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Patient advocate recalls two medical errors that nearly killed her

HARRIS MEYER

Linda Kenney, director of peer support programs, Betsy Lehman Center for Patient Safety

Patients, families and providers need support after medical errors occur.

For the healthcare community, I would say try to listen differently to patients if they think something is wrong.

I've had two experiences with medical errors, 20 years apart, that almost killed me. The difference now is providers are acknowledging these things. Before it was deny and defend.

Ironically, the same month that *To Err is Human* came out in 1999, I was having a right ankle replacement at a prominent Boston hospital. The anesthesiologist and I decided to use a peripheral nerve block behind the knee for post-operative pain management.

They started to inject the medication, Bupivacaine. Within a minute I had a grand mal seizure followed by full cardiac arrest. I flatlined for 15 minutes.

They rushed me in for a cardiac bypass and opened my chest within 35 minutes. My husband and my kids were devastated when they got the call from the surgeon saying they'd have to crack my chest.

I was in the hospital for 10 days. I am one of the lucky ones. Not everyone survives that kind of event.

They said I had an allergic reaction to the anesthesia, but I didn't get any information or support.

I found out the medication had gone into my vascular system instead of into my nerves. The doctors decided it was a 1 in a million event.

What struck me was the impact on my family and my care providers. I later spoke with my surgeon, who was crying and saying I was a miracle from God. I eventually talked with the anesthesiologist and asked him how he was doing, and found out he wasn't doing so well.

I tried to reach out to the hospital. It took three years before they'd meet with me. I think they thought I'd sue them. I just wanted to help improve the systems that had not done well by me, my family or the anesthesiologist, who was just as cut off from support as I was.

That's when I started doing this work of helping healthcare organizations build support for staff and clinicians, and setting up peer support networks for patients and families.

The second event was this past July, when I had an emergency hernia repair at the same hospital. I went back to the ER three days later with fluid leaking from my wound. They sent me home and told me it was normal, even though I knew from previous hernia repairs that it was not normal.

I returned to the ER one week after discharge, with fever and pain. The surgical resident said it looked like a superficial infection and they'd give me antibiotics and send me home.

My cousin, who's a nurse and was with me, said I was really sick and I wasn't leaving. Then the resident came back and agreed I was really sick and admitted me to the ICU.

It turned out that during the hernia repair, they had sliced my stomach and the contents were leaking into my abdomen. I had what they called a septic

abdomen. They had to load me up with five different antibiotics and put a drain in before they could go in and take everything out.

My husband and one of my daughters were retriggered emotionally, remembering what had happened 20 years before.

I was out of work, without pay, for 2½ months.

I think the hospital has responded well. A patient safety officer came to my room. They reached out to me to set up a time to meet. My husband and I will meet with a couple of the doctors, the patient safety officer, and the patient relations person. I'll listen to what they have to say.

But my family is angry. They were angry 20 years ago, too.

What lessons do I draw from these experiences? For the healthcare community, I would say try to listen to patients if they think something is wrong.

Also, we need to provide support to providers. If you are my doctor and you are compromised because you lost a patient, I don't want to be the next patient. I want to make sure you are emotionally, physically and spiritually fit.

For patients and families, don't assume that because you're going to one of the best hospitals that you'll be safe. Have a loved one there to speak up for you.

And for those who have experienced medical harm, I would encourage them to talk to someone who's been in the same situation.

If I had cancer, I would have been inundated with support. But when something goes wrong with medical care, it can be just as devastating. We need to help normalize these reactions and support these people's needs, so they aren't traumatized the next time they go to the hospital.

The mere fact that I'm talking to you now is a miracle. When you survive something like this, you want to make sure no one else goes through it again.

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https://www.modernhealthcare.com/safety-quality/no-national-reporting-system-volume-medical-errors-still-unknown

With no national reporting system, volume of medical errors is still unknown

HARRIS MEYER

Leah Binder, left, with her late grandmother Estelle Greifer, who died after suffering a pressure ulcer.

No one knows how frequently patients experience harm in healthcare settings, though nearly everyone agrees it's far too common.

For the purpose of improving patient safety, wouldn't it help to know whether the number of patients who die each year due to preventable medical errors in U.S. hospitals is 44,000 or 400,000?

That's the grisly range of estimates produced by researchers over the past 20 years, starting with the Institute of Medicine's *To Err is Human* report in 1999. The IOM's estimate that at least 44,000 and as many as 98,000 people die in hospitals due to adverse events shocked the nation into paying greater attention to patient safety.

The magnitude of risk obviously matters a lot to patients and their families. Patient safety experts and healthcare leaders say they'd like more accurate statistics about how many people are killed and injured, by what types of errors or harms, and in what clinical settings, so they can better target their improvement efforts.

But 20 years after the IOM authors called for developing a mandatory, nationwide system for reporting adverse events causing death or serious harm, no such system has been established. Thus, no one knows how frequently patients experience harm in healthcare settings, though nearly everyone agrees it's far too common.

More than two dozen states require providers to report adverse patient events, but they typically limit reportable events to a narrow range of "never events" defined by the National Quality Forum, which only covers a small fraction of all harm events and errors. Only a few states report facility-specific information, and some do not report any information to the public, according to the National Academy for State Health Policy.

"If you walk into a hospital CEO's office today and ask how many people were injured from care last month, most CEOs could not answer that," said Dr. Ashish Jha, a professor of global health at Harvard University. "That's a travesty. If you aren't tracking how much harm you're doing, it's hard to figure out how to manage it."

That's at least partly because there's disagreement about how to measure patient harm more accurately, whether it's possible to pinpoint the number more precisely, and whether that's even necessary to enhance patient safety.

Challenges include defining errors and avoidable harm, determining whether deaths were caused by errors or other factors, and the perceived burden of data collection. Another difficulty is identifying adverse events in physician offices, outpatient surgery and diagnostic centers, nursing facilities, and other care settings that provide a growing proportion of care but lack the safety infrastructure found in hospitals.

"All those debates are a bit of a waste of time," said Dr. Don Berwick, one of the authors of To Err is Human, who would like to see better measurement but doesn't want that to hold up patient safety improvement efforts. "The number of deaths is certainly in the tens of thousands, and it's too high."

There also is disagreement about whether it's more effective to have healthcare staff voluntarily report adverse events or use automated harm surveillance tools embedded in the electronic health record. Most hospitals currently rely on voluntary reporting.

A 2011 Health Affairs study, however, found that voluntary reporting missed 90% of adverse events. Use of safety indicators built into the EHR produced

better results, enabling real-time detection of problems that protected patients, according to a Health Affairs study published last year.

“How do you know if you’re making progress in safety if you are using methods that miss 90% of safety problems?” said Dr. David Classen, a professor of medicine at the University of Utah who co-authored those studies and has helped develop automated surveillance tools.

The CMS currently is developing electronic clinical quality measures that use data from EHRs to capture hospital harm events, including hyperglycemia, hypoglycemia, opioid-related respiratory events, acute kidney injury, medication-related bleeding and pressure injuries. Agency officials hope to eventually develop a broad harm measure, according to CMS Administrator Seema Verma.

Beyond the methodological debates, however, there is continuing provider resistance to public reporting of errors. “If you don’t do well, you don’t want transparency,” said Leah Binder, CEO of the Leapfrog Group, which publishes hospital safety report cards. “And (providers) are effective in getting lawmakers to their point of view.”

In the years after the IOM report shook up the healthcare industry, a number of studies offered even higher estimates of hospital inpatient deaths from medical errors. A 2004 report by HealthGrades estimated about 195,000 inpatient deaths per year. The HHS Office of Inspector General in 2010 reported 180,000 deaths among Medicare patients alone.

A literature review published in the Journal of Patient Safety in 2013 estimated 210,0000 to more than 400,000 premature deaths a year due to preventable harm. A BMJ analysis in 2016 calculated an annual average of 251,000 deaths due to medical error, which it said understated the patient safety problem because of gaps in medical records and because the review included only inpatient deaths.

Last year, a national survey by the Commonwealth Fund, the New York Times, and the Harvard T.H. Chan School of Public Health found that 23% of seriously ill patients reported experiencing a serious medical error, including 14% at a hospital and 7% at a doctor’s office or clinic.

Earlier this year, the Leapfrog Group, which represents healthcare purchasers, estimated 160,000 avoidable deaths in hospitals. In June, the Betsy Lehman Center for Patient Safety, using 2017 claims data,

reported 62,000 preventable harm events in Massachusetts that resulted in $617 million in excess health insurance costs.

Jha has no patience with the argument that it's impossible to develop more robust measures of medical errors and patient safety, particularly with the near-universal adoption of EHRs. He said it's just never become a priority, and that federal government action likely is needed.

"This is not rocket science; it's hard but we could do it," he said. "Every hospital executive should know how many adverse events occur in their facilities. That should be at their fingertips."

The BMJ authors, led by Dr. Martin Makary of Johns Hopkins University, said medical error is the third most-common cause of death in the U.S. and urged the Centers for Disease Control and Prevention to report medical error as a cause of death in its annual compendium of vital health statistics. They argued that doing so would boost the visibility of the patient safety problem and heighten pressure to address it. The CDC has refused, saying medical errors aren't considered the underlying cause of death and often aren't reported on death certificates.

Leapfrog's Binder strongly supports the BMJ authors' proposal. Her grandmother Estelle Greifer died in March at age 103, after developing a pressure ulcer in a South Florida hospital that turned into a Stage 4 condition in a rehab facility. That's considered a "never event"—a medical error that never should occur. Neither the hospital nor the rehab facility took responsibility for the condition, she said.

But patient safety officials likely would not count her grandmother's death as medical error because of her age and other medical conditions.

"She had lived a very long, very rewarding life, but it was cut short in an excruciating way by a completely preventable error," Binder said. "We have to bring more visibility to the problem of medical errors, and that's how you bring visibility, by counting the toll it's taking on human lives."

"That's one death I can count, and I will count."