Common Medical Errors

The Physician Insurers Association of America (PIAA), a trade association of physician-owned malpractice carriers, states that failure-to-diagnose represents one-fifth of all negligence and malpractice claims.

Over half of all failure-to-diagnose claims against primary care providers includes colorectal conditions, breast abnormalities and acute myocardial infarction and unstable angina.

Cases tried in U.S. Federal and state civil courts for malpractice litigation involving colon and rectal disease over a 21 year period, show that over 40% were for failure to timely diagnose mostly colon cancer. Another 40% were for iatrogenic colon injury or medical complications during treatment.

The average delay in diagnosis involving breast cancer malpractice litigation was 15 months. While the majority of women with breast cancer are postmenopausal, the majority of women involved in breast cancer litigation are premenopausal, with the average age being 40 years old. Of the 45 cases studied, 37 found the lump through self-examination, however less than half had appropriate follow-up, including mammograms. Of those having mammograms 80% were read as normal (7).

PIAA conducted a study on malpractice for acute myocardial infarction misdiagnoses. They found that 26% of the misdiagnoses of were gastrointestinal disorders and another 21% misdiagnosed as musculoskeletal pain. When the physicians did suspect a possible cardiac diagnosis, EKG was ordered only 5% of the time. In 29 cases the delay to failure to initiate thrombolytics was a factor in treatment. The average indemnity payment was $255,200 on these claims; a 44% increase than cases in which thrombolytics were not a factor (8). Pediatrics ranked tenth among 28 medical specialties for medical malpractice claims against physicians. In 33% of cases between 1985 and 1997 diagnostic errors were a factor involving pediatrician malpractice. Meningitis was the most prevalent, followed by nonarteriogenenic aneurysms, appendicitis, brain damage in infants and congenital genital anomalies (9).

A recent lawsuit involving the University of New Mexico (UNM) Hospital involved claims by parents of children treated there for leukemia. The hospital paid $35 million to settle the malpractice claim and acknowledged the survival rate was lower than the national average. Nationally three out of four children were alive five years after diagnosis of acute lymphoblastic leukemia, compared to two out of four at UNM. A study released in June 2000 issue of Journal of Perinatology stated that over 60% of cases involving malpractice for a neonatal intensive care unit identified treatment error/delay and missed/delayed diagnosis as the reason for litigation. The greatest frequency involved full-term, Caucasian infants with neurologic conditions covered by private insurance (10).

The American Journal of Emergency Medicine identified eight frequently missed high-risk diagnoses that accounted for almost 60% of closed malpractice claims. Included were: chest pain, abdominal pain, fractures, wounds, pediatric fever/meningitis, subarachnoid hemorrhage, aortic aneurysm & epiglottis. One fourth of the indemnity awards were for missed myocardial infarction, with the average award $175,000. Failure to diagnose fractures and head injuries for intoxicated patients also contributed to major monetary losses (11).

Role of Autopsy

Advances in medical technology, including diagnostic imaging and sophisticated laboratory methods have led to increased diagnostic confidence and decline in autopsies. Only about five percent of patients who die in a hospital undergo autopsy examinations compared to a 40% autopsy rate 30 years ago.

The proponents of autopsy state there is about a 40% difference in antemortem and postmortem diagnosis. Examining malignant neoplasms on autopsy, one study reported 44% had been missed or misdiagnosed (12). A report in Mayo Clinic Procedings examined autopsy results of critically ill patients in an intensive care unit. Pulmonary emboli was identified as the most frequently missed diagnosis, followed by myocardial infarction and bacterial infections (13).

Medication Prescribing Errors

The IOM states that 7,000 deaths are caused in hospitals by medication errors alone. Four to seven percent of hospital admissions are caused by drug errors or drug interaction. An interesting report from Reuter Health using data from Medlink, a national data repository, looked at medication names in a standardized format. It stated that about one-third of medication errors resulting in patient harm are initiated or perpetuated by health care workers who are not told of these mishaps. The most common medication errors were linked to insulin and anticoagulants, aminophylline and warfarin. The most frequent problems included errors of omission, improper doses or quantities and dispensing medicines in error.

Name confusion is among the most common cause of drug-related errors. Examples include sound-alike names for Celebrex, a arthritis medication: Cerebyx, an antidepressant. The FDA is developing new standards to prevent such name mix-ups and to prevent look-alike packaging.

Risk Management Efforts

Many malpractice carriers are increasing their risk management efforts by educating physicians through seminars, videos and offering financial incentives to encourage risk management strategies. The Florida Society of Internal Medicine and Frontier HealthCare collaborated to draft protocols to help prevent missed diagnosis (8). Included in the algorithms are patient handouts that discuss different symptoms and describes various diagnostic procedures, sample documentation for exams and follow-up, flow sheets for dates for screening procedures, a ticker system to track diagnostic testing and appointments, and an analysis of why physicians get sued.

Florida and Texas now mandate risk management programs for insurers selling malpractice policies in those states. In Colorado, Copic Insurance, a physician-owned carrier, has nine different risk management guidelines for primary care and specialty physicians. The company requires physicians to comply with the guidelines to receive coverage and must sign compliance agreements annually when renewing their policies. Copic reports that claim frequency and severity rank below national rates with insurance costs remaining stable over the last five years.

Conclusion

The publicity about medical errors is leading a reform in health care. Consumers are becoming more sophisticated about medical care, choosing hospitals and health plans with proven track records. Health care is responding collectively with action plans to reduce error and liability. The arena of medical litigation will change as previously private data, such as the National Practitioner Data Bank, becomes public knowledge.

References

4. Takacsi, C: “Medical Error- Prevention Strategies Face Barriers to Acceptance”, Medscape Money and Medicine 2000 May 30

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Pharmacy systems require data to systems that don’t interface with example, computer-ordering also will slow the process. For communicating with existing systems instigate massive lawsuits. Health care providers believe it will this will force a change in the finger Patient safety advocates believe errors could be reduced by 50% if provisions, such as errors that result in no serious consequence. This would be collected and analyzed specifically so that problems can be corrected before harm occurs. Patient safety advocates believe this will force a change in the finger pointing of serious medical errors. Health care providers believe it will instigate massive lawsuits. Technology that is unable to communicate with existing systems also will slow the process. For example, computer-ordering systems that don’t interface with pharmacy systems require data to be reentered. Recent studies have shown that one-third of computerized drug entry systems surveyed allowed health providers to override errors such as prescribing inappropriate medication for a particular condition.

Current Legislation
Within the last year Congressional hearings have begun and three bills were introduced in the House and Senate to deal specifically with medical errors. The Senate bills call for mandatory reporting while the House bill calls for voluntary reporting. S.2388 would amend the Public Health Service Act to reduce accidental injury and death from medical mistakes. S.2378 amends the Social security Act to improve the safety of Medicare and Medicaid programs. H.R.3672 will provide for voluntary reporting by health professionals of medication error information to assist public and nonprofit agencies in developing and disseminating information to prevent medication errors. Currently about one-third of the states have their own mandatory reporting requirements.

Future Trends
Health plans and consumers are beginning to demand better health care management. The Leapfrog Group, comprising 70 businesses and organizations drafted proposals to offer hospitals incentives to improve quality and reduce preventable deaths. Leapfrog wants to prove that major forces can work to improve quality of health care. For example, recommending employees needing an operation to facilities that perform the surgery frequently, stating safety is greater at such hospitals.

Monitoring activities are also increasing. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the National Committee for Quality Assurance are aligning on patient safety standards. These agencies are advocating for safety programs that focus on improvement, not blame, in order to maintain accreditation. The new requirements also stipulate those patients and their families be informed about results of care, including unfavorable outcomes. Recently federal health officials announced plans to reverse a long-standing policy to allow Medicare beneficiaries to obtain information about physicians that may have made mistakes in caring for patients. This would allow peer review organizations (PROs) that investigate patient complaints to disclose their findings, even if a physician objects.

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- Fatal mistakes and misuse of medical technology are now the eighth major cause of death in the United States. The IOM recognizes the estimates are low for two important reasons. First, the data was extracted from medical records only recognizing that many injuries and most errors are either not recorded (by intent or inadvertent omission) in the medical record. Second, outpatient injuries are excluded, whether without hospital safeguards or other regulations and peer review, errors may be much higher (1).

The IOM report goes on to recommend that $30 million to be spent creating a new National Patient Safety Center. This center would set national safety goals, track progress in meeting them, and invest in research to learn about prevention. It would also serve as a clearinghouse on the latest information on patient safety.

The fundamental recommendation on reporting medical errors is very controversial. Two types of medical reporting systems are identified: voluntary reporting of errors that result in minimal or no harm; and mandatory reporting of errors resulting in death or serious permanent injury. Many fear that reporting egregious events will dramatically increase malpractice liability. The IOM believes that a no-fault compensation and enterprise liability may lend itself to a more conducive environment.

In the New England Journal of Medicine critics of the IOM state that the while the report gives the impression that doctors and hospitals are doing very little about the problems of safety, the opposite is true. Safety has improved, deaths from substandard care have decreased and mortality from both common and sophisticated procedures has declined, largely due to advances in technology. The critics contend that systematic approaches to prevention of medical errors will be expensive to build, upgrade and maintain, with costs ultimately be passed onto the insurers and health plans (2).

New Strategies to Reduce Medical Errors
- Simmons, President of the National Coalition on Health Care, states that the three major problems affecting health care are intertwined: rising costs, decreasing coverage and poor quality. He advocates changing the culture of medicine to emphasize best practices and “evidenced-based” care to reduce medical errors and improve quality of patient care. He suggests integrating quality-related information and payment policies into benefit contracts (3).

Computerized order entry systems, bar-coded medications and hand held wireless devices are just a few of the ways in which technological advances are playing a positive role in the reduction of medical errors. In 1993, Brigham & Women’s Hospital began an inpatient computerized physician order-entry system. It has been credited with saving between $5 to 10 million dollars and reducing medication errors by 55%. The VA reported a 70% reduction in medication errors over a five-year period using bar-coded medications and wireless computer technology and a reduction of patient readmissions due to drug interactions (4).