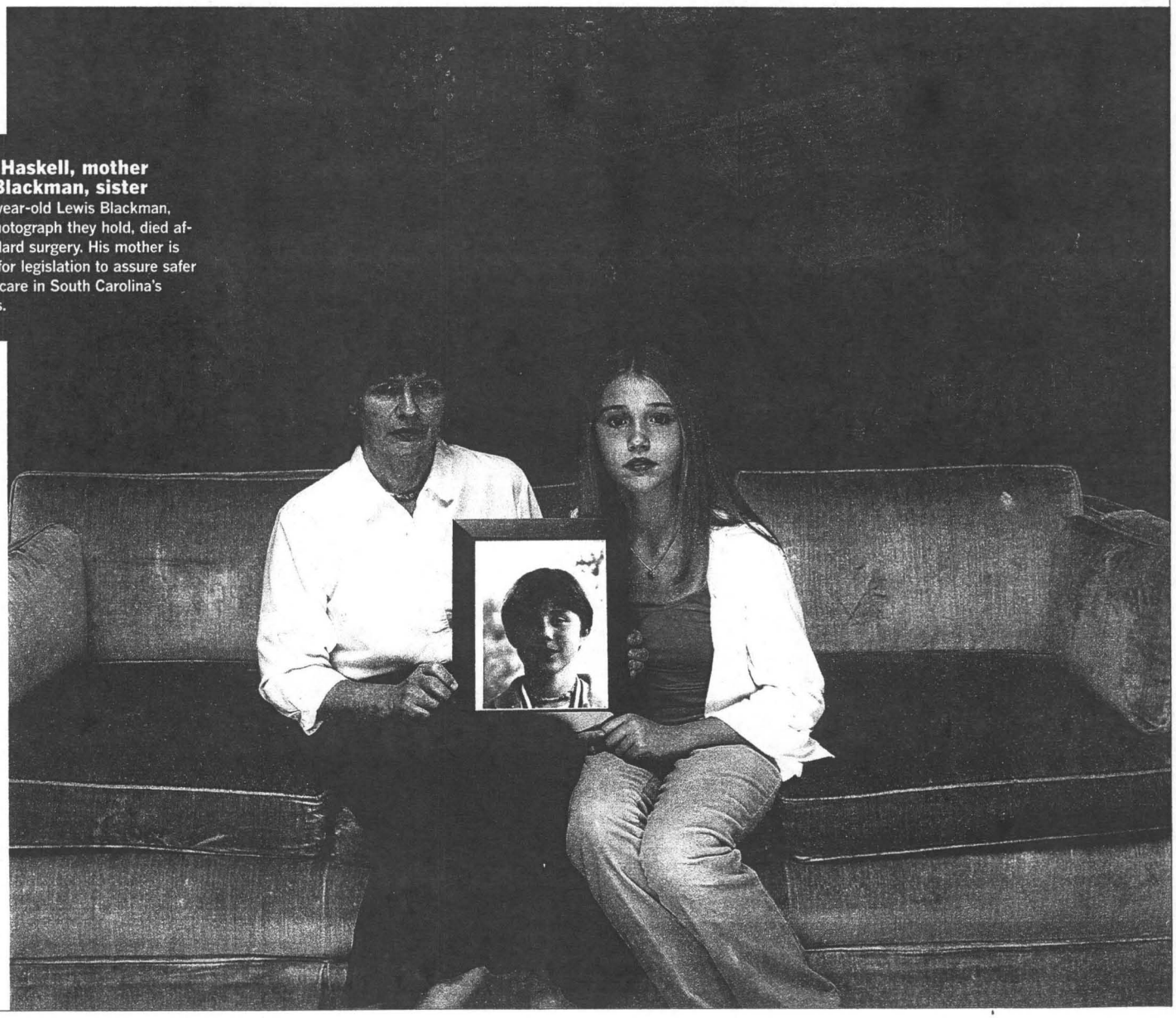
Fatal Mistakes

Every year at least 98,000 Americans die—and millions more are injured—as a result of medical errors. Now victims' families are fighting back. But how do you fix a system that's more concerned with innovation than safety?

By Trudy Lieberman Photographs By Kristine Larsen



Helen Haskell, mother
Eliza Blackman, sister
Fifteen-year-old Lewis Blackman, in the photograph they hold, died after standard surgery. His mother is fighting for legislation to assure safer medical care in South Carolina's hospitals.

Four years ago, 15-year-old Lewis Blackman went to a hospital in Charleston, S.C., for standard surgery to correct a chest malformation he was born with. The operation went well, the surgeon said. But soon things began to go wrong.

According to Lewis' mother, Helen Haskell, 53, a resident doctor prescribed an adult dosage of Toradol for postsurgical pain, and over the next four days Lewis received 17 doses, despite the drugmaker's recommendation not to give it to patients under 16.

The boy grew weaker, unable to keep food and liquids down. Three days after the operation he suddenly developed excruciating abdominal pain. His mother says the family asked for an attending physician to examine him, but all they saw was a parade of interns and residents and nurses who prodded him to get up and walk to ease his pain.

Finally, a fourth-year resident ordered a blood test. The results—delayed because the computers were down—shed little light on the case. Haskell says a blood count that would have shown bleeding or infection was never done.

Lewis's condition worsened dramatically—still no physician came to see him. The boy finally died, and a day later an autopsy showed that a large duodenal ulcer had eaten a hole in his intestines.

Lewis Blackman had bled to death.

Nobody expects to die from medical treatment. But they do every day—and in alarming numbers. The Institute of Medicine in Washington estimates that at least 98,000 people die in hospitals each year from medical errors. And about 2 million patients acquire infections, according to the U.S. Centers for Disease Control and Prevention.

Thousands more are injured because of mistakes made in doctors' offices, nursing homes and outpatient clinics. A new study by the Duke Clinical Research Institute in Durham, N.C., for example, found that inappropriate drugs are prescribed for one in five patients over 65.

In response to such pervasive mistakes—which cost billions of dollars every year and are often undocumented or even covered up—the House and Senate this year passed separate bills calling for a voluntary reporting system of errors. But experts say the bills, which have not yet been reconciled, are only a first step in protecting patients from medical missteps. So far, little has been done.

Why do so many die from botched and inadequate treatment in a country that claims to have the best medical system in the world?

The answer circles back to an increasingly complex system of care that was designed with efficacy, not necessarily patient safety, in mind. Ironically, as medical technology offers treatments and cures undreamed of four decades ago, safety has suffered. "Forty years ago medicine was safer but not as effective," says Robert Wachter, M.D., chief of medical service at the University of California San Francisco Medical Center. "These changes [in technology] require more specialized doctors, communication and teams working together." That doesn't always happen.

"Care is so poorly organized," says Carol Haraden, vice president of the Institute for Healthcare Improvement, a Boston nonprofit that works with practitioners in the delivery of care. "Right now doctors operate in fiefdoms. The lung specialist doesn't remember you have depression or a kidney disorder."

U.S. health care, Haraden says, is a system of add-ons. Each year new technology, new hospital wings and new medicines pop up without much thought about how they fit into the course of care. "The flow is horrible," she says. And shortages of nurses and other medical personnel don't help.

David Shipp, husband
Shipp, a Louisville, Ky., resident, suspected mistakes led to the death of his wife, Doris, from colon cancer. When the doctors who reviewed her case refused to tell him their findings, Shipp set out to get Medicare to change its policy.

Take, for example, the recommendation that patients receive antibiotics one hour before surgery to reduce the risk of infection. Sounds simple, but some hospitals don't have procedures for making it happen. Who's responsible—the nurse on the floor, the anesthesiologist or the doctor waiting in the operating room?

"We have not devoted the attention, effort and resources to turn health care into a highly reliable industry," says Mark R. Chassin, M.D., executive vice president at Mount Sinai Medical Center in New York. "I don't see any real leadership, and there's still no demand from the public for excellence in health care."

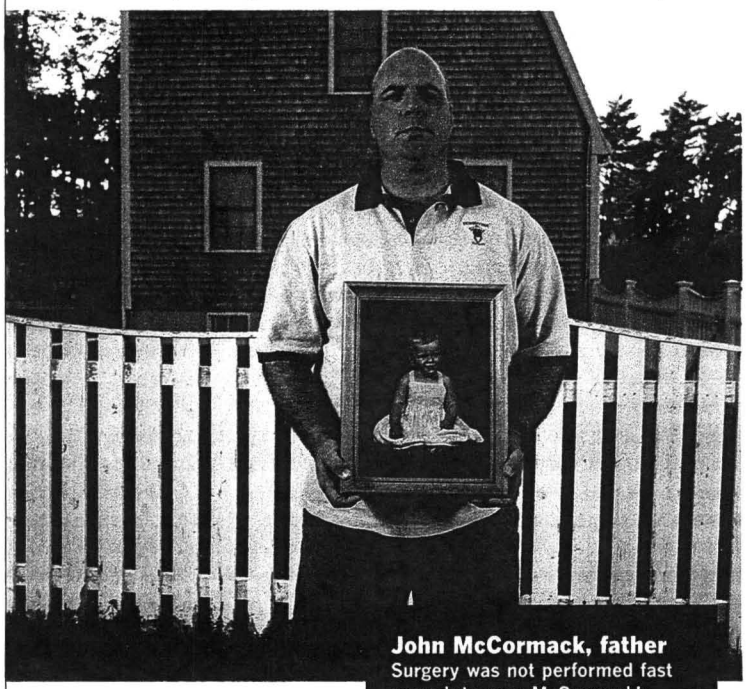
In the absence of such leadership, a variety of businesses and hospital systems are pushing for improvements themselves. Their efforts, however laudable, are piecemeal at best, and they are finding that changing the culture of medicine to keep patients safe is about as easy as threading a needle in the dark.

If hospitals, for example, would adopt computerized drug-ordering systems

for doctors, experts say, the number of serious drug errors could be cut by 50 percent. Yet only about 10 percent of the country's 6,000 hospitals have a fully implemented system.

The Leapfrog Group, a nationwide consortium of more than 150 large companies that provide health benefits to their employees, is seeking more affordable and higher-quality care. The group began a voluntary campaign in 2001 to encourage hospitals to adopt computer drug-ordering systems and other reforms such as staffing intensive care units with specialists trained in critical care. Last year Leapfrog targeted 1,200 hospitals in metropolitan areas, but only 38 have complied with its standards for electronic drug ordering.

New York has done the best job, with 17 targeted hospitals adopting the system. In California only six hospitals have done so. But in much of the country, no hospitals meet the standards. Some are reluctant to make the investment, which ranges from $500,000 to $15 million, depending on the size of the hospital.



John McCormack, father
Surgery was not performed fast enough to save McCormack's 13-month-old daughter, Taylor. After her death he fought for more accountability by Massachusetts doctors involved in medical error cases.

Doctors, too, have resisted. "Many see it as questioning their judgment or slowing down the work flow," says Leapfrog executive director Suzanne Delbanco. They have been slow to use computerized medical records and devices for electronic prescriptions to reduce errors. Some doctors balk at the startup costs, about $20,000.

Consumers sometimes resist new technologies, too. Last month the Food and Drug Administration approved a tiny implantable chip bearing the individual's ID number that would give doctors access to his or her medical records. Proponents say the chips will reduce errors and speed necessary information to doctors in emergencies. But others fear the chips could infringe on the patient's right to privacy.

Patient advocates say there are many other ways to reduce medical mistakes—improved patient education, better coordination between primary care physicians and specialists, increased nursing staff in hospitals and nursing homes and more accountability by doctors and other providers. But until more of these measures take hold, the errors—and their subsequent cover-up—are unlikely to stop. And families will still have few places to turn, says Rosemary

What to Look Out For

Patients and their families need to know where medical errors most often occur and how to improve the chances of avoiding them.

WRONG MEDICATIONS

In a hospital with 100 patients who take four different drugs four times a day, with 10 possible places in the system where things can go wrong, there are 480,000 opportunities each month for an error to occur somewhere in the medication chain.

Doctors can prescribe the wrong drug. Pharmacists can misinterpret a doctor's handwriting, supply the wrong drug, mislabel it or mix it under unsanitary conditions. A nurse can give the drug to the wrong patient.

What you can do:

- Give hospital personnel a list of all the medicines you take, including dietary supplements and over-the-counter drugs.
- Get a copy of your medication administration record, which lists the drugs you are supposed to take in the hospital. Protest if it's not accurate. Take it with you if you are transferred to another part of the hospital or a nursing home.
- If possible, go to a hospital with a computerized drug-ordering or bar-coding system, which matches the drugs patients receive with a bar code on their ID bracelet.
- Whenever you get a new prescription, tell the doctor if you are taking a similar drug for the same condition and what other medications and supplements you take. Read the prescription back to the doctor—if you can't read it, your pharmacist probably can't either.

HOSPITAL INFECTIONS

Infections are usually caused by the failure of doctors and nurses to wash their hands, the failure to give antibiotics before surgery and the improper handling of tubes and other invasive devices.

What you can do:

- Have a family member make sure you've received antibiotics before you go in for surgery.
- If you have a catheter in place, ask every doctor who examines you how long you will need it. Catheters can cause blood and urinary tract infections if kept in too long.
- Note whether hospital workers wash their hands or change gloves when examining you, inserting tubes or changing dressings. Raising the subject may prompt them to practice good hygiene.

INADEQUATE CARE

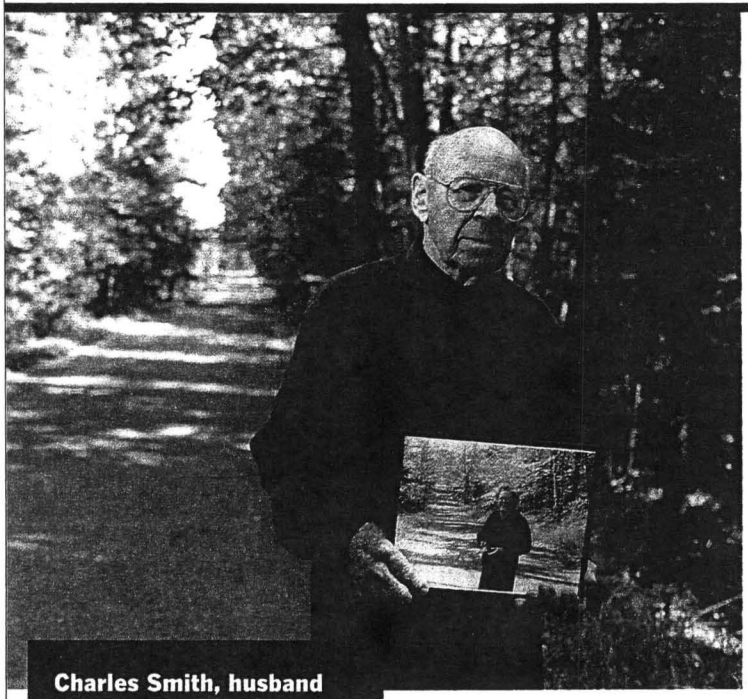
In 2003 the RAND Corp., a national research firm, found the chances of getting appropriate, adequate care that follows accepted medical guidelines are at best 50-50.

What you can do:

- Follow up on test results. Don't wait for the doctor to call you.
- Understand the treatment guidelines for your condition, which you can find on the National Guideline Clearinghouse's website at **www.guideline.gov**. Although the material may be technical, showing it to your doctor may prompt him or her to prescribe appropriate treatment.

Useful Websites

- For more on the safe use of medications, go to AARP's website, **www.aarp.org/wiseuse**.
- To find your state's Quality Improvement Organization, go to **www.cms.hhs.gov/qio** and click on "Directory."
- To find hospitals with computerized drug-ordering systems, go to the Leapfrog survey results at **www.leapfroggroup.org/consumer**.



Charles Smith, husband
His wife Polly's cancer went undetected until it was too late because follow-up tests were never prescribed. So Smith worked to have more nondoctors placed on Maine's medical licensing board.

Gibson, a senior program officer at the Robert Wood Johnson Foundation and co-author of *Wall of Silence: the Untold Story of the Medical Mistakes That Kill and Injure Millions of Americans* (Lifeline Press, 2003). "The CEO of the hospital sends condolences," she says. "A letter to the Joint Commission on Accreditation of Healthcare Organizations goes in a file. It's a crapshoot whether the health department or the state medical board will look at their case."

Sometimes, frustrated families resort to costly malpractice suits to avenge the death of their loved ones. And some turn their anger into action, trying to change the system and to slow the wave of medical errors.

David Shipp is a retired textbook salesman from Louisville, Ky., who was suspicious of wrongdoing when his wife, Doris, 70, died of colon cancer in 1999 after an initial misdiagnosis of bladder abnormality. He asked a Peer Review Organization, a group of independent doctors who ensure that Medicare patients receive adequate treatment, to examine the case. Two doctors refused to disclose the results of the review, and Shipp received a letter saying only that the PRO would take any necessary action if warranted.

Shipp sought the help of Public Citizen, a consumer advocacy group in Washington. In 2001 the group successfully challenged Medicare's policy allowing doctors to block the release of review findings in federal District Court, and the U.S. Court of Appeals upheld the ruling. Medicare beneficiaries can now file complaints with state quality improvement organizations, the new name for PROs.

In Massachusetts, John McCormack was devastated by the death of Taylor, his 13-month-old daughter, when doctors at a local hospital failed to perform timely surgery that would have relieved swelling on her brain. He waged a campaign to allow the families of those who died from medical errors to be represented in their cases before the Massachusetts Board of Registration in Medicine, which disciplines doctors. Last spring the legislature finally approved such representation over objections from the Massachusetts Medical Society.

Charles Smith of Deer Isle, Maine, pushed for more lay people on the state Board of Licensure in Medicine to assure that doctors in medical error cases are appropriately disciplined; his efforts were in vain. His wife, Polly, 73, had died of ovarian cancer 39 days after diagnosis. She'd had abdominal pains for years, and a radiologist who performed a CT scan three years before her death wrote that he could not rule out the possibility of an ovarian tumor. No more tests were done. "I note with great regret that the diagnosis never occurred to me," Polly's doctor said.

As for Helen Haskell, Lewis Blackman's mother, she's playing the waiting game. For more than a year she's been fighting to get a modest bill enacted in South Carolina that would require hospitals to display the ranks of medical personnel on name badges, to explain their roles in a patient's care and to give families an emergency number to call if they believe their patient is not getting proper medical attention. But the South Carolina Hospital Association has managed to stymie the proposal, calling it burdensome to hospitals. "We support the intent of the bill," says Patti Smoake, vice president of the group. "We want to make sure hands aren't tied, so staffing problems aren't created."

While Haskell vows to continue fighting for safe hospital care, there has been progress on one other front: In September 2002, two years after her son, Lewis, died, the label on Toradol, which is banned in five European countries, was changed to limit the use in children to a single injection—that's just 2 percent of the amount her son would have received had he lived long enough to finish the full course of treatment. ■

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Sound Off—*What do you think should be done to stop medical mistakes? We'd like to to hear from you. Please send your ideas (no more than 125 words) online to www.aarp.org/bulletin or to Sound Off on Mistakes, AARP Bulletin, 601 E St. N.W., Washington, DC 20049.*

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