Medical Errors: Practicing Physician and Public Views

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Institute of Medicine Report on Medical Errors

- 44,000 to 98,000 Americans die each year as a result of medical errors
- These errors result in total national costs estimated to be between $17 billion and $29 billion
- Errors are primarily due to system failures
- Recommends a mandatory non-punitive system of reporting of errors and creating of safety systems
- Reports of errors should be confidential
Methodology

The Harvard School of Public Health and the Henry J. Kaiser Family Foundation’s *Medical Errors: Practicing Physician and Public Views* is based on two surveys, one of physicians and one of the public, both designed and analyzed by a team of researchers from HSPH and KFF.

**Physician Survey**

The fieldwork for the survey of physicians was conducted April 24 – July 22, 2002 by mail or online with 831 physicians by Harris Interactive, Inc. The sample was drawn from the national list of physicians provided by Medical Marketing Service, Inc. This list includes both American Medical Association members and non-members and is update weekly. The margin of sampling error was +/- 3.5 percentage points.

**General Public Sample**

The survey of the public was conducted by telephone April 11 – June, 2002 with a nationally representative sample of 1,207 adults 18 years and older. The fieldwork for the survey was conducted in Spanish and English by ICR/International Communications Research. The margin of sampling error was +/- 2.6 percentage points.
Personal Experience with Medical Errors

The percentage to said that they had been personally involved in a situation where a preventable medical error had been made in their own care or that of a family member.

**Public**
- Yes: 42%
- No: 57%
- Don't Know: 1%

**Physicians**
- Yes: 35%
- No: 65%

Health Consequences of Medical Errors

Among the general public and physicians, the percentage who reported experience with a medical error that resulted in:

- **Serious health consequences**: 24% (The public) vs. 18% (Physicians)
- **Minor health consequences**: 13% (The public) vs. 10% (Physicians)
- **No health consequences**: 5% (The public) vs. 7% (Physicians)

Perceived frequency of preventable medical errors

When people seek help from a health care professional, how often do you think preventable medical errors are made in their care?

<table>
<thead>
<tr>
<th></th>
<th>Very often</th>
<th>Somewhat often</th>
<th>Not too often</th>
<th>Not often at all</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>10%</td>
<td>39%</td>
<td>37%</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Physicians</td>
<td>19%</td>
<td>59%</td>
<td>21%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Blendon, et. al. “Views of practicing physicians and the public on medical errors.”
The New England Journal of Medicine, v347, n24: 1933-1940
Perceived number of deaths each year due to medical errors

<table>
<thead>
<tr>
<th></th>
<th>Public</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>500</td>
<td>24%</td>
<td>26%</td>
</tr>
<tr>
<td>5,000</td>
<td>36%</td>
<td>46%</td>
</tr>
<tr>
<td>50,000</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>100,000</td>
<td>7%</td>
<td>9%</td>
</tr>
<tr>
<td>500,000+</td>
<td>4%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Who is responsible for preventable medical errors?

Which of the following do you think is a more important cause of preventable medical errors that result in serious harm?

- Mistakes made by individual health professionals
- Mistakes made by Institutions where they work

**Public**

- Mistakes made by individual health professionals: 55%
- Mistakes made by Institutions where they work: 38%

**Physicians**

- Mistakes made by individual health professionals: 58%
- Mistakes made by Institutions where they work: 43%

Perceptions about whether deaths due to medical errors are preventable

<table>
<thead>
<tr>
<th></th>
<th>Public</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of them</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>Three quarters</td>
<td>29%</td>
<td>27%</td>
</tr>
<tr>
<td>Half of them</td>
<td>42%</td>
<td>41%</td>
</tr>
<tr>
<td>One-quarter</td>
<td>13%</td>
<td>21%</td>
</tr>
<tr>
<td>None of them</td>
<td>1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

The proportion of the deaths due to medical errors that respondents feel could realistically be prevented

“Very Important” Causes of Preventable Medical Errors - Physicians

Understaffing of nurses in hospitals
- 53%

Overwork, stress, or fatigue on the part of health professionals
- 50%

Failure of health care professionals to work as a team
- 39%

Influence of HMOs and other managed care plans
- 39%

Complexity of medical care
- 38%

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“Very Important” Causes of Preventable Medical Errors - Public

- Insufficient time spent by doctors with patients: 72%
- Overwork, stress, or fatigue on the part of health professionals: 70%
- Failure of health care professionals to work as a team: 67%
- Understaffing of nurses in hospitals: 65%
- Complexity of medical care: 62%

Percentage who feel each solution would be **very effective** reducing preventable medical errors

<table>
<thead>
<tr>
<th>Solution</th>
<th>Public</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giving doctors more time with patients</td>
<td>78%</td>
<td>46%</td>
</tr>
<tr>
<td>Requiring hospitals to develop systems to avoid errors</td>
<td>74%</td>
<td>55%</td>
</tr>
<tr>
<td>Better training</td>
<td>73%</td>
<td>36%</td>
</tr>
<tr>
<td>Using intensivists in ICUs</td>
<td>73%</td>
<td>34%</td>
</tr>
<tr>
<td>Required reporting of errors to a state agency</td>
<td>71%</td>
<td>23%</td>
</tr>
<tr>
<td>Increasing the number of RNs</td>
<td>69%</td>
<td>51%</td>
</tr>
<tr>
<td>Reducing the work hours of physicians in training</td>
<td>66%</td>
<td>33%</td>
</tr>
<tr>
<td>Required reporting of errors to a government agency</td>
<td>62%</td>
<td>21%</td>
</tr>
</tbody>
</table>

Blendon, et. al. “Views of practicing physicians and the public on medical errors.”  
Suppose a patient needs a specialized medical procedure. This person can choose a hospital that does a large number of these procedures or a hospital that does not do as many. At which hospital do you think this patient would be more likely to have a preventable medical error made in their care, or wouldn’t it make a difference?

<table>
<thead>
<tr>
<th>Option</th>
<th>Physicians</th>
<th>Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>A hospital that does a large number of the procedures</td>
<td>4%</td>
<td>23%</td>
</tr>
<tr>
<td>A hospital that does not do as many</td>
<td>71%</td>
<td>49%</td>
</tr>
<tr>
<td>Wouldn’t make much difference</td>
<td>24%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Should hospital reports of serious medical errors be confidential and only used to learn how to prevent future mistakes or should they also be released to the public?

- Kept confidential: 86% (Physicians) 34% (Public)
- Released to the public: 14% (Physicians) 62% (Public)

Reporting of medical errors

Should physicians be required to tell patients if a preventable medical error resulting in serious harm is made in their care, or not?

- **Should be required**
  - Public: 89%
  - Physicians: 77%

- **Should not be required**
  - Public: 9%
  - Physicians: 22%

Conclusions (1)

Overall

- Patient safety issue remedies principally an “influential/leadership” top concern
- Public support for change is significant but level of interest is likely to be episodic
- Missing information is why many physicians are “lukewarm” about recommended changes
- Need for more focus on how influential/leadership groups can change physician beliefs and behavior
A 67-year-old man goes to the hospital for surgery. He has an allergy to antibiotic drugs, which is noted on his medical record. The surgeon does not notice the information about the allergy and orders an antibiotic to be given at the end of the surgery. A hospital nurse gives the patient the antibiotic.

Version A: The patient wakes up with a rash all over the body. The mistake is noticed, the antibiotic was stopped and the patient fully recovered.

Version B: The patient wakes up with a rash all over his body and gasping for air. The mistake is noticed, the antibiotic is stopped, but the patient stops breathing. Despite every effort, the patient dies.

Responsibility for the error resulting in serious harm

When read the vignette with the medical error resulting in serious harm, percent saying each bore “a lot” of responsibility for the error

- **Surgeon**
  - Public: 92%
  - Physicians: 95%

- **Hospital**
  - Public: 48%
  - Physicians: 57%

- **Nurse**
  - Public: 48%
  - Physicians: 82%

Public and physician support for the right to sue

When read the vignette with the medical error resulting in serious harm, percent saying each should be sued for malpractice

- **Surgeon**
  - Public: 69%
  - Physicians: 55%

- **Hospital**
  - Public: 44%
  - Physicians: 33%

- **Nurse**
  - Public: 21%
  - Physicians: 44%

Patient and physician support for revoking medical license

When read the vignette with the medical error resulting in serious harm, percent saying each should lose their license to practice medicine

- Public
- Physicians

Surgeon
- Public: 50%
- Physicians: 8%

Nurse
- Public: 25%
- Physicians: 8%

Blendon, et. al. “Views of practicing physicians and the public on medical errors.”
Public Views of Proposals Restrict Size of Malpractice Settlements

<table>
<thead>
<tr>
<th>Proposal</th>
<th>Favor</th>
<th>Oppose</th>
</tr>
</thead>
<tbody>
<tr>
<td>A limit on the amount a patient can be awarded as punishment to doctors for negligence or carelessness</td>
<td>64%</td>
<td>31%</td>
</tr>
<tr>
<td>A limit on the amount that patients can be awarded for their emotional pain and suffering</td>
<td>75%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Conclusions (2)
Policy Issues

• Long Term debate likely over whether hospital reports of medical errors should be publicly released

• Little support among public and many physicians for a “no fault” medical error system

• Support among both groups for limits on size of malpractice settlements