View as "PDF version"

Patient Safety Tip of the Week

August 13, 2019

Betsy Lehman Center Report on Medical Error

We, and others, have often tried to quantitate the human and financial costs attributable to medical error. Cost estimates often range widely for the same type of medical error, largely because the methodologies used have differed considerably and because it has often been difficult to separate out which costs were the result of the error and which would have occurred anyway.

The Betsy Lehman Center for Patient Safety in Massachusetts recently reported their analysis of the financial costs of medical errors and the behavioral, physical, emotional, and financial harms to those who suffered the errors (Betsy Lehman Center 2019).

The analysis used claims data from Medicare and the Massachusetts All-Payer Claims Database (APCD). The latter includes both commercial health insurance and Medicaid claims. They focused on 98 diagnostic codes known to be associated with preventable harm events. They then calculated the probability that these claims were related to preventable error and estimated the additional health care costs resulting from those events by comparison to patients matched for similar conditions who did not have claims for these codes.

In addition, they identified 998 people (from 5,001 randomly selected households in a previous Massachusetts health survey) who reported a medical error in the previous five years in their own care or in the care of a family or household member. They then conducted a 30-question "re-contact survey" with 253 of those respondents about the physical, emotional, behavioral, and financial impacts of the errors, as well as the communication and support offered by providers after the errors. Ten of the re-contact survey questions allowed for open-ended narratives. For a comparison group, 371 respondents who had reported no recent experience with medical error to ask a brief set of questions regarding their perceptions of the health care system and patient safety.

Overall, they identified almost **62,000 preventable harm events** that resulted in over **$617 million in excess health care insurance claims**. That accounts for about 1% of the total Massachusetts expenditures on healthcare in 2017. That is likely an underestimate because the most common types of errors (eg. medication and diagnostic error) could not be identified through health insurance claims data.

Pressure ulcers, postoperative and other hospital-acquired infections, and hemorrhage were the most frequently reported events. The medical errors occurred in all healthcare settings: hospitals 41%, emergency departments 15%, doctor's offices or clinics 27%, and other 17%.

We've always had a problem with studies that rely on administrative data. There is considerable variability in the coding practices of hospitals. We've seen "good" hospitals code for lots of complications and "bad" hospitals code for few. We've actually found average length of stay (sLOS) for specific conditions to be a much better indicator of whether complications or adverse events occurred. Nevertheless, the methodology used in the Betsy Lehman Center report at least provides an estimate of the financial impact of medical errors.

But, forget the statistics! The real lessons in this report come from the behavioral, physical, emotional, and financial harms to those who suffered the errors and the behavior of the hospitals and healthcare providers. Perhaps the most important finding in the report deals with what the facilities and healthcare providers did when errors occurred. Massachusetts does have a law requiring providers to disclose medical errors that cause significant harm and encourages apology, But, **only 19% of the patients said that they received an apology** after the medical error. Only one quarter (25%) of respondents were offered one or more types of emotional, functional, or financial support services. The most common additional help offered among all respondents reporting experience with a medical error was spiritual support (13%).

The report concludes that **over 60% of people were dissatisfied with the communication from providers after an error**. But,open communication was linked to lower levels of adverse emotional impacts and health care avoidance.

Among the 28 percent of respondents who reported receiving an acknowledgment of the error, 23 percent reported also receiving an explanation of the actions being taken to prevent similar errors from happening in the future.

Nearly 40 percent of respondents didn't discuss the error with anyone other than family and friends, primarily because they believed it "would not do any good." Of those who did, almost two-thirds (62%) said they hoped to prevent harm to future patients by speaking up. Lawyers were consulted just seven percent of the time and errors were reported to government agencies only one percent of the time.

A key finding was that medical errors are associated with long-lasting **loss of trust** and **avoidance of health care**. 57% of those who experienced an error said they sometimes or always continue to avoid the individual doctors or the health care facility involved in the error. In fact, more than a third of all respondents said that they continue to sometimes or always **avoid all medical care**.

There were also frequent **financial impacts** on those who experienced a medical error. Nearly half (49%) reported two or more financial impacts from the errors. That often involved more health care expenses and loss of work.

Particularly rich were some of the specific comments made by patients who suffered errors. Many "expressed empathy for the clinicians and staff involved in the errors, noting that they seemed stressed, harried, burnt out or otherwise unable to do their jobs well under current constraints." They often had significant insight into factors contributing to the errors, such as breakdowns in systems, teamwork, and communications, to workforce factors.

Transparency and open communication are critical after a medical error. Disclosure and apology are key elements to helping patients and families deal with what has happened to them. They also help providers deal with what's happened. We hope you will remember all our previous columns on disclosure and apology listed below. Also, "communication and resolution" programs (see our April 2018 What's New in the Patient Safety World column "More Support for Communication and Resolution Programs") may be particularly important for those who have suffered financial hardships resulting from errors.

Some of our prior columns on Disclosure & Apology:

July 24, 2007	"Serious Incident Response Checklist"
June 16, 2009	"Disclosing Errors That Affect Multiple Patients"
June 22, 2010	"Disclosure and Apology: How to Do It"
September 2010	"Followup to Our Disclosure and Apology Tip of the Week"
November 2010	"IHI: Respectful Management of Serious Clinical Adverse Events"
April 2012	"Error Disclosure by Surgeons"
June 2012	"Oregon Adverse Event Disclosure Guide"
December 17, 2013	"The Second Victim"
July 14, 2015	"NPSF's RCA2 Guidelines"
June 2016	"Disclosure and Apology: The CANDOR Toolkit"
August 9, 2016	"More on the Second Victim"
January 3, 2017	"What's Happening to "I'm Sorry"?"
October 2017	"More Support for Disclosure and Apology"
April 2018	"More Support for Communication and Resolution Programs"

Other very valuable resources on disclosure and apology:

- IHI's "Respectful Management of Serious Clinical Adverse Events" (Conway 2010)
- The Canadian Disclosure Guidelines (Canadian Patient Safety Institute 2008)
- The Harvard Disclosure Guidelines (Massachusetts Coalition for the Prevention of Medical Errors 2006)
- The ACPE Toolkit (American College of Physician Executives)

- Oregon Patient Safety Commission Oregon Adverse Event Disclosure Guide.

References:

Betsy Lehman Center for Patient Safety. The Financial and Human Cost of Medical Error... and how Massachusetts can lead the way on patient safety. Betsy Lehman Center 2019; June 2019
https://www.betsylehmancenterma.gov/research/costofme

Full report
https://www.betsylehmancenterma.gov/assets/uploads/Cost-of-Medical-Error-Report-2019.pdf

Executive summary
https://www.betsylehmancenterma.gov/assets/uploads/CoME-Exec-Summary.pdf

Key Findings Graphic
https://www.betsylehmancenterma.gov/assets/uploads/Cost-of-Medical-Error-Key-Findings.pdf