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*195,000 U.S. deaths blamed on hospital error

New estimate doubles previous figure, report says

Reuters

Updated: 12:33 p.m. ET July 28, 2004

WASHINGTON - As many as 195,000 people a year could be dying in U.S. hospitals because of easily prevented errors, a company said on Tuesday in an estimate that doubles previous figures.

Lakewood, Colorado-based HealthGrades Inc. said its data covers all 50 states and is more up-to-date than a 1999 study from the Institute of Medicine that said 98,000 people a year die from medical errors.

"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, vice president of medical affairs at the company.

The company, which rates hospitals based on a variety of criteria and provides information to insurers and health plans, said its researchers looked at three years of Medicare data in all 50 states and Washington, 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 company said in a statement.

HealthGrades included as mistakes failure to rescue dying patients and the death of low-risk patients from infections — neither of which the Institute of Medicine report included.

1.14 million 'patient-safety incidents'

It said it found about 1.14 million "patient-safety incidents" occurred among the 37 million hospitalizations.

"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 incidents," it added.

"One in every four Medicare patients who were hospitalized from 2000 to 2002 and experienced a patient-safety incident died."

The U.S. government said it is trying to spearhead a move to get hospitals and clinics to use electronic databases and prescribing methods. The Institute of Medicine report said many deaths were due to medication prescribing errors or to errors in delivering medications.

"If the Centers for Disease Control and Prevention'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," Collier said.

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Investigators: Problems could risk patient safety

The Associated Press Updated: 4:36 p.m. ET July 20, 2004

The private organization that clears hospitals to receive Medicare payments missed most problems later identified by state inspectors, potentially compromising patient safety, congressional investigators said Tuesday.

The Joint Commission on Accreditation of Healthcare Organizations, made up mainly of health professionals, failed to find 167 of 241 "serious deficiencies" in a survey of 500 hospitals that were reviewed between 2000 and 2002, the Government Accountability Office said. The agency, Congress' investigative arm, was formerly called the General Accounting Office.

Many of the overlooked problems related to fire safety, while others involved substandard care. In a Texas hospital, a patient died after receiving a double dose of narcotics in the emergency room and "medications were administered without physician orders," the report said.

A California hospital lacked "a sanitary environment to avoid sources and transmission of infections and communicable diseases and failed to develop a system for ensuring the sterilization of medical instruments," the GAO said.

Hospitals received billions from Medicare

Hospitals approved by the commission are considered automatically eligible for participation in Medicare. It holds a unique status among accrediting agencies in that the federal Centers for Medicare and Medicaid Services has no authority to force the commission to change its accreditation program.

The commission accredited 82 percent of U.S. hospitals in 2002, the GAO said. Those hospitals received \$98 billion for Medicare-covered services that year.

Sen. Charles Grassley, R-Iowa, and Rep. Pete Stark, D-Calif., who jointly requested the report, are introducing legislation to increase Medicare's authority over the commission.

Commission president Dennis O'Leary said his group made sweeping changes to the accreditation process earlier this year. "In our view, it is irresponsible to alarm the public using statistics that have little meaning," O'Leary said in response to the GAO report.

Twenty-two of the 28 people on the commission's board represent hospitals, doctors and other health professionals.

Medicare chief Mark McClellan said his agency agreed with the GAO report, but noted that no problems were found in most hospitals that were reviewed.

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