Read Gov't Report Showing 1 in 7 Hospitalized Medicare Beneficiaries Harmed by Care

by Marian Wang
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One out of every seven hospitalized Medicare beneficiaries experiences an "adverse event," which means the patient is harmed as a result of medical care. That's according to a study released today [1] by the Department of Health and Human Services' inspector general.

The "adverse events" contribute to an estimated 15,000 patient deaths [2] each month and add at least $4.4 billion [3] to the government's annual Medicare expenses, the report projected. These findings were based on a nationally representative random sample taken from the nearly 1 million Medicare beneficiaries discharged from hospitals in October 2008.

The report's findings were "consistent with previous studies" but "nonetheless disturbing [4]," Carolyn Clancy, director of the Agency for Healthcare Research and Quality, said in a written response to the report.

Medicare and Medicaid chief Donald Berwick, in a separate response, said that his agency is working to improve care not only for hospitalized patients, but is also trying to address "issues in dialysis centers and ambulatory and long term care settings."

It's interesting that he mentions this. Because the inspector general report only covered hospital care, the statistics it contains don't include many of the adverse events we've reported on in a particular subset of Medicare beneficiaries—patients receiving care in dialysis clinics [5].

But the report did highlight the story of one hospitalized dialysis patient who almost died when the tube feeding blood back into his body dislodged—a incident that as we've noted, is potentially deadly but also preventable [6]:

[O]ne beneficiary had excessive bleeding after his kidney dialysis needle was inadvertently removed, which resulted in circulatory shock, a transfer to the intensive care unit, and emergency insertion of a tube into the trachea (windpipe) to ease breathing. When the tube was removed the following day, the patient aspirated (inhaled foreign material into his lungs), which required a life-sustaining intervention.

Of the adverse events it identified, the inspector general's report judged about 44 percent to be preventable.

The inspector general called on both the Centers for Medicare and Medicaid Services and the Agency for Healthcare Research and Quality to broaden the definition of adverse events and better measure such incidents, noting that "to date, no adverse event reporting system exists, and there are no Federal standards regarding State systems."