

In Hospital Deaths from Medical Errors at 195,000 per Year USA

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An average of 195,000 people in the USA died due to potentially preventable, in-hospital medical errors in each of the years 2000, 2001 and 2002, according to a new study of 37 million patient records that was released today by HealthGrades, the healthcare quality company.

The HealthGrades Patient Safety in American Hospitals study is the first to look at the mortality and economic impact of medical errors and injuries that occurred during Medicare hospital admissions nationwide from 2000 to 2002. The HealthGrades study applied the mortality and economic impact models developed by Dr. Chunliu Zhan and Dr. Marlene R. Miller in a research study published in the Journal of the American Medical Association (JAMA) in October of 2003. The Zhan and Miller study supported the Institute of Medicine's (IOM) 1999 report conclusion, which found that medical errors caused up to 98,000 deaths annually and should be considered a national epidemic.

The HealthGrades study finds nearly double the number of deaths from medical errors found by the 1999 IOM report "To Err is Human," with an associated cost of more than \$6 billion per year. Whereas the IOM study extrapolated national findings based on data from three states, and the Zhan and Miller study looked at 7.5 million patient records from 28 states over one year, HealthGrades looked at three years of Medicare data in all 50 states and D.C. This Medicare population represented approximately 45 percent of all hospital admissions (excluding obstetric patients) in the U.S. from 2000 to 2002.

"The HealthGrades study shows that the IOM report may have underestimated the number of deaths due to medical errors, and, moreover, that there is little evidence that patient safety has improved in the last five years," said Dr. Samantha Collier, HealthGrades' vice president of medical affairs. "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 U.S."

HealthGrades examined 16 of the 20 patient-safety indicators defined by the Agency for Healthcare Research and Quality (AHRQ) - from bedsores to post-operative sepsis - omitting four obstetrics-related incidents not represented in the Medicare data used in the study. Of these sixteen, the mortality associated with two, failure to rescue and death in low risk hospital admissions, accounted for the majority of deaths that were associated with these patient safety incidents. These two categories of patients were not evaluated in the IOM or JAMA analyses, accounting for the variation in the number of annual deaths attributable to medical errors. However, the magnitude of the problem is evident in all three studies.

"If we could focus our efforts on just four key areas - failure to rescue, bed sores, postoperative sepsis, and postoperative pulmonary embolism - and reduce these incidents by just 20 percent, we could save 39,000

people from dying every year," said Dr. Collier.

The HealthGrades study was released in conjunction with the company's first annual Distinguished Hospital Award for Patient Safety™, which honors hospitals with the best records of patient safety. Eighty-eight hospitals in 23 states were given the award for having the nation's lowest patient-safety incidence rates. A list of winners can be found at <http://www.healthgrades.com>.

Study Highlights Among the findings in the HealthGrades Patient Safety in American Hospitals study are as follows:

- About 1.14 million patient-safety incidents occurred among the 37 million hospitalizations in the Medicare population over the years 2000-2002.
- Of the total 323,993 deaths among Medicare patients in those years who developed one or more patient-safety incidents, 263,864, or 81 percent, of these deaths were directly attributable to the incident(s).
- One in every four Medicare patients who were hospitalized from 2000 to 2002 and experienced a patient-safety incident died.
- The 16 patient-safety incidents accounted for \$8.54 billion in excess in-patient costs to the Medicare system over the three years studied. Extrapolated to the entire U.S., an extra \$19 billion was spent and more than 575,000 preventable deaths occurred from 2000 to 2002.
- Patient-safety incidents with the highest rates per 1,000 hospitalizations were failure to rescue, decubitus ulcer and postoperative sepsis, which accounted for almost 60 percent of all patient-safety incidents that occurred.
- Overall, the best performing hospitals (hospitals that had the lowest overall patient safety incident rates of all hospitals studied, defined as the top 7.5 percent of all hospitals studied) had five fewer deaths per 1000 hospitalizations compared to the bottom 10th percentile of hospitals. This significant mortality difference is attributable to fewer patient-safety incidents at the best performing hospitals.
- Fewer patient safety incidents in the best performing hospitals resulted in a lower cost of \$740,337 per 1,000 hospitalizations as compared to the bottom 10th percentile of hospitals.

[The complete study](http://www.healthgrades.com), including the list of AHRQ patient-safety indicators, can be found at <http://www.healthgrades.com>.

"If the Center for Disease Control's annual list of leading causes of death included medical errors, it would show up as number six, ahead of diabetes, pneumonia, Alzheimer's disease and renal disease," continued Dr. Collier.

"Hospitals need to act on this, and consumers need to arm themselves with enough information to make quality-oriented health care choices when selecting a hospital."

Distinguished Hospital Awards and Findings

In addition to its findings on patient safety, HealthGrades today honored 88 hospitals in 23 states with the Distinguished Hospital Award for Patient Safety, the first national hospital award to focus purely on hospital patient safety. The award was designed to highlight hospitals with the best records of patient safety in the nation and to encourage consumers to research their local hospitals before undergoing a procedure.

HealthGrades based the awards on a detailed study of patient safety events in hospitals nationwide from 2000 to 2002, using the list of patient-safety incidents developed by AHRQ. "Best" hospitals were identified as the top 7.5 percent of the hospitals studied and had significantly different patient-safety incident rates and costs compared to hospitals that were average or in the bottom 10th percentile. Among the "best" hospitals, the lower number of avoidable deaths and in-patient hospital costs were directly related to their lower overall patient-safety incident rates.

"If all the Medicare patients who were admitted to the bottom 10th percentile of hospitals from 2000 to 2002 were instead admitted to the "best" hospitals, approximately 4,000 lives and \$580 million would have been saved," said Dr. Collier.

References:

[Health Grades, Inc.](#)

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