

# Higher toll cited from hospital errors

## Wider definition used in new tally

By Scott Allen, Globe Staff | July 27, 2004

The number of hospital patients who die from preventable errors may be twice as high as previously estimated and shows no sign of decreasing, according to a new national review of Medicare records by a Denver-based health care ranking group.

The findings would make medical mistakes the third-leading cause of death in the country, behind heart disease and cancer.

"There is little evidence that patient safety has improved in the last five years," said Dr. Samantha Collier, vice president of medical affairs at HealthGrades, which publishes rankings of hospitals and doctors. "The equivalent of 390 jumbo jets full of people are dying each year due to likely preventable, in-hospital medical errors, making this one of the leading killers in the US."

The analysis is sure to be controversial, in part because the group used a broad definition of medical errors. This definition change -- counting cases in which hospital staff failed to respond quickly to signs of infection or other dangerous problems -- accounts for almost the entire increase in the number of deaths.

Several observers questioned whether Medicare records are accurate or detailed enough to determine whether doctors and nurses were slow to react to a fatal illness. A 1999 study by the Institute of Medicine, which advises the federal government on health care issues, stuck to more clear-cut mistakes, such as overdoses and post surgical infections. That study counted 98,000 deaths in 1999; HealthGrades said there were 195,000 deaths annually from 2000 to 2002, and estimated that Americans paid an extra \$19 billion in medical care costs for the victims of mistakes.

Patient safety analysts say HealthGrades' report confirms their suspicion that the Institute of Medicine death estimate is too low. One of the coauthors of the institute study, Dr. Lucian Leape of the Harvard School of Public Health, has long said his estimate was based on a conservative definition of mistakes that underestimated the real toll.

Study after study has shown that medical errors are widespread, harming up to one in 25 patients who are admitted to the hospital.

"This should give you pause when you go to the hospital," said Dr. Kenneth W. Kizer of the National Quality Forum, a Washington-based group that develops quality measurements for health care. He said HealthGrades' tally would be even larger if researchers factored in errors at nursing homes, private doctors' offices, and other outpatient settings.

HealthGrades officials say their study is particularly gloomy because it suggests there has been no improvement in the death rate following several high-profile mistakes, including the chemotherapy overdose that killed Globe health columnist Betsy Lehman in 1994.

But others said it's too soon to expect dramatic improvements in the hospital mortality rate, arguing that it took decades for other industries such as airlines and automakers to see major declines in accident rates. "By and large, we shouldn't be expecting year-to-year jumps" in safety, said Dr. Gregg Meyer, medical director of the Massachusetts General Physicians Organization, a group practice representing more than 1,200 doctors.

HealthGrades looked at billing information for 37 million Medicare patients across the country, which list a variety of problems ranging from postoperative infections to reactions to blood transfusions to leaving surgical tools in patients. The group zeroed in on 16 types of mishaps identified by the federal Agency for Healthcare Research and Quality as important, estimating a national death rate based on Medicare patients whose deaths could be attributed to them. HealthGrades' study is not being published in a scientific journal, which would have forced the research to undergo independent criticism. Instead, the firm is releasing the study in part as a promotion of its ranking services.

The increase in deaths the group found comes almost entirely from adding "failure to rescue" the patient as a medical error, which would include such errors as delays in recognizing that a patient has pneumonia. Although safety analysts agree that such errors can be fatal, no one previously has tried to tally up the casualties.

Treating a clinician's failure to act promptly as a medical mistake "is a fairly new concept," said Leape of Harvard. "I happen to think it's a great concept, but it really hasn't been widely validated."

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