THE ENORMOUS COST OF MEDICAL ERRORS

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ABSTRACT

The Institute of Medicine (1999) reports that up to 98,000 patients die each year from preventable medical errors. According to Sulz and Young (2009) medical errors, especially in hospitals, have been a well known problem which commands very little attention by those in power. In many instances physicians and hospitals would be reimbursed for having the error and then reimbursed again for rectifying the error if the patient lived. These errors included diagnostic and treatment errors, surgical errors, drug errors and delay in treatment to name a few.

It is frightening to hear that one of the major causes of medical errors was miscommunication among health care professionals. Brownlee (2007) points out that lack of cooperation among the players in the current health care delivery system is one of the major reasons of the epidemic of medical errors in medical care. Emanuel (2008) points out that too many patients are the victims of preventable medical errors and infections that occur in the hospital.

This paper will attempt to find the major causes of medical errors and make recommendations to reduce these preventable mistakes that result in lives lost, disability and enormous costs for our health care delivery system.

INTRODUCTION

The health care delivery system in the United States is facing tremendous challenges as it attempts to respond to calls from everyone for reform. There are calls from government, businesses and consumers for better health care at a price that we can all afford. This reform effort is uncovering many problems involving costs, access and our poor health status when compared to other countries. There is another problem found in health care that is rarely mentioned by the media that involves errors in medical care delivery. There is overwhelming evidence that many people are being hurt by the very system that is supposed to be offering them a cure for their medical problems. These people are being hurt, disabled and killed by the medical care system that is thought to be their only way to get their health improved.

Medical care and hospitals on one hand provide us with a hope of the cure of illness and disease and on the other hand can be very dangerous and in some cases actually be a threat to our life. There are mistakes made in medical care delivery that could be avoided. The Institute of Medicine, IOM, (1999) released a study revealing that as many as 98,000 of the 33 million individuals hospitalized each year die and many more receive secondary infections because of poor quality health care while hospitalized. According to Black and Miller (2008) the percentage of hospital admissions experiencing injury or death is 2.9 percent on the low side and 3.7 percent on
the high side. Medical errors and hospital acquired infections have become epidemic in this country and the problem seems to be getting worse.

The IOM (1999) defines medical errors as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim." These errors typically occur in operating rooms, emergency departments and intensive care units. There is mounting evidence that entering the medical care system at any location increases the risk of adverse drug events, errors in care delivery and hospital acquired infections. These errors are increasing the cost of health care delivery, longer hospital stays, disability, death and the loss of trust in medical care. In fact, medical errors are now estimated to be the eighth leading cause of death in the United States.

Health care services are produced as required and are not prepared ahead of demand so they must be evaluated as produced. Therefore, if mistakes are made in the delivery of these services it is too late to correct the faulty delivery. This makes it very important that systems be designed to prevent errors in the delivery of health care services before they are delivered.

Epidemic of Medical Errors

According to Sultz and Young (2009) medical errors, especially in hospitals, have been a well known problem which commands very little attention by those in power. In many instances physicians and hospitals actually received reimbursement for having the error and then are reimbursed again for rectifying the error if the patient lives. According to Brownlee (2007) the most common error in medical care delivery involves administering drugs to patients. These drug errors include the administration of the wrong drug, the wrong dose of the right drug or drug interactions that harm the patient. The IOM (1999) points out that these drug errors add $5,000 to the cost of every hospital admission.

Emanuel (2008) points out that too many patients are the victims of preventable medical errors and infections that occur in the hospital. It is frightening to hear that one of the major causes of medical errors is miscommunication among health care professionals Brownlee (2007) points out that lack of cooperation among the players in the current health care delivery system is one of the major reasons of the epidemic of medical errors in medical care. In many instances the teams of medical care professionals simply do not talk to each other about the care of their patient. These mistakes are often made because there is not adequate knowledge on how to make the system work error free.

HOSPITAL ACQUIRED INFECTIONS

According to the Centers for Disease Control and Prevention (2009) Healthcare-associated infections, or nosocomial infections, are infections that patients acquire during the course of receiving treatment for other conditions within a healthcare setting. A very good example of this type of hospital acquired infection is Methocycline Resistant Staphlococcal Aureus better known as MRSA. These healthcare-associated infections are one of the top ten leading causes of death in the United States.
THE NEED FOR TEAMWORK AND COMMUNICATION

The cause of the vast majority of these medical errors are a direct result of poor communication among health providers and a lack of team work in the delivery of health care services. The solution to this problem will require the development of a culture of safety in health services delivery.

The current health care delivery system is a fragmented system of care that usually requires patients to see multiple providers in many locations virtually guaranteeing that these providers do not have access to complete patient information. Making matters worse there is no incentive to improve safety and quality of care. These medical errors are caused by a faulty system that actually encourages mistakes.

The system must be better designed so that it becomes more difficult for mistakes to be made. Brownlee (2007) argues that the system requires far too many people to do everything right every time in order to arrive at a successful patient outcome. This type of system is perfect for "latent errors." These are mistakes in medical care delivery that are waiting to happen.

According to Spear (2009) the old approaches to medical care delivery must be replaced with a more sophisticated approach that is improved when problems are revealed and modified or dropped completely when the situation changes. This is clearly the case with medical errors which need to be eliminated by dealing with the known flaws found in this complicated system. This can only be accomplished by medical staff not attempting to work around this problem but immediately redesigning the process when problems are uncovered.

Spear (2009) recommends that the approach followed by ALCOA in reducing workplace injuries by a substantial amount be applied to the epidemic of medical errors currently found in the delivery of health care services in this country. The new CEO of ALCOA, Paul O'Neill, made safety problems reportable directly to him within twenty four hours of their occurrence. He then designed a system that had the ability to detect problems when and where they occur. These safety problems are then swarmed at the time and place of occurrence. This makes it possible to gather information that would probably be lost over time. After a solution to the problem is discovered the new knowledge is then shared with everyone who needs to know. This approach, utilized by high velocity organizations, usually exhibit the following capabilities: it is designed to capture existing knowledge and building in tests to reveal problems, swarming and solving problems to build new knowledge and sharing the new knowledge gained throughout the organization.

DISCUSSION

These medical errors and hospital acquired infections can be prevented but it will require a great deal of reform in the way medical care is delivered in this country. Medical care is a service that is intangible produced by individuals who are quite capable in making mistakes in the way the service is delivered. This care is produces by the system developed to deliver medical care services to Americans. Systems usually get precisely the outcome that they are designed to deliver.

There are several targets that require transformation in health care. These targets are unjustified variation in care, fragmentation of care giving and perverse payment incentives that reimburses by units of work rather than payment for predetermined outcomes. The health care
delivery system needs to approach medical errors the way ALCOA reduced safety problems. They need to solve the problems the minute they occur not accept them as a cost of doing business. They need to swarm the problem, discover the cause and immediately share the results with the rest of the organization.

REFERENCES


