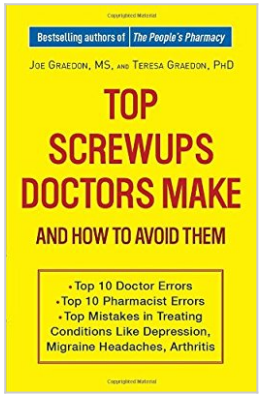

Top Screwups Doctors Make and How to Avoid Them

By Joe Graedon, Teresa Graedon

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A primary care doctor is skeptical of his patient's concerns. A hospital nurse or intern is unaware of a drug's potential side effects. A physician makes the most "common" diagnosis while overlooking the signs of a rarer and more serious illness, and the patient doesn't see the necessary specialist until it's too late. A pharmacist dispenses the wrong drug and a patient dies as a result.

Sadly, these kinds of mistakes happen all the time. Each year, 6.1 million Americans are harmed by diagnostic mistakes, drug disasters, and medical treatments. A decade ago, the Institute of Medicine estimated that up to 98,000 people died in hospitals each year from preventable medical errors. And new research from the University of Utah, HealthGrades of Denver, and elsewhere suggests the toll is much higher.
Patient advocates and bestselling authors Joe and Teresa Graedon came face-to-face with the tragic consequences of doctors' screwups when Joe's mother died in Duke Hospital—one of the best in the world—due to a disastrous series of entirely preventable errors. In *Top Screwups Doctors Make and How to Avoid Them*, the Graedons expose the most common medical mistakes, from doctor's offices and hospitals to the pharmacy counters and nursing homes. Patients across the country shared their riveting horror stories, and doctors recounted the disastrous—and sometimes deadly—consequences of their colleagues' oversights and errors. While many patients feel vulnerable and dependent on their health care providers, this book is a startling wake-up call to how wrong doctors can be.

The good news is that we can protect ourselves, and our loved ones, by being educated and vigilant medical consumers. The Graedons give patients the specific, practical steps they need to take to ensure their safety: the questions to ask a specialist before getting a final diagnosis, tips for promoting good communication with your doctor, presurgery checklists, how to avoid deadly drug interactions, and much more.

Whether you're sick or healthy, young or old, a parent of a young child, or caring for an elderly loved one, *Top Screwups Doctors Make and How to Avoid Them* is

an eye-opening look at the medical mistakes that can truly affect any of us—and an empowering guide that explains what we can do about it.

From the Hardcover edition.

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JOE GRAEDON, M.S., is one of the country's leading consumer pharmacology experts and a frequent speaker on topics including pharmaceuticals, nutrition, and home remedies. TERESA GRAEDON, Ph.D., is a medical anthropologist. Together, they are bestselling coauthors, syndicated newspaper columnists, and award-winning internationally syndicated radio talk-show hosts. Their media appearances include *Dateline NBC, Extra, The Oprah Winfrey Show, Good Morning America, Today,* and *NBC Evening News*. The Graedons maintain an interactive website at www.PeoplesPharmacy.com.

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CHAPTER 1

INTRODUCTION

Statistics are people with the tears wiped away. -IRVING SELIKOFF, MD

Imagine the headlines today if a jumbo jet crashed and killed everyone on board. Now imagine three jumbo jets crashing on the same day. There would be cries of outrage, demands for explanations, investigations, and immediate corrections to air traffic safety.

The death toll from health care screwups adds up to at least 500,000 Americans annually. That is the equivalent of more than three jumbo jets crashing every day of the year (or over 1,000 jets annually). Because these individuals are dying at home, in hospitals, or in nursing homes, no one is counting the bodies. There is no outrage, no plan to change a system that allows too many to die unnecessarily. The medical profession seems largely immune to the consequences of its errors.

If our calculations are correct, it means that medical mistakes are the third leading cause of death in the United States, right after heart disease (631,636) and cancer (559,888) and way ahead of strokes, the next big killer (137,110).1 Teasing out the total number of people dying from health care errors turns out to be incredibly difficult. In the airline industry, when a plane crashes, the death toll is known almost immediately. But to figure out how many people die each year because of misdiagnosis, medication mistakes, preventable infections, oversights, suboptimal treatment, and just plain mess-ups, we need to consider a range of statistics. There is no one place to go for such data, and the estimates that we found vary enormously.

To Err Is Human

In 1999, an organization of the country's leading health experts issued an astonishing report titled To Err Is Human.2 The Institute of Medicine (IOM), tasked with making unbiased policy recommendations to improve the health of Americans, estimated that as many as 98,000 citizens died each year in hospitals and 1 million patients were injured from a range of mistakes. The report created a firestorm of controversy inside and outside the medical community. There was a lot of hand wringing, a fair amount of denial, and eventually some brainstorming about how to improve things.

Five years later, two of the country's leading safety experts, Lucian Leape, MD, and Donald Berwick, MD, wrote a tough article in the Journal of the American Medical Association titled: "Five Years After To Err Is Human: What Have We Learned?" The answer: not much. Their conclusion: still no nationwide monitoring system and little evidence of patient safety improvement.3

Then came another bombshell. A leading independent health care ratings organization called HealthGrades reviewed Medicare data from hospitals around the country and concluded that the IOM report had grossly underestimated the number of deaths. The 2004 report concluded that the death rate was roughly twice the previous number, or an average of 195,000 citizens dying annually from preventable in- hospital medical errors.4

Another investigative report released by journalists from the Hearst Corporation in 2009, titled Dead by Mistake, estimated that 200,000 Americans died that year from hospital infections and preventable medical errors.5 In 2010, an in-depth study from the Department of Health and Human Services estimated that 134,000 Medicare hospital patients are harmed from medical care each month and 180,000 die every year as a result.6 Almost half the deaths were preventable. This mortality number includes only senior citizens, so the total annual mortality resulting from medical care is substantially higher.

More alarming than the incredible numbers of deaths was the lobbying effort by the American Medical Association, the American Hospital Association, and other special-interest groups that blocked any organized system for reporting medical errors.7 A decade after all the agonizing and brainstorming by eminent experts, we still lack a way of actually detecting and tracking medical screwups. According to Christopher Landrigan, MD, a leading patient safety investigator, "We need a monitoring system that is mandatory. There has to be some mechanism for federal-level reporting, where hospitals across the country are held to it."8

Without some sort of compulsory reporting system, hospitals may miss or ignore "93 percent of events that cause either permanent or temporary harm to a patient."9 That was the conclusion the Inspector General of Health and Human Services made based on a careful review of 278 Medicare hospitalizations.10 A 2010 study published in the New England Journal of Medicine revealed that harm to patients resulting from medical care remains common, even in places where significant resources have been devoted to improving safety.11 Nearly one in five hospital patients in the study suffered harm, and two-fifths of those injuries could have been prevented.12 A study in 2011 estimated that 6.1 million Americans are injured each year due to medical misadventures.13

Dead by Mistake Key Findings

"20 states have no medical error reporting at all, five states have voluntary reporting systems and five are developing reporting systems.

"Of the 20 states that require medical error reporting, hospitals report only a tiny percentage of their mistakes, standards vary wildly and enforcement is often nonexistent.

"In terms of public disclosure, 45 states currently do not release hospital-specific information.

"Only 17 states have systematic adverse-event reporting systems that are transparent enough to be useful to consumers."14

What these data mean is that we have no idea how many people are actually dying from medical mess-ups.

And, dear reader, please note that everything we have been discussing until now has to do with hospitals. It does not include nursing homes (where oversight is far less rigorous and where mishaps rarely get reported) or outpatient settings such as urgent care centers, clinics, private offices, pharmacies, or surgical centers, where physicians and other health care providers have no requirement (and a disincentive) to acknowledge or report mistakes. Even in hospitals, doctors are far less likely to report medical errors than nurses. In one study, "registered nurses provided nearly half of the reports; physicians contributed less than 2 percent."15 In another study of Massachusetts hospitals, physicians disclosed less than one-third of preventable adverse events.16

It would be reasonable to conclude that measuring medical mistakes is imprecise. In fact, research shows that "never events," that is, events that should never happen, are severely underreported. The Institute for Healthcare Improvement, an organization that promotes patient safety, has developed a standardized approach to reviewing patient records to detect signals of problems in medical care. This technique, known as the Global Trigger Tool, was used in one study to review approximately eight hundred patient records. The Global Trigger Tool identified more than 350 medical errors, while a computerized record review found thirty-five in the same set of records. Voluntary reporting had revealed only four of these mistakes. It's little wonder that the investigators concluded that relying on voluntary reporting alone could result in serious misjudgments of patient safety.17 In fact, 33 percent of the patients in this study experienced adverse events. This is ten times more than prior studies have found.

The Tip of the Iceberg

As we did our research for this book, we began to sense we were seeing only the tip of the error iceberg. To get a more comprehensive overview of the entire problem, we talked with Peter Pronovost, MD, PhD, one of the country's leading experts on patient safety. Dr. Pronovost is a professor of medicine at the Johns Hopkins University School of Medicine, where he directs the Quality and Safety Research Group. He also serves as the medical director for the Center for Innovation in Quality Care. Dr. Pronovost developed a "checklist" to reduce bloodstream infections. His five-item summary of the most critical infection prevention procedures distilled from the Centers for Disease Control and Prevention guidelines can be used at the bedside. Where the checklist is implemented and enforced and the infection rates are reported, hospital-acquired infections drop significantly.18 Dr. Pronovost was given a MacArthur "genius" grant in 2009 for his insights and research.

When we interviewed Dr. Pronovost on March 24, 2010, he told us that at least 100,000 people are killed each year by infections they catch in a hospital.19 He estimated that as many as 100,000 more die from diagnostic errors and suggested that the number may be double that. In addition, Dr. Pronovost counted an additional 50,000 to 100,000 who die from mistakes of commission (medical misadventures). Sins of omission are also significant; he calculated that on average, patients get only about half of the evidence-based therapies they deserve. Such sins would include things like inadequacies in diagnostic testing or not prescribing an essential medication.20 He admitted that there is no good way to evaluate the harm from these oversights, but he believes deaths from this source may even be more numerous than from any other type of mistakes. He confirmed that [it's] "absolutely right that medical mistakes are the third leading cause of death in America, and the scope of it is frightening. That hasn't really been made public."

These figures don't even include diagnostic mistakes that occur outside hospitals. No one has figured out how to count incorrect diagnoses that are made in doctors' offices, nursing homes, or urgent care clinics. There is reason to believe that these could far outstrip the number of wrong diagnoses that occur in hospitals.

Iatrogenic Deaths

The Merriam-Webster online dictionary defines iatrogenic as "induced inadvertently by a physician or surgeon or by medical treatment or diagnostic procedures." The total number of deaths that could be considered iatrogenic is difficult to determine. No one organization is counting all the deaths from the various problems that arise in the course of medical care. Pharmacy researchers have attempted to tackle the formidable task of figuring out how many drug-related complications occur outside of hospitals. One study estimated that these account for 199,000 deaths each year.21

If you add deaths from medications prescribed in hospitals and nursing homes, the number is far higher. Then there are the deaths caused by misdiagnosis, infections acquired in hospitals or nursing homes, excessive radiation, unnecessary surgery, and postoperative complications. Blood clots resulting from surgical procedures or immobilization in hospital beds account for more than 100,000 deaths annually, and many are preventable. If we add all these figures up, the iatrogenic death toll is over 700,000 a year. This figure exceeds the annual death rate from heart disease or cancer. A great many of these deaths could and should be prevented.

Treatment-Attributable (Iatrogenic) Deaths

Fatal drug reactions (in hospital): 106,00022 (range is 76,000 to 137,000)

Fatal drug reactions (outpatient): 198,81523-24

Fatal drug reactions (nursing homes): 41,65225-26 (range is 27,768 to 55,535)

Deaths related to misdiagnosis: 132,50027-30 (range is 40,000 to 225,000)

Health care-acquired infections in hospitals: at least 100,00031-33

Deaths from infectious diarrhea in nursing homes: 16,50034 (These infections are caused by Clostridium difficile, a highly infectious and potentially deadly bacteria.)

Excessive radiation from CT (computerized tomography) scans: 29,50035

Unnecessary surgery: 12,00036-37

Surgical and postoperative complications: 32,59138-39

Lethal blood clots in veins (deep vein thrombosis and pulmonary embolism): 119,00040-45 (range is 100,000 to 200,000)

Approximate number of iatrogenic deaths = 788,558

Collateral Damage

Medical screwups can lead to pain and suffering as well as death or disability. According to the Food and Drug Administration, 1.3 million people are injured each year by medication mistakes.46 We have heard from hundreds of people by mail or e_mail and through comments on our website. Many have experienced extreme pain and weakness from their cholesterol-lowering medicine. Often the discomfort gradually disappears once the medication is discontinued. But there are far too many situations that change people's lives permanently.

M. described on our website the sad consequences of a screwup during her husband's carotid artery surgery. The doctor came to tell her that the surgery had been successful, but while they were talking, her husband nearly died. It took more than twenty minutes to revive him, and he suffered severe brain damage as a result of that lengthy oxygen deprivation.

M. was initially told that her husband's heart had just stopped on its own. But once he was in rehab, she started reviewing his case with several cardiologists. They concluded, on the basis of tests, that there was nothing wrong with his heart.

When she finally requested his medical record, she hired an expert to help her review it. They discovered that the anesthesiologist had removed the breathing tubes and all the monitors in the operating room, before her husband was moved to the recovery room. When his throat swelled shut, no one noticed. He was blue and in serious trouble when the staff began reviving him. Since his throat had swelled shut, it was nearly impossible to replace the breathing tube for the oxygen.

M.'s husband had a history of sleep apnea, so the usual procedure would have been to keep him intubated until he was fully awake. Because the anesthesiologist did not follow the appropriate protocol, this fifty-seven-year-old man now has no short-term memory, can't initiate simple tasks, does not speak, and cannot be left alone.

When a patient is harmed as a result of health care, doctors call it an adverse event. Such complications can occur because of a problem in the operating room, as with M.'s husband. Other adverse events may result from reactions to medications. One man became blind in one eye because of a medication called amiodarone (Cordarone, Pacerone) prescribed for atrial fibrillation (an irregular heart rhythm). The drug destroyed his optic nerve. His wife reported on our website that they were not informed of this risk ahead of time and that the doctor insisted upon this drug although it is not the only treatment option.

Treatment-Attributable Adverse Events

Hospitalized patients with adverse events 45.8 percent47

Outpatients with adverse drug events (ADEs) 18 percent48 to 25 percent49

Health care-acquired infections 1.7 million50

Annual cost of preventable adverse events $45.6 billion51

Preventable adverse drug reactions 1.5 million52

Medication mistakes More than 1/day/hospital bed53

ICU medication errors Median 106 per 1,000 patient-days54

Treatable/preventable outpatient adverse 7.8 million55 drug events (ADE)

Percentage of ADEs not addressed by 24 percent56 physician

ADEs in Medicare patients in hospitals (2004) 888,00057

Adverse events in Medicare patients (2008) 3.2 million58

Annual cost of medical mistakes $17 billion to $29 billion59

Other adverse events occur when people catch nasty bugs while they are being treated for an unrelated problem. As dangerous as hospitals can be when it comes to spreading deadly infections, they are not the only place where people are exposed. Increasingly, surgery takes place in outpatient ambulatory surgical centers. According to the Ambulatory Surgery Center Association, three-quarters of the operations that take place each year are done in outpatient settings. 60 People go to these facilities for procedures like colonoscopies, cataract surgery, and arthroscopic surgery on knees, shoulders, and other joints. An audit of such facilities showed that many are not following basic infection control guidelines. Two-thirds of the centers studied had "lapses in infection control identified during the inspections."61

See No Evil

By any measure, medical errors and adverse drug reactions take a terrible toll. The cost in human terms is incalculable, and the cost in dollars is astronomical. If medical mistakes and misadventures were a disease, there would be a great deal of hand wringing. We would have an organization comparable to the American Heart Association or the American Cancer Society to publicize the problem, and huge sums of tax dollars would be spent researching the causes and seeking solutions to all these screwups. Instead, the medical establishment mostly acts as if this problem were invisible.

Users Review

From reader reviews:

Ruth Brown:

Your reading 6th sense will not betray you actually, why because this Top Screwups Doctors Make and How to Avoid Them guide written by well-known writer who knows well how to make book which can be understand by anyone who all read the book. Written throughout good manner for you, dripping every ideas and writing skill only for eliminate your hunger then you still uncertainty Top Screwups Doctors Make and How to Avoid Them as good book not simply by the cover but also with the content. This is one e-book that can break don't assess book by its handle, so do you still needing yet another sixth sense to pick this specific!? Oh come on your examining sixth sense already alerted you so why you have to listening to yet another sixth sense.

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Elbert Gibson:

As a scholar exactly feel bored for you to reading. If their teacher expected them to go to the library or even make summary for some publication, they are complained. Just minor students that has reading's spirit or real their hobby. They just do what the educator want, like asked to go to the library. They go to presently there but nothing reading critically. Any students feel that studying is not important, boring in addition to can't see colorful images on there. Yeah, it is to become complicated. Book is very important for you personally. As we know that on this time, many ways to get whatever we would like. Likewise word says, ways to reach Chinese's country. So , this Top Screwups Doctors Make and How to Avoid Them can make you experience more interested to read.

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