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Study Finds No Progress in Safety at Hospitals

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We're not making progress in preventing medical malpractice and hospital negligence, according to a disappointing article last week in the New York Times. The article presented details from a study conducted in ten North Carolina hospitals, from 2002 to 2007. The bottom line is that harm to patients was common, and the number of incidents did not decrease over time. This is in spite of hospitals' stated intentions during that time to decrease errors resulting in deaths and injuries to patients.

This information is especially important as applied to Texas, because Governor Rick Perry and the Republican Legislature essentially provided immunity to doctors and hospitals with the passage of a law in 2003 that limited non-economic damages to a figure so low that

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qualified attorneys now will very rarely accept a potential client's case for malpractice. The costs of litigation are simply too high to risk for such a small recovery. Unless you are a high wage-earner who has lost years of income due to medical negligence, you will have a hard time finding a lawyer willing to help you in Texas. Children and retired people are pretty much out of luck if they are injured by medical malpractice.

The study quoted in the New York Times was lead by assistant professor Dr. Christopher P. Landrigan of Harvard Medical School and will be published in The New England Journal of Medicine. Dr. Landrigan said "It is unlikely that other regions of the country have fared better." Here are excerpts from the article:

It is one of the most rigorous efforts to collect data about patient safety since a landmark report in 1999 found that medical mistakes caused as many as 98,000 deaths and more than one million injuries a year in the United States. That report, by the Institute of Medicine, an independent group that advises the government on health matters, led to a national movement to reduce errors and make hospital stays less hazardous to patients' health.

Among the preventable problems that Dr. Landrigan's team identified were severe bleeding during an operation, serious breathing trouble caused by a procedure that was performed incorrectly, a fall that

dislocated a patient's hip and damaged a nerve, and vaginal cuts caused by a vacuum device used to help deliver a baby.

Dr. Landrigan's team focused on North Carolina because its hospitals, compared with those in most states, have been more involved in programs to improve patient safety.

But instead of improvements, the researchers found a high rate of problems. About 18 percent of patients were harmed by medical care, some more than once, and 63.1 percent of the injuries were judged to be preventable. Most of the problems were temporary and treatable, but some were serious, and a few — 2.4 percent — caused or contributed to a patient's death, the study found.

An expert on hospital safety who was not associated with the study said the findings were a warning for the patient-safety movement. "We need to do more, and to do it more quickly," said the expert, Dr. Robert M. Wachter, the chief of hospital medicine at the University of California, San Francisco.

A recent government report found similar results, saying that in October 2008, 13.5 percent of Medicare beneficiaries — 134,000 patients — experienced "adverse events" during hospital stays. The

report said the extra treatment required as a result of the injuries could cost Medicare several billion dollars a year. And in 1.5 percent of the patients — 15,000 in the month studied — medical mistakes contributed to their deaths.

For the most part, the reporting of medical errors or harm to patients is voluntary, and that “vastly underestimates the frequency of errors and injuries that occur,” Dr. Landrigan said. “We need a monitoring system that is mandatory,” he said. “There has to be some mechanism for federal-level reporting, where hospitals across the country are held to it.”