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RECENT MEDICAL MALPRACTICE STUDIES:

ALARMING AND COSTLY MEDICAL ERRORS; MAJOR ERRORS GO UNREPORTED; LAWSUITS CONTINUE TO DROP

(December 2010)

Recent studies confirm that our nation's medical malpractice "crisis" is not a lawsuit crisis. It's the amount of medical malpractice itself.

1. ALARMING AND COSTLY MEDICAL ERRORS

Office of Inspector General, U.S. Department of Health and Human Services (November 2010)

Injuries and Deaths. "Of the nearly 1 million Medicare beneficiaries discharged from hospitals in October 2008, about 1 in 7 experienced an adverse event that met at least 1 of our criteria (13.5 percent). This rate projects to an estimated 134,000 Medicare beneficiaries experiencing at least 1 adverse event in hospitals during the 1-month study period."¹

"An estimated 1.5 percent of Medicare beneficiaries experienced an event that contributed to their deaths, which projects to 15,000 patients in a single month."²

"An additional 13.5 percent of Medicare beneficiaries experienced events during their hospital stays that resulted in temporary harm. Temporary harm events are those that require intervention but do not cause lasting harm. Although many cases represent fairly minor occurrences, such as hypoglycemia, others were classified as temporary harm only because the patients were in the hospital for lengthy periods as a result of other, more serious, diagnoses, allowing hospitals enough time to address the harm prior to discharge. Additionally, 28 percent of beneficiaries who experienced adverse events also had temporary harm events during the same stay."³

Preventable Harm. "Physician reviewers determined that 44 percent of adverse and temporary harm events were clearly or likely preventable. ... Preventable events were linked most commonly to medical errors, substandard care, and lack of patient monitoring and assessment."⁴

“Because many adverse events we identified were preventable, our study confirms the need and opportunity for hospitals to significantly reduce the incidence of events.”⁵

Large Costs — \$4.4 Billion Per Year. “Hospital care associated with adverse and temporary harm events cost Medicare an estimated \$324 million in October 2008. Sixteen percent of sample beneficiaries in the Medicare Inpatient Prospective Payment System who experienced events incurred additional Medicare costs as a result. The added costs equate to an estimated 3.5 percent of Medicare’s expenditure for inpatient care during October 2008. To give these figures an annual context, 3.5 percent of the \$137 billion Medicare inpatient expenditure for FY 2009 equates to \$4.4 billion spent on care associated with events. Two-thirds of Medicare costs associated with events were the result of entire additional hospital stays necessitated by harm from the events. Additionally, these Medicare cost estimates do not include additional costs required for follow-up care after the sample hospitalizations.”⁶

New England Journal of Medicine (November 2010)

Harm Common. “In a statewide study of 10 North Carolina hospitals, we found that harm resulting from medical care was common, with little evidence that the rate of harm had decreased substantially over a 6-year period ending in December 2007.”⁷

Not Surprising. “Our findings validate concern raised by patient-safety experts in the United States and Europe that harm resulting from medical care remains very common. Though disappointing, the absence of apparent improvement is not entirely surprising. Despite substantial resource allocation and efforts to draw attention to the patient-safety epidemic on the part of government agencies, health care regulators, and private organizations, the penetration of evidence-based safety practices has been quite modest. For example, only 1.5% of hospitals in the United States have implemented a comprehensive system of electronic medical records, and only 9.1% have even basic electronic record keeping in place; only 17% have computerized provider order entry. Physicians-in-training and nurses alike routinely work hours in excess of those proven to be safe. Compliance with even simple interventions such as hand washing is poor in many centers.”⁸

“Most medical centers continue to depend on voluntary reporting to track institutional safety, despite repeated studies showing the inadequacy of such reporting.”⁹

Findings Have National Implications. “Since North Carolina has been a leader in efforts to improve safety, a lack of improvement in this state suggests that further improvement is also needed at the national level.”¹⁰

2. MAJOR ERRORS GO UNDERREPORTED

Hearst Newspapers. A September 2010 Hearst Newspapers investigation revealed that most states fail to report medical errors.¹¹ According to the study,

- “Twenty-three states don’t have a medical-error detection program. Even those with mandatory programs miss a majority of the harm.”¹²
- “Outside of New York and Pennsylvania, which have robust error reporting systems, a Hearst sampling showed other states with mandatory programs didn’t account for between 97 percent and 75 percent of harmful events — based on a conservative definition of harm.”¹³

State-specific examples.

- **California.**
 - “Eighty-seven hospitals — more than 20% of the 418 hospitals covered under a law that took effect in 2007 — have made no reports of medical errors, according to the California Department of Public Health.”¹⁴
- **Nevada.**
 - After examining 425,000 billing records in 2008 and 2009, the *Las Vegas Sun* “identified 3,689 cases of preventable harm that could be categorized as sentinel events, meaning Nevada law requires them to be reported to the state.”¹⁵
 - According to the *Sun*, “During those same two years, all Nevada hospitals reported just 402 sentinel events.”¹⁶
 - “In its investigation, the Sun found that at the 13 acute-care hospitals in the Las Vegas Valley in 2008-09, there were: 710 surgical accidents; 2,010 cases where patients were infected with lethal bacteria; 969 cases of injuries such as bloodstream infections involving central-line catheters, advanced-stage pressure sores and postoperative falls.”¹⁷
- **Washington.** A Hearst Newspapers investigation found that:
 - Thousands are “harmed each year by medical care in Washington hospitals, some fatally and some suffering serious disabilities” and that even “[t]hough Washington is one of 27 states that require hospitals and other facilities to report serious medical errors, just a fraction [of] the errors that likely happen here are reported.”¹⁸
 - “[T]here are likely at least 2,200 reportable incidents a year in Washington.”¹⁹ In 2009, facilities reported only 198 to the Washington health department.²⁰
 - “Nearly 7,000 patients spent 29,000 days at Yakima Regional last year; it is one of the largest facilities in the state that hasn’t filed any adverse event reports since the law went into effect in June 2006.”²¹

- “Washington’s 162 walk-in surgery centers were added to the list of facilities required to report this year. In the first two quarters of 2010 only four of them have reported a total of five adverse events. Experts say that number is also incredibly low based on the volume of work being done in these facilities, which do more than 340,000 surgical procedures each year.”²²
- “Washington’s medical error reporting program isn’t able to enforce the reporting law because it’s underfunded and lacks enforcement powers — and because the rules laying out which incidents must be reported make it easy for hospitals to rule that an error isn’t a ‘reportable error.’”²³

3. LAWSUITS CONTINUE TO DROP

National Center for State Courts.²⁴

- “Like other torts, medical malpractice claims continue to decline.”²⁵
- “Just as torts typically represent a single-digit proportion of civil caseloads, medical malpractice cases comprise a similar proportion of torts. Despite their continued notoriety, rarely does a medical malpractice caseload exceed a few hundred cases in any one state in one year.”²⁶
- For example, based on nine states reporting, researchers found that in 2008 incoming medical malpractice cases represented:
 - 0.7 percent of the tort caseload in Minnesota and Oregon²⁷
 - 1.8 percent of the tort caseload in Connecticut²⁸
 - 1.9 percent of the tort caseload in Wisconsin²⁹
 - 2.3 percent of the tort caseload in New Jersey³⁰
 - 4.3 percent of the tort caseload in Mississippi³¹
 - 4.7 percent of the tort caseload in Iowa³²
 - 6.0 percent of the tort caseload in Puerto Rico³³
 - 7.4 percent of the tort caseload in Kansas³⁴
- Long-term data show a 15 percent decrease in medical malpractice filings in general jurisdiction courts in seven states from 1999 to 2008.³⁵ Of those states, Mississippi experienced the sharpest decline, with a 45 percent decrease in incoming med mal cases over the ten-year period.³⁶
- “As was seen in Mississippi in 2003, the enactment of tort reform legislation can profoundly affect the filing patterns of medical malpractice caseloads. However, medical malpractice caseloads are often so small that a change of as few as 50 or 100 filings can create a similar effect.”³⁷

NOTES

¹ U.S. Department of Health and Human Services, Office of the Inspector General, *Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries* (November 2010), pp. i-ii, found at <http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf>.

² *Id.* at ii.

³ *Id.* (emphasis in original).

⁴ *Id.* (emphasis in original).

⁵ *Id.* at iii.

⁶ *Id.* at ii-iii (emphasis in original).

⁷ Christopher P. Landrigan et al., “Temporal Trends in Rates of Patient Harm Resulting from Medical Care,” *N Engl J Med* 2010; 363:2124-2134, 2130 (November 2010)(citations omitted), found at <http://www.nejm.org/doi/full/10.1056/NEJMsa1004404#t=articleTop>.

⁸ *Id.*

⁹ *Id.* at 2130-2131.

¹⁰ *Id.* at 2133.

¹¹ Cathleen F. Crowley and Eric Nalder, “Year after report, patients still face risks,” *Times Union*, September 20, 2010, found at [http://www.timesunion.com/local/article/Year-after-report-patients-still-face-risks-665059.php#page-](http://www.timesunion.com/local/article/Year-after-report-patients-still-face-risks-665059.php#page-1)

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¹² *Id.*

¹³ *Id.*

¹⁴ Molly Hennessy-Fiske, “‘Error-free’ hospitals scrutinized,” *Los Angeles Times*, November 27, 2010, found at <http://www.latimes.com/news/local/la-me-hospital-errors-20101128,0,522066.story>.

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ Eric Nalder, “Despite law, medical errors likely go unreported,” *Seattle Post-Intelligencer*, September 27, 2010, found at http://www.seattlepi.com/local/427266_medicalerrors23.html.

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

²³ *Id.*

²⁴ R. LaFountain et al., *Examining the Work of State Courts: An Analysis of 2008 State Court Caseloads*, National Center for State Courts (2010), p. 31, found at http://www.ncsconline.org/d_research/csp/2008_files/EWSC-2008-Online%20Version%20v2.pdf.

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Id.*