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Third Annual Patient Safety in American Hospitals Study

HealthGrades, a leader in assessing hospital safety, has issued its April 2006 report. The study points out that more than half a decade has passed since the Institute of Medicine released its first critical report on health care quality and medical errors. HealthGrades confirmed that unfortunately progress is slow, "results in general are at best modest, and the gap between the best possible care and actual care remains large."

Approximately 1.24 million total patient safety incidents occurred in almost 40 million hospitalizations in the Medicare population. These incidents were associated with 9.3 billion of excess costs during 2002 through 2004. For the second year in a row, patient safety incidents have **increased**, up from 1.14 and 1.18 million reported in HealthGrades First and Second Annual Patient Safety in American Hospital Studies, respectively. Of the 304,702 deaths that occurred among patients who developed one or more patient safety incidents, 250,246 were potentially preventable.

The following patient safety incidents were the most costly, and accounted for 68 percent of all excess attributable costs:

1. Decubitus ulcer - 2.94 billion
2. Selected infections due to medical care – 2.04 billion
3. Postoperative pulmonary embolism or deep vein thrombosis – 1.32 billion

Legal remedies for problems such as infections are almost non-existent. Proof that an infection was caused by negligence, although well accepted by the medical community, is extremely difficult to prove in court. This study once again demonstrates that health care costs are severely affected by medical errors while the costs of remuneration in the legal system is miniscule.

Patient safety does make a big difference. If all hospitals perform at the level of the top 15 percent, 280,134 fewer patient safety incidents and 44,153 fewer deaths among Medicare patients would have occurred, saving $2.45 billion during the years 2002 through 2004. Medicare beneficiaries experiencing one or more patient safety incidents had a one-in-four chance of dying during their hospitalization, a rate that is unchanged since HealthGrades' first study. While the results were dismal, Pennsylvania was one of the states that performed better than expected with respect to safety in its hospitals. The study is extremely detailed with respect to the patient safety indicators causing death and injury such as failure to rescue, foreign body left in during procedure, infections, and the like.

The report came out at about the same time as information from the administrative office of Pennsylvania Courts, showing a dramatic decrease in the number of medical malpractice cases filed. Many counties in the state had absolutely no medical malpractice cases filed, notwithstanding the presence of large hospitals within those counties. The number of filings in 2000 was 2,632 statewide, and in 2005 it had dropped to 1,698, representing a percentage drop of 37.8 percent. The statewide total number of cases that went to trial in 2005 was under 250. Because of the considerable obstacles to winning medical malpractice cases, doctors and hospitals tend to win much more.

Therefore, while HealthGrades shows a steady or increasing problem with patient safety, the number of people able to bring successful cases against dangerous doctors and hospitals has declined precipitously.

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