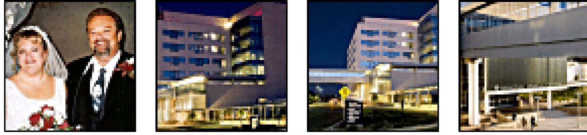
SFGate.com

Secrecy shields medical mishaps from public view

Cathleen F. Crowley,Eric Nalder, Hearst Newspapers

Sunday, August 9, 2009



Richard Flagg drowned in his blood.

Stanley Stinnett choked on his vomit.

Both were victims of the leading cause of accidental death in America - mistakes made in medical care.

Experts estimate that 98,000 people die from preventable medical errors each year. More Americans die each month of preventable medical injuries than died in the terrorist attacks of Sept. 11, 2001.

Meanwhile, a federal Centers for Disease Control and Prevention study concluded that an additional 99,000 patients a year succumb to hospital-acquired infections. Almost all of those deaths, experts say, also are preventable.

These numbers are not absolutes. There is no definitive study - which is part of the problem - but all of the available research indicates that the death toll from preventable medical injuries and infections approaches 200,000 per year in the United States.

Ten years ago, a highly publicized federal report called the death toll shocking and challenged the hospital industry to cut it in half.

Instead, federal analysts believe the rate of medical error is actually increasing.

A national investigation by Hearst Newspapers, including The Chronicle, found that the hospital industry, the federal government and most states have failed to take the effective steps outlined in the report a decade ago.

Consequently, over that period, as many as 2 million Americans have died needlessly of preventable medical mistakes.

Secrecy built into the system has kept both the scope of the crisis and the specific problem areas out of public view.

Now, as the Obama administration wrangles with Congress over access to health care, frustrated patient-safety leaders say another priority must finally be addressed - making hospitals safer.

Back in November 1999, the report "To Err Is Human" was issued with the highest of hopes. Its authors - 22 top medical experts backed by the national Institute of Medicine - believed it promised the start of a revolution in patient safety.

The report certainly sparked awareness of the scale of the problem. But some of its authors say the revolution was doomed by a lack of political leadership and the health care lobby's vested interest in maintaining business as usual, especially secrecy surrounding dangerous medical errors.

"We didn't show leadership and take charge and do what needed to be done," said report co-author Dr. Lucian Leape, who is considered the father of the modern patient safety movement.

No nationwide system

The report marked the first time that an authoritative voice urged both the medical industry and its critics to stop blaming the problem of hospital errors on individual doctors and nurses. People make mistakes, the report said, so medicine must design systems to reduce

errors and prevent harm.

Like a car ignition that won't release the keys until a driver shifts into park, the safe systems envisioned by the authors make it easy for health care workers to do the right thing.

In the operating room, for instance, don't allow two small containers, both filled with colorless liquid - one a dye and one a potentially lethal antiseptic - to be close at hand during surgery. That mistake caused a patient at a Seattle hospital to die after the antiseptic was injected into her bloodstream.

The report also called for a mandatory nationwide reporting system for medical errors. That never happened.

The American Medical Association "came out foaming at the mouth," said Arthur Levin, president of the Center for Medical Consumers.

The AMA and the American Hospital Association vehemently opposed an attempt by President Bill Clinton to require hospitals to make information about serious errors public. The groups launched a multimillion-dollar advertising campaign that said mandatory reporting would drive medical errors underground. From 2000 to 2002, they spent $81 million on lobbying and political donations, records show.

Mandatory reporting was dead on arrival.

Reportable causes of death

By contrast, Americans know exactly how many people die from car accidents each year because lawmakers decided long ago that was a step toward preventing them. Motor vehicle deaths are the No. 1 cause of accidental death in the Unites States, with more than 43,600 deaths in 2006, according to the Centers for Disease Control. The next three causes - poisoning, firearms and falls - account for 90,000 deaths, combined.

But it is clear that if medical errors and infections were better tracked, they would easily top the list.

Today, both the AMA and the hospital association continue to oppose requiring public reports of hospital errors. AMA officials say they support voluntary reporting but still have the same concerns about mandatory reporting as they did a decade ago.

The Obama administration does not support a nationwide, mandatory reporting system either.

"The best thing to do is to create the incentives and the knowledge around best practices to prevent the errors from ever occurring," Nancy-Ann DeParle, the president's health adviser, told Hearst Television.

"If we prevent the errors from occurring, then we don't have to worry about ... a massive reporting system," she said.

Key points ignored

Other key recommendations from "To Err Is Human" have never been followed, either. The report:

-- Said the public "has the right to be informed about unsafe conditions" in their hospitals. But 45 states plus the District of Columbia don't provide hospital-specific information, either because they don't allow access or because they don't collect the data.

-- Recommended the creation of a national patient safety center. Critics say the center is underfunded and has fallen far short of expectations.

-- Urged that hospitals improve the level of safety within their walls. Hundreds of hospitals responded, a few of them comprehensively pursuing safer care. Thousands did much less.

A difficult task

Forces beyond hospitals' control make the task of reducing errors difficult. The complexity of medicine is increasing so rapidly that doctors and hospitals can't keep up with the knowledge - let alone incorporate new information and technologies in systematic ways, said Dr. David Lawrence, a "To Err Is Human" co-author and the retired chairman of the Kaiser Foundation Health Plan.

On top of that, hospitals can actually lose money by providing safer care. For example, when Utah's Intermountain Healthcare hospital chain improved its system for prescribing heart patients the proper medications on discharge, rehospitalizations were reduced by 900 beds a year. As a result, the hospital lost $3.5 million in revenue.

"To my hospital administrators, there was actually a certain amount of whining about this," said Intermountain executive Dr. Brent James, another "To Err Is Human" co-author.

Some reform is under way. Last year, Medicare stopped paying for eight types of medical errors, and some states and private insurers have followed suit.

Experts believe health care reform must include changing the payment system to reward hospitals for the quality of their care, not just the quantity.

Too late for some

If patient safety improves, it will happen too late for too many, including Richard Flagg and Stanley Stinnett.

In 2000, surgeons at Meadowlands Hospital in Secaucus, N.J., mistakenly removed Flagg's healthy lung, leaving behind a tumor in the 60-year-old barge captain's diseased lung, according to the state Board of Medical Examiners. The tumor bled and made him cough. Flagg survived three years, attached to oxygen, until the tumor ruptured and he drowned in his blood.

Stinnett, 49, entered the emergency room at Memorial Medical Center in Modesto with broken ribs after a 2006 motorcycle accident. He left in a body bag.

A series of errors killed him - starting with improper treatment of an intestinal obstruction, according to testimony from his family's medical experts. The drug oxycodone suppressed his gag reflex, and when he threw up the vomitus shut off his airway, one expert concluded. The doctor denied wrongdoing, but the jury awarded the family $8.5 million. The doctor is appealing.

Stinnett was, like many Americans, at one of his life's most vulnerable moments when he entered the hospital, and he didn't have much choice about his care.

"They did nothing for him but fill him with medication to let him die peacefully," said his widow, Holly Stinnett. "There was nothing wrong with him to begin with but four fractured ribs."

Is meaningful reform ever going to happen?

"There's a point at which you have to say, 'Is it ethical to allow preventable harm to continue to occur when you know how to prevent it?' " said Levin, the medical consumers advocate. "When do you say enough is enough?"

How to protect yourself against hospital errors

Steps a patient can take to avoid medical errors and infections acquired through health care:

-- Involve an assertive friend or family member.

-- Bring someone who knows your medical history and will ask questions if you are unable to ask them yourself.

-- Use Web sites like Medicare's Hospital Compare (www.hospitalcompare.hhs.gov), the Joint Commission's Quality Check

(www.qualitycheck.org) and Leapfrog Group (www.leapfroggroup.org/cp) to research hospitals.

-- Check your state health department's Web site for hospital and physician safety records.

-- Know your medical history. Bring a list of your medications, supplements and allergies.

-- Ask questions.

-- Know what your prescription medications and medical procedures are meant to treat. Ask about alternative treatments.

-- Know how and when to take prescription medications, the prescribed dose, and any activities or other medications you should avoid. Be sure you can read the doctor's prescription. If you can't, the pharmacist may not be able to either.

Before a medical procedure

-- Ask how often it has been performed at the hospital and by your doctor. Learn what you should do to prepare and what you should expect doctors and nurses to do once you arrive for the procedure. Find out how you can expect to feel and any activities to avoid during recovery. Know whether you will need follow-up care. If the follow-up care plan changes, ask why.

-- Ask about the infection-control procedures at the hospital.

-- Remind those caring for you to take proper precautions.

-- Make sure doctors and nurses wash their hands before touching or examining you. Also ask hospital visitors to wash their hands and not place purses and jackets on your bed.

In the hospital

-- Make sure those administering medication or other treatments check your ID bracelet.

-- Ask that the procedure site be labeled with permanent marker.

-- Make sure bandages on wounds remain secure and dry.

Other resources

Agency for Healthcare Research and Quality Patient Tip Sheet www.ahrq.gov/consumer/20tips.htm

The Joint Commission's Speak Up patient safety materials www.jointcommission.org/PatientSafety/SpeakUp

Fifteen steps you can take to reduce your risk of a hospital infection from the Committee to Reduce Infection Deaths www.hospitalinfection.org/protectyourself.shtml

Sources: PULSE of NY, the Center for Medical Consumers, Agency for Healthcare Research and Quality, the Joint Commission, Committee to Reduce Infection Deaths, National Patient Safety Foundation, and the Food and Drug Administration.

Reporters and editors from these news organizations contributed to this report: The Chronicle, the Houston Chronicle, the Albany Times-Union, Hearst Television and the Toni Stabile Center for Investigative Journalism at Columbia University's Graduate School of Journalism.

http://sfgate.com/cgi-bin/article.cgi?f=/c/a/2009/08/09/MNN9191UIJ.DTL

This article appeared on page **A - 1** of the San Francisco Chronicle