily disclosed harm, and only 7.6 percent of physicians.

As for litigation related to the harm, 20 percent of respondents reported filing a lawsuit. According to the authors, *"approximately 1 in 5 patient harms resulted in a lawsuit. This is similar to the Harvard Medical Practice Study…Other studies have estimated that as few as 2% to 3% of patients pursue litigation. These findings all suggest that the vast majority of patient harms never result in a lawsuit."*[8]

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[1] John T. James, *A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care*, Journal of Patient Safety, September 2013, http://www.documentcloud.org/documents/781687-john-james-a-new-evidence-based-estimate-of.html.

[2] *Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human,* National Patient Safety Foundation, 2015, http://www.npsf.org/?page=freefromharm.

[3] Classen et al., *'Global Trigger Tool' Shows That Adverse Events in Hospitals May Be Ten Times Greater Than Previously Measured*, Health Affairs, April 2011, http://content.healthaffairs.org/content/30/4/581.abstract.

[4] Landrigan et al., *Temporal Trends in Rates of Patient Harm Resulting from Medical Care*, New England Journal of Medicine, November 24, 2010, http://www.nejm.org/doi/full/10.1056/NEJMsa1004404.

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[6] Van Den Bos et al., *The $17.1 Billion Problem: The Annual Cost of Measurable Medical Errors*, Health Affairs, April 2011, http://content.healthaffairs.org/content/30/4/596.full.pdf+html.

[7] Dhruv Khullar, M.D., M.P.P., Ashish K. Jha, M.D., M.P.H., and Anupam B. Jena, M.D., Ph.D., Reducing Diagnostic Errors — Why Now?, N Engl J Med, December 24, 2015, http://www.nejm.org/doi/pdf/10.1056/NEJMp1508044.

[8] Lyu et al., *Medical Harm: Patient Perceptions and Follow-up Actions*, Journal of Patient Safety, November 13, 2014, http://journals.lww.com/journalpatientsafety/Abstract/publishahead/Medical_Harm___Patient_Perceptions_and_Follow_up.99712.aspx; Olga Pierce and Marshall Allen, *The Two Things That Rarely Happen After a Medical Mistake*, November 21, 2014, http://www.propublica.org/article/the-two-things-that-rarely-happen-after-a-medical-mistake?utm_source=et&utm_medium=email&utm_campaign=dailynewsletter.