kaisernetwork.org Health Policy As It Happens

Transcript provided by kaisernetwork.org, a free service of the Kaiser Family Foundation[1]
(Tip: Click on the binocular icon to search this document)

Kaiser Family Foundation and Harvard School of Public Health
"Medical Errors TeleConference"
December 11, 2002
Washington, D.C.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

MALE VOICE: Dave, how are you?

MALE VOICE 2: Good morning. How are you?

MALE VOICE: I'm fine, thank you. Nice talking to you.

MALE VOICE 2: Sorry about your announcement, but, as you said, you plan to emerge stronger from this.

MALE VOICE: Ladies and gentlemen, welcome to the Harvard School of Public Health and Kaiser Family Foundation conference call. At this time it is my pleasure to introduce your host for this call, Mr. Drew Altman.

DREW ALTMAN: Welcome, everybody. Good morning. Welcome to this press conference on our medical errors study.

I guess there are up sides and down sides to this, but on the one hand we're sorry we couldn't hold our usual event in Washington. But, on the other hand, I understand some of you are having snow and ice or bad weather and maybe it's more convenient to do it this way.

What we're doing today - let me just say that with me is Bob Blendon. I think you all know Bob from the Harvard School of Public Health. And Dr. Mollyann Brodie, who's our V.P. for public opinion research. And assorted others who may participate as we move forward.

What we're doing today is releasing a major new study about medical errors that's based on companion surveys of the public and of physicians. And the surveys were designed and analyzed by a team of researchers at the Harvard School of

Public Health and the Kaiser Foundation. And the results of the study are also being published in The New England Journal of Medicine on December 12, and I am told that I need to be clear with all of you that this information is embargoed until 5 p.m. today. Is that the right time? People are nodding at me.

Here's how it's going to work. If you want to ask a question, if you want to get in the queue to ask a question at any time during the call, you just press one and that will – hopefully, it's as simple as it sounds and it will work, and that will put you in the queue to ask a question when we're done.

I'm just going to make a couple of introductory comments and then for the most part leave this to Bob and Molly. But I have been doing these kinds of studies for a long time. It's rare that I'm surprised any longer by the results that we get in our studies.

I was more than a little bit surprised this time. I was surprised to see that after we explained what the term meant so people knew what we were talking about when we were asking them about medical errors, four out of ten people told us that they or a family member had experienced a medical error at some point in their lives. And many told us that there were serious consequences, such as death, obviously, long term disability.

I was also surprised to see that more than one in three physicians said that they or a family member had a similar experience, personal experience in their own lives. And I for one took that as significant corroborating evidence, because I assume that physicians are more likely to know a medical error when they see one.

Everybody understands these are self-reported experiences. I suppose it's possible that if you convene teams of clinicians who reviewed every case, they would disagree in some cases. But my reaction is that if you cut these numbers in half, they're still very – literally in half – they're still very significant findings.

So one thing that this study says to me is that this really a significant problem that perhaps warrants greater attention even than we are giving it these days in American health care.

Having said that, I would also say that at the same time, and this is what Bob is going to show you, and Molly will show you, like all the big health care problems, this is not going to be an easy problem to address. It's not the public's top health care priority. And as you'll see, there are major disagreements between experts and physicians and the public about both the causes of the problem and also the proposed solutions to the problem as well.

My own view is I do think that it could be an emerging

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

issue, a sleeper issue, if national leaders start to talk about it more, what I see in this survey, and some other work we've done suggests to me that the American people will respond, that they would resonate to this issue.

And I think the challenge is to convince people and also physicians that errors are not just the result of individual mistakes, but also of the failures of institutional systems that can be addressed through broader institutional and policy solutions.

So that's just a very quick introduction. I'll turn you over now to Molly and then Bob to walk you through the findings. And then we'll take your questions. And just remember, if you do want to ask a question, all you've got to do is press one and that should work. And we're hoping that you've signed up and you have the chart packs. Because both Molly and Bob are going to be using them. Molly?

MOLLYANN BRODIE: Thank you, Drew

Good morning, everyone. As Drew said, I'm going to start by just giving you a brief methodology, just reviewing it. And then we will walk you through the chart pack sort of chart by chart. So if you have that out, it might be helpful.

We connected two separate but virtually identical surveys. One was a nationally representative random sample of over 1,200 adults by telephone. The margin of sampling error in that is plus or minus 2.6 percent. And one nationally

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

representative random sample of 831 practicing physicians. And that margin of sampling error in that survey was plus or minus 3.5 percent.

Early in each of the surveys we gave all respondents a common definition of medical error. I'm going to read that to you now, just so we're all working from the same definition as well. We said to them, sometimes when people are all and receive medical care, mistakes are made that result in serious harm, such as death, disability, or additional or prolonged treatment. These are called medical errors. Some of these errors are preventable, while others may not be.

Subsequent to that, we asked people about their attitudes and perceptions of the extent of the problem, the causes, and the effectiveness of some of the proposed solutions, and about their own personal experiences.

Now, as a note, this approach about asking about personal experiences is fundamentally different than the other studies you may have seen that estimate the number of medical errors. Those studies are generally based on hospital medical record chart reviews.

What we have here is reported experiences across all aspects of health care. And, with that, let's turn to chart one. You can start looking at the findings from the survey.

So in part one you'll see that 42 percent of the public and 35 percent of the physicians told us that, yes, they had

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

been personally involved in a situation where a preventable medical error was made in their own care or that of a family member.

So the first thing to note is that this is doctors' personal experience and of that patients themselves or witnessing their families' care. It's not their experiences as a doctor, which we'll get to later.

The second thing to note is that this is a substantial minority who say this. And, as we said, these are based on self-reported experiences, not medical chart review. But we are reassured by the fact that the physician reports are so similar to the public, and given that I think they're in a better position to evaluate the care that they or a family member receives.

But even if you believe that there's extensive over-reporting going on here, go ahead and cut these percentages by any amount. You're still left with the impression that these experiences are happening to an awful lot of people.

If you turn to part two, you'll see that about a quarter of the public and about one in five doctors say that they have had a personal experience with medical error that resulted in a serious health consequence. About another one in ten of each group said that the error had a minor consequence.

And if you then turn to chart three, it shows more details about those serious health consequences. So you'll

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

notice that 16 percent of the public and eleven percent of physicians told us that they had a personal experience, either they or their family, with a medical error that resulted in severe pain. Eleven percent and six percent further down said that it resulted in long-term disability. Ten percent and seven percent said it resulted in death.

Now, people could and did report multiple consequences. So they could say, yes, I had an experience with a medical error that resulted in severe pain and, yes, I had an experience with medical error that resulted in long-term disability. So that's why these numbers don't add up to the 24 percent that you saw above.

If you turn to chart four, you'll see that we're now just looking among those who had they had a personal experience with an error. Up until this point all the numbers are based on the total public, on total physicians. Here we're just looking among that group who said that they had an error, and you'll see that both doctors and the public are very likely to assign responsibility for that error to the doctor who was involved.

So eight in ten of the public and seven in ten of the physicians said that the doctor involved in the situation had a lot of responsibility for that situation. Many fewer assigned a lot of responsibility to the nurses or to the other health professionals involved. You've got the 25 percent for the

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

nurses you see for both the public and the physicians.

However, you'll notice on the next bar that twice as many of the public than of doctors assigned a lot of responsibility to the institution involved.

So I think the bottom line message from this chart is that people involved in these situations blame the individual doctors. They're not likely to see it as a system error.

Again, in chart five, we're looking among those who experienced an error. And on the left-hand side you can see that about three in ten of the public and of physicians who had these personal experiences reported that the health professional involved actually told them that an error had happened. On the right-hand side you'll see that about a third said that the physician involved had actually apologized to them.

Now, what this means to me is that at least in three of ten of these self-reported cases, the doctor actually admitted that there had been a problem, which provides more corroboration for these self reports.

However, if you look at chart six, you'll see that even though many people reported experiencing these errors, few said that they or the family member actually resorted to legal action. It was six percent of the public and two percent of the doctors with this personal experience who said that they or a family member actually sued.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And then finally, as a final look at personal experiences, if you look at chart seven, we're now looking at physicians' reported experiences in their role as a physician. So up until now we've been talking about physicians' experiences in their role as an individual patient, themselves, or witnessing their family member's care. Here you'll see on the left that 29 percent of physicians told us that in the past year in their role as a physician they had seen a medical error that resulted in serious harm to a patient.

And if you look on the right-hand side, among that 29 percent six in ten thought that it would be very or somewhat likely that they would see a similar error in the same institution in the next year. This suggests to me that it's unlikely that this problem might simply fade away on its own.

I think it's a good place to turn it over to Bob to discuss what people think can be done about the problem.

ROBERT BLENDON: On chart eight, let me just take a second to explain why you asked this. The research shows that people take more action and talk to more people around problems that are the most salient to them, out of all the problems they can think of the ones that are most fore.

So we asked this about medical errors. And what you can see is when the public thinks about health care, it is not the topmost salient issue.

But in order to clarify this, and we have this actually

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

in our vignettes in the paper, if there's an incident that's very, very visible, people will worry about it, like an airline crash. But if you did surveys of people about problems about airlines, crashes is not the number one or two things on their mind.

So at the moment, the most salient things obviously are to people are cost of health care and cost of prescription drugs. So they're not focusing on the generic problems of medical errors

For physicians, what's really important, which is chart nine, is that of their top three issues, malpractice and problems with dealing with insurance companies and health plans plus costs top their list, and we'll return to the malpractice issue before. But you realize that physicians on a day to day basis are more worried about malpractice than they are about the medical error issue per se. And that I think affects some of their answers to questions later on.

In chart ten, we asked about their sense of the magnitude, public and physicians, of the number of deaths. And what we did was try to look at it versus the IOM estimates. And what you see is that both the public and physicians, the majority of them are at the 5,000 or less death level, versus the IOM, as everyone remembers, was 44,000 and 98,000.

What's important then – you know, we're engaged in interviewing people all the time, and we have to say what we

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

think is really in their minds. For most Americans and physicians, 5,000 deaths is a lot of people. The World Trade Towers had 3,000. But in the aggregate, when they think about it, it's hard for them to believe that 100,000 people could have died.

So what you have is not that these people don't think there are a lot of unnecessary deaths here. They just do not see it as the magnitude of what the Institute of Medicine report suggested.

In chart eleven what you find is that the public is more likely than physicians to see preventable medical errors occurring more frequently. Physicians are much more cautious about how many errors that they have.

In chart twelve, back to Molly's point, when people, both physicians and the public think about errors, the majority of them still hold individual health professionals accountable, not institutions. And that's important because the system focus, let's make the system responsible and not the individuals, is not yet widely held by people. They still see individual professional being the principal decision-maker that could lead to a mistake on care.

On 13, and this is a surprise, along with Drew saying there are many basically the public and physicians correspond in basically believing that about half or less of all medical errors could be prevented.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

What's a surprise is people who survey the public in general in other areas tend to find people believing that most things can be prevented, and lawyers, everything else, professionals, are less likely to believe that. And in this case the public is almost identical to physicians in thinking, you know, about half of these errors can be prevented and the other half can't. Which means there is some expectation that not every one of these things with the best of efforts, attentions, could be prevented.

The real finding, in my view, is really on chart fourteen and chart fifteen. And that really is that the medical community finds very few of the proposals – and what we did was take the major proposals put forth by the major groups trying to change medicine today and asked the public and physicians did they agree on them. What you see is the medical community very lukewarm, the public much more supportive of these proposals. The only two they agree on are the nursing shortage, which has gotten a lot of attention recently, and the idea that there would be a hospital system that would sort of track things and try to prevent errors. There you find agreement. But after that it goes downhill afterwards.

And what is for those of you who have covered these issues for many years just quite striking to me, there have been 100 front page stories on the need to reduce the hours the house staff works, because it leads to medical errors. And

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

after all that a majority of physicians still don't think that would be very effective.

Many of the discussions about errors, including errors that occurred in Boston, focused on Page 15 on the use of computers to order drugs and medical tests. So you track it down and you find that the overwhelming majority of physicians just are lukewarm about these kinds of what sort of in the more elite institutions has become the cutting edge things to do about medical errors.

You also notice, and it's so powerful, in a prior issue of The New England Journal the editor wrote an editorial which basically said let's go beyond high risk, high volume centers. We all know that we agree. All the science, all the research says this really matters. And in this area of medical errors, neither the majority of the public nor the majority of physicians agreed that if you sent these high risk medical procedures to these high volume centers it would be a very effective way of reducing medical error.

So this is an incredible gap between essentially both the general public and the practicing physicians, though for different reasons.

And then I want to emphasize, and we're going to return to this in a minute, the public and physicians, there are a lot of these issues which only deal with what goes on in medical practice, and so public opinion plays a limited role. But

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

where it will play a very big role is do we release information to a state agency. If the information is released, is it made public, which we'll go to in the next slide.

And what you can see is that there's not a lot of enthusiasm among physicians for basically having information released and clearly if it is they want it confidential, which is chart sixteen.

So you can see right away what is an extraordinary different which will play very much, is is this released. Physicians are not at all enthusiastic about the information being released. If it is, is it kept confidential? This is fundamental, it was in the editorial in The New England Journal. Physicians believe professions are about the professions dealing with these internally, not having public accountability and lawyers, the public clearly not thinking a lot about this but likely to respond to an individual, very visible case. They're going to say, why wouldn't I want to know which hospital makes more errors. Don't tell me that they're dealing with it internally.

And this is likely to be a very strong issue.

On the other side of the table, basically both physicians and public agree that when a medical error, mistake is made, the physician should tell the patient. There they're in complete agreement.

I'm not going to spend much time on 18 and 19. We

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

asked people, both public and physicians, what they thought were the underlying causes of medical errors. And basically the public picks a lot of issues. It looks like anything they could think of from their own experience. Physicians basically only come down on overwork, stress, fatigue in their own lives or not enough nurses. Otherwise, they really are not identifying most of the problems that others may have suggested for it. And that lack of identifying that among physicians rolls right over in their seeing that these things are not very effective.

So let me just wrap up this section. I think the most interesting finding to me, really two. And one is that the medical community way lags behind in its belief that a lot of the recommendations have been made to make health care more safe is very effective. And they just are very skeptical and it's going to take a lot of evidence to move these people.

And, secondly, there is a dispute brewing that's going to be out there between the public, and in the public's case their representatives are likely to be state attorney generals, malpractice lawyers and people in the media who say we want this information reported, we make it public. And the medical profession's view is that it's not a good idea in the first place to report it. But, if you do, only on the basis of confidentiality.

That's sort of our take on the second half.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

DREW ALTMAN: This is Drew Altman again. Tnanks a lot, Bob.

We're ready to take questions and I'm told that there are some. So let's just go ahead.

OPERATOR: Alice Debner with The Boston Globe has a question. Go ahead, Ms. Debner.

MS. DEBNER: I actually have two questions. One on the technical, and I just want to double check. I talked with Bob a little bit about this earlier.

The figures in chart three are percentages of the whole, right, now percentages of the subset?

MOLLYANN BRODIE: Yes, it is.

ROBERT BLENDON: So the ten percent of deaths, just so we're all in agreement, are ten percent of the population reported that someone in their family died from a medical error. Molly is that correct?

MOLLYANN BRODIE: Yes, that's absolutely correct.

MS. DEBNER: Okay. Because the numbers are large. I just wanted to be [**unintelligible**]

ROBERT BLENDON: Absolutely.

MS. DEBNER: And the second, the more substantive question is, do you think that the approach that's being taken to stem medical errors needs to change as a result of this, and how so?

DREW ALTMAN: This is Drew. One take that I have is,

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the reason I called it an emerging issue or a sleeper issue, is that this is really, this is an issue that the public is only just now learning about. There are experts who are taking a strong leadership role on this issue, but you don't have a lot of very visible, publicly visible national leaders talking about this issue.

And so I think it's going to take that in order for the public to see this as a national problem, as a solvable problem, as a problem that can be addressed through systems changes, institutional changes and through public policy and not just as something that individual mistakes made by individual physicians. Which is why my overall take on this is that leadership on this issue would be very popular with the public, but there will be physician resistance, as Bob underscored, to many of the proposals made by experts.

Bob may have a different take on this.

ROBERT BLENDON: Let me just take the other half of the equation. I think the physician lukewarmness to this is going to require, A, more research, and B, much more grass root physician education in the medical community about things that can work. I mean, it's absolutely staggering to me that something like computerized ordering of prescriptions, which at Harvard is like giving water to people when they're thirsty – I mean, everybody just says, of course that's what you're going to do to reduce this – has so little take.

And so I'm trying to say to myself, what would it take. Well, you're going to have to have medical society meetings and specialty society meetings where they really go through these discussions and the evidence and the implications. Because I think this sort of top-down elite view in medicine about what needs to be done is not permeating practicing physicians. Part of it may be the change causes a lot of problems for it. Older physicians don't know how to use computers. They've got to carry something around. But whatever it is, we're not permeating the practice community. And in any profession, if the practicing community doesn't really believe that the change is important, you're not going to get it done unless there's either huge lawsuits or massive legislation.

And most of these issues are within medicine issues. So I think that they really have to do more grass roots professional education here.

DREW ALTMAN: And I think it's fair to say that in the physician response you'll see a mix of legitimate concerns and issues take public reporting and self-interest. And so it's a complicated mix of both of those things.

Molly, did you want to add something or no? Okay, next question.

OPERATOR: The next question comes from David Brown with The Washington Post. Go ahead, please, sir.

DAVID BROWN: Hi. How things are defined, what serious

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

means or [**unintelligible**] resulting from individual actions and institutional actions, these are all objective and extremely important in evaluating a study like this. And I'm wondering why you didn't sample. I assume you didn't sample what the details of any of the events that these people were talking about, the people who said that they had experienced or observed medical errors. Because it seems to me that someone might think that not getting enough local anesthesia when sutures were put in fits your definition. And that is sort of a sub-standard technique but it would not be a medical error by lots of people's definition.

And this is all occurring in a black box and nobody has any idea if people are talking about the same severity of events.

ROBERT BLENDON: Molly, do you want me to answer or do you want to answer?

MOLLYANN BRODIE: You want to start?

ROBERT BLENDON: Yes. The issue is that this study wasn't designed to elicit this. We're asking people about a lifetime experience of they or their family member. And so every [**unintelligible**] shows that you can ask people about a severe event two years ago and not before. So they may know that a relative suffered some serious problem from a mistake that they talk about, but you can't ask them 20 years ago what it was. Didn't they give the anesthetic properly, what it was.

People have no recall of detailed events more than a couple years old. They will remember they died, they will remember they came home when they were disabled. But they will not remember the content.

In order to do that study, it would have to be a different study. You would have to ask people

SUSAN STARTS HERE

MALE VOICE continued: - -about an error just made in the last two years. And then with that very large base of errors in the last two years, ask them. Otherwise the recall of people, some of them might have had their child injured twenty years ago, they just won't remember if it was the drug or the anesthetic. So that's why you just can't follow up with those details cause all other research has shown that peoples' memories are really very lose and fuzzy about the content of what happened in an event after multiple years.

MR. BLENDON: And I guess I would just add that you're point is well taken. This is people's self perception based on their own definition of what happened and people in these cases have limited access to information. They're not medical experts so they can't, you can't necessarily think that they're defining it the same way a medical expert is, but I would go back to the fact that the physician or court's were so consistent with the public reports, which gives me at least some assurance that you might imagine that physician's are

using a more common definition and are in a better position to judge this. So, you know, you take all that together, and again, do what Drew did, cut the numbers in half, still a lot of people reporting that there's problem.

MALE VOICE: I don't think you can take it as exactly right or what, as I said earlier, teams of clinician's reviewing every case would conclude. But I think certainly the weight of the evidence here is in support of the institute of medicine's conclusion that this is a very big problem. And secondly, beyond the measurement of the frequency of medical errors, is the also important question of, how would the public respond to a bigger effort to address this issue. And for that, perceptions are actually more important – chart reviews and up the number of errors.

[some tape breakup]

MALE VOICE: The next question comes from Joyce Frieden [**Misspelled?**] of "Internal Medicine News." Go ahead please.

MS. FRIEDEN: Yes, this is just a clarification. You asked the physicians if they had I assume witnessed any errors. You didn't, I'm guessing you didn't ask them if they had committed any serious errors themselves and I wondered if you had thought about asking that.

MALE VOICE: We chose not to ask that, because that raises all types of human subject issues. What they did about that. So we chose not to ask them about their own errors.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

There's a lot of concern about the ethics of that. The difficulty of honesty reporting for it. And also the implications if you then ask them if they didn't report their patient. So we felt that there were a lot of issues that would have been involved. And we around with human subjects and ethical issues, and we chose not to ask them that.

MALE VOICE: Thank you.

MALE VOICE: Do we have other questions?

MALE VOICE: Not as this time.

MALE VOICE: Okay. Thank you all very much. Have a great day. We are all available for follow up discussions in Boston. Or in California, if you'd like. The number out here is 650 854 9400. And Bob, what number would you like to use?

MR. BLENDON: 617- 432-4502

MALE VOICE: Okay. Thanks a lot everybody.

MR. BLENDON: Take care. Right.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.