

## *Virtual Mentor*

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### **VIEWPOINT**

#### **Medical Errors**

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- In 1999, the Institute of Medicine reported that there are an estimated 44,000 to 98,000 deaths among Americans each year due to medical error.<sup>1</sup>
- A *JAMA* article in 2000 categorized medical error deaths as follows:<sup>2</sup>
- 12,000 deaths/year from unnecessary surgery.
- 7,000 deaths/year from medication errors in hospitals.
- 20,000 deaths/year from other errors in hospitals.
- Patients with some serious medical conditions are more likely to die in the hospital if they are admitted on a weekend than if they are admitted on a weekday.<sup>3</sup>
- More than half of the surgical errors occur in either a hospital-based ambulatory surgery unit or freestanding ambulatory setting.<sup>4</sup>
- According to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the most common reported surgical errors involve surgery on the wrong body part or site (76 percent), surgery on the wrong patient (13 percent), the wrong surgical procedure (11 percent).<sup>4</sup>
- Of the surgical errors reported to JCAHO, 41 percent related to orthopedic/podiatric surgery; 20 percent related to general surgery; 14 percent to neurosurgery; 11 percent to urologic surgery; and the remaining to dental/oral maxillofacial, cardiovascular-thoracic, ear-nose-throat, and ophthalmologic surgery.<sup>4</sup>
- Factors contributing to the increased risk of surgical errors included: emergency cases (19 percent); unusual physical characteristics, including morbid obesity or physical deformity (16 percent); unusual time pressures to start or complete the procedure (13 percent); unusual equipment or set-up in the operating room (13 percent); multiple surgeons involved in the case (13 percent); and multiple procedures being performed during a single surgical visit (10 percent).

#### **References**

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3. Bell CM, Redelmeir DA. Mortality among patients admitted to hospitals on weekends as compared with weekdays. *N Engl J Med*. 2001;345(9):663-668.
4. Joint Commission on Accreditation of Healthcare Organizations. Sentinel Event Alert. 2001;24. Available at:  
[http://www.jointcommission.org/sentinelevents/sentineleventalert/sea\\_24.htm](http://www.jointcommission.org/sentinelevents/sentineleventalert/sea_24.htm).

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