■ Managed care forcing doctors to treat cases beyond their abilities

A report in the December 23, 1999 issue of the *New England Journal of Medicine* found that nearly 1 out of 4 primary care physicians feel that they are not qualified to perform the level of care their managed care arrangements expect them to.

24% of more than 12,000 doctors surveyed felt they were not capable of delivering the level of complex care that would keep the patient from having to be referred to more expensive (not to mention experienced) specialists.

Managed care plans (including government funded ones) use primary care doctors as gatekeepers to limit the number of patients going to more costly (not to mention experienced) specialists. Many times, HMOs will offer doctors bonuses for low referral rates.

38% of specialists questioned felt the primary care doctors were waiting too long to refer the patients for more specialized care. The researchers go on to say, "among specialists, more than 1 in 3 reported that the complexity or severity of patients' conditions at the time the patients were referred to them by primary care physicians was greater than it should be."

The study did not determine whether any patients received sub-standard care from primary care doctors who have low referral rates to specialists.

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■ MDs go on strike, death rate drops

The June 10, 2000 issue of the *British Medical Journal* reports that on March 9, 2000, doctors in the Israel Medical Association began sanctions to reduce their contact with patients (in other words, a strike) in order to protest a new four-year wage contract for doctors. Since going on strike, the death rate in Israel has dropped considerably according to a survey of Israeli Burial Societies.

"The number of funerals we have performed has fallen drastically," said Hananya Shahor, Director of Jerusalem's Kehilat Yerushalayim Burial Society. "This month, there were only 93 funerals compared with 153 in may 1999, 133 in the same months in 1998, and 139 in May 1997."

Meir Adler, who manages the Shamgar Funeral Parlour says, "there definitely is a connection between the doctors' sanctions and fewer deaths. We saw the same thing in 1983 (when the doctors applied sanctions for four and a half months)".

There is one town in Israel where the death rate has remained constant, the town of Netanya. Netanya has only one hospital and the doctors there signed a no-strike clause with their contract. The doctors in Netanya have not participated in the country-wide sanctions.

A similar situation also occurred in the United States. According to Robert Mendelsohn, M.D., In his book *Confessions of a Medical Heretic*, (1979) in Los Angeles County, California in 1976 the doctors went on a work slowdown to protest soaring malpractice insurance premiums.

There was an 18% drop in the death rate.

When the strike ended, the death rate went back to where it had been before the strike.

In retrospect, that may not have been the best argument they could have made about high malpractice insurance rates.

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Bad Doctors Not Reported

Reuters Health reports that in a June 6, 2001 letter to US Attorney John Ashcroft, consumer advocate Dr. Sidney M. Wolfe, director of Public Citizen's Health Research Group, asked the Justice Department to make good on a 4-year-old promise to provide information on nearly 2600 doctors who have voluntarily given up their federal narcotic prescribing licenses.

The Justice Department was to have kept information on the doctors in the National Practitioner Data Bank (NPDB) after their license had been surrendered. It is the responsibility of the US Drug Enforcement Agency (DEA) to turn over the names to the data bank. The doctors involved either violated the federal Controlled Substances Act or engaged in other unacceptable medical practices.

The NPDB is not accessible to the public. Hospitals, medical societies and managed care organizations are, however, required to check a doctor's background using the data bank in order to admit or credential them for practice.

According to Wolfe, organizations that "rely on it for accurate information…for 2,592 doctors who have done things serious enough to have their license surrendered, there will be a blank page in the NPDB."

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New law will require hospital errors to be reported

The August 2, 2002 issue of the *Baltimore Sun* reports that the Maryland Office of Health Care Quality is working on writing regulations that would require hospitals to report all medical errors that cause patients serious harm. They hope to have them in place early in 2003.

In all cases where mistakes cause death or serious injury, or require corrective treatment, hospitals would have to determine what went wrong in the case and provide a plan to prevent similar mistakes from occurring in the future.

The new rules would also require hospitals to inform patient's families about medication and surgical errors that result in a negative outcome.

According to Carol Benner, Director of the Office of Health Care Quality, "This will encourage hospitals to rally take a look at their systems, at problems that cause these errors. It's what other states are doing. It is the right thing."

To date, approximately 15 other states have passed mandatory reporting rules.

In 1999, the National Academy of Science's Institute on Medicine released a report urging mandatory reporting of serious medical errors to the appropriate state agencies.

Their recommendations came in response to what they termed a "national epidemic" of medical errors that kill 98,000 hospital patients every year.

Predictably, hospitals are concerned that disclosing medical errors in such a public forum will expose them to liability and unwanted media attention.

Beverly Miller, vice president of the Maryland Hospital Association, said her group wants to keep the reports confidential. Stating that she favors the release of "non-identifiable information" that doesn't identify specific cases, Miller echoes many hospital administrator's concerns about opening themselves up to legal liability and unwanted media attention.

Commentary: Many times medicine deals with a crisis situation, whether it involves a patient's health or their own institutional health, by simply masking the symptoms rather than fixing the cause. In this case, public disclosure of "non-identifiable information" rather than specific details is simply an attempt to cover up the symptoms. To be blunt, the liability and unwanted media attention hospitals are worried about are exactly what will fix the problem and improve patient safety as quickly as possible. We can't think of any better motivators.

98,000 patient deaths every year demand it.

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One third of drug errors in elderly are preventable

A report given on March 24, 2002 at the annual meeting of the *American Society for Clinical Pharmacology and Therapeutics* in Atlanta, Georgia says that one third of all medication errors that happen with elderly patients are preventable.

The researchers collected data on 27,500 patients over the age of 65. They found an error rate of more than 4%, or 1,202 medication errors, by examining such things as doctor, clinic and emergency room notes.

Researchers found that the most errors occurred in emergency room situations. These errors primarily came from mixing blood-thinners such as warfarin with other drugs. Nonsteroidal anti-inflammatory drugs (commonly known as NSAIDS and available over-the-counter) were also identified as a major problem contributing to errors.

Commentary: Aside from recommending that patients simply ask their doctors whether their drugs have any dangerous side effects or interactions, the researchers suggest that the industry use . . . computers! Ever on the cutting edge, the $1.3 trillion dollar a year medical industry is just now discovering that computerized warning systems should be able to keep track of dangerous drug side effects and interactions. Why, we will even bet that one day computers may replace typewriters and accounting ledgers. Just think!

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40% of new doctors feel unprepared for job

A study in the May 9, 2003 British Medical Journal says that 40% of recent medical school graduates felt that their education had inadequately prepared them for their jobs as doctors.

The study, done at the University of Oxford, surveyed 3446 doctors who graduated from UK medical schools in 1999 and 2000. Although the results varied from school to school, 42% of the students disagreed with the statement: "My experience at medical school prepared me well for the jobs I have undertaken so far."

Only 36% of the doctors agreed that they were prepared to practice.

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Parents Not Told Of Errors

The *Alternative Health Newsletter* reports on November 21, 2000 that the journal *Archives of Disease in Childhood* found that almost half of the parents of children in hospitals who received the wrong medication or dosage were never informed of the mistakes.

The study was done at the Royal Hospital for Sick Children in Glasgow, Scotland. The hospital specializes in taking care of children and babies that require risky and complex treatment.

It was found that one mistake happened for every 662 hospitalized children. While most of the errors were deemed "minor", 10% of them required extra treatment to remedy the problem.

In 48% of the cases, the parents of the children were never told what had happened.

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21% Of Hand Surgeons Have Operated On Wrong Site

A report in the February 2003 issue of The Journal of Bone and Joint Surgery says that 21% of 1,050 hand surgeons surveyed said they had operated on the wrong site at least once in their surgical careers.

The study authors, Dr. Eric Meinberg and Dr. Peter Stern at the University of Cincinnati College of Medicine in Ohio, found that nearly two thirds of the mistakes occurred on the wrong finger and the rest involved the wrong hand completely.

According to the authors, “Wrong-site surgery is a preventable and largely indefensible surgical complication.”

In 1998, the American Academy of Orthopedic Surgeons (AAOS) launched a campaign to reduce wrong site procedures. Along with verbally verifying the intended surgical site and procedure in the operating room, the AAOS recommended that surgeons simply sign the correct surgical site with their initials before surgery. The authors say 70% of the surgeons surveyed had heard of the campaign but only 45% had changed their procedures.

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Student doctors not taught to report medical errors

Reuters Health news service reports that a survey presented on February 20, 2003 at a meeting of the American College of Preventive Medicine in San Diego, California found that only about half of the medical residents (student doctors) at a community hospital were aware the hospital had a system in place to report medical errors and the vast majority of them never used it.

Researcher Dr. Dorothea Wild says, “I was surprised that the knowledge of error reporting by physicians was low and that they were using it so little.”

“If physicians don’t learn how to report errors during residency, they’re unlikely to learn it later on,” she said.

There have been many other studies showing that medical errors are underreported. According to Dr. Wild, it has to do with the way hospitals approach the issue. “The traditional hospital culture is one of blame and blaming the individual making the mistake instead of looking at the whole system.” This keeps hospitals from finding the “vulnerable spots” and taking steps to correct them.

The study did find that 35 of 36 nurses surveyed at the hospital not only knew about the error reporting system but the majority of them used it regularly. “Nurses actually did a better job of reporting errors than doctors did,” Wild said. “Doctors could learn a lot from nurses in that respect.”

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Half of all hospital injections are done wrong

The March 29, 2003 British Medical Journal reports that errors are made in nearly half of all hospital injections.

The most common errors involved injecting the medications too quickly and preparing drugs incorrectly by using the wrong dose or dissolving them in the wrong solution.

Study author Nick Barber, of the School of Pharmacy in London, says the speed at which an injection is given can be dangerous if it is done too fast. “This is because there is a load of potent foreign chemical shooting around your body – if it hits the brain or heart [all at once] it can have a marked effect,” he said.

The authors believe the rate of mistakes they discovered is likely to be the same in the rest of Europe and the U.S.

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■ Patient Advocate Group: Medication Errors Abound

An August 22, 2003 report issued by the patient advocate group Public Citizen Health Research Group points out how common medication errors have become.

The report says that recent research in the New England Journal of Medicine found that 25% of 661 surveyed patients reported an adverse reaction to medications. The Institute for Safe Medication Practices reports that 1 in 20 prescriptions filled at pharmacies has an error.

Drugs with similar names can cause confusion. Before it was renamed, the thyroid medicine Levoxine has been confused with the heart medication Lanoxin, causing several deaths. Lamictal, an epilepsy drug has been confused with Lamisil, given for nail infections. Celebrex, an arthritis drug, has been confused with the anti-depressive drug Celexa.

Commentary: Drugs are dangerous enough in their own right without having to worry about getting the names mixed up. Better to concentrate on keeping your body healthy with chiropractic wellness care.

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■ Medical Complications Cause 32,000 Deaths, Cost $9 Billion A Year

On October 7, 2003, a combined study by the U.S. Agency for Healthcare Research and Quality and Johns Hopkins University reported that medical complications cause more than 30,000 deaths and add billions of dollars to patient's medical bills.

The study examined 7.5 million hospital stays at 984 U.S. hospitals in 2000. The data projected that U.S. patients endured an extra 2.4 million days in hospitals and spent an additional $9.3 billion in excess costs as a result.

Hospital-acquired septic infections and reopening of surgical wounds were the costliest. Post-operative infections were responsible for an average of 11 extra days and $58,000 in costs. Re-opened wounds cost 9.4 extra days and $40,000.

According to the study author Chunliu Zhan, these same complications lead directly to 32,000 deaths a year. Zhan also went on to say, "our results clearly show that medical injuries in hospitals pose a significant threat to patients and incur substantial costs to society."

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Research Doesn't Support Many Common Medical Tests

The November 15, 2003 issue of the British Medical Journal reports that many of the commonly performed medical diagnostic tests do not have high quality evidence that proves they are effective at monitoring the diseases for which they were ordered.

Researchers at Hope Hospital in Manchester, UK, led by Dr. P.J. Sullivan reviewed the records of 90 patients to see which clinical tests were ordered in their case and why they were ordered. After identifying which tests were done, the research team performed a Medline search to see which tests were supported by evidence that they were effective.

Of the 165 tests they examined, only about half of them were supported by high-quality evidence. In fact, the researchers found that there were no studies whatsoever for such common tests as serial chest x-rays to rule out lung cancer and ESR tests to evaluate TB.

He added that "it may be that some of these tests could benefit from more scientific study." Many tests that medicine uses these days "were devised a long time ago, based on logic and common sense. Newer tests are much more rigorously investigated before manufacturers are permitted to market them."

Sullivan and his team concluded there is a "clear need for further high quality research into medical tests."

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Data On Risk, Quality Of Care Generally Unavailable

The January 2004 issue of the British Medical Journal highlights a study that found a serious lack of published information regarding the risk of various surgical procedures and the quality of care provided by doctors and hospitals.

Researchers examined publicly reported data about the quality of surgical care in California, the most populous state having the highest number of surgeries. They discovered data for only 12% of the types of surgeries performed.

The information they did find was only related to the quality of care at the hospital level. No information was found relating to the quality of individual surgeons, groups of surgeons or health plans. There was no information on post-surgical functional assessments such as how many patients were able to walk again after hip replacement surgery.

The researchers also found that the available information on hospital quality of care was from two to five years old.

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■ U.S. Medical "System" Creates Errors

At the May 4, 2004 opening session of the American College of Obstetricians and Gynecologists annual meeting in Philadelphia, Pennsylvania, Dr. Lucian Leape of the Harvard School of Public Health in Cambridge, Massachusetts, reported that American doctors annually write 28 million erroneous prescriptions – the wrong drug, the wrong dose or the wrong patient.

The reason? Leape, the world's leading expert on medical errors, says it's because "the system," the U.S. medical system, is designed in such a way that it promotes errors.

For example, while limits have been put on the number of hours medical residents are on call, no limits have been put on the hours attending physicians are allowed to work. As a result, senior doctors can be affected by the same lack of sleep that affects the medical judgment and abilities of young doctors.

Another problem is that doctors are still being trained to think by and for themselves rather than working with a team including nurses and residents. In fact, research is currently being conducted to see if a team-based approach can reduce the error rate as well as translate into cost savings.

Preliminary data from that study indicates that 43% of medical malpractice claims at one Boston area hospital could have been prevented by a team approach.

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Doctor's Neckties Can Spread Infection

Reuters Health news service reports on May 24, 2004 that a presentation made to the 104th General Meeting of the American Society for Microbiology finds that doctor's neckties were eight times more likely to carry pathogens than the neckties of other hospital workers who do not come into contact with patients.

Lead researcher Steven Nurkin, a medical student at the Bruce Rappaport Facility of Medicine in Haifa, Isreal noticed that doctor's ties often came into contact with patients or their bedding. After seeing the patient or doing a procedure, the doctor's would wash their hands and then adjust their tie, likely contaminating their hands.

Nurkin and his colleagues swabbed 42 neckties of doctors who regularly saw patients and 10 neckties of hospital security guards.

Twenty doctor's ties contained numerous pathogens. Only one tie from the security guards contained a single pathogen, the common Staphylococcus aureus.

Recommendations to correct the problem ranged from having doctors switch to bow ties, or use tie tacks, detergent spray or "necktie condoms." They also came up with the brilliant idea of simply not wearing them.

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Hospitals Violate Law, Do Not Report Medical Errors

On September 29, 2004, the New York Times reported that an audit by the state's comptroller found that hospitals in New York routinely violate a New York State law requiring them to promptly report medical errors that have occurred.

The audit found thousands of instances where hospitals either did not report, or delayed for weeks or even months, reports of patient deaths and mistaken surgery that may have been crucial to investigations trying to determine what went wrong.

According to the comptroller, the State Health Department did not make or follow rules as to how and when to punish violators. As a result, they only punished the hospitals on very few occasions.

Between January 2001 and May 2003, nearly 66,000 mistakes were reported. According to the audit while there were thousands of law violations in that period, the State Health Department only fined 2 hospitals and issued citations against 37.

More than 5000 of the cases were of the type that should have been reported within 24 hours. 84% of them were reported an average of 40 days late. One case, in particular, was reported more than two years late.

In the more serious cases, involving death or surgery on the wrong part of the body, hospitals are required to investigate and file a thorough report to the state within 30 days (a 15 day extension is allowed if necessary). In more than half of these cases deadlines were missed and in 11% of the cases the investigative reports were never filed at all. Those that were filed were often incomplete.

A State Health Department spokesman, William Van Slyke, said, "We welcome, of course, any critique by the comptroller's office, but to paint this as anything other than an already excellent program would be a mischaracterization."

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1/3 Of Americans May Have Experienced Medical Errors

On November 17, 2004, a study reported by WebMD Medical News says that a third of Americans say that they or a family member have experienced preventable medical mistakes, many of which led to severe pain, disability and death.

The study was a national survey of more than 2000 adults conducted by the Henry J. Kaiser Family Foundation, the U.S. Agency for Health Care Research and Quality and the Harvard School of Public Health.

In a 1999 Institute of Medicine report, experts claimed that medical errors cause upwards of 98,000 deaths per year. Many of those same experts have expressed concern that improvements in the system have been slow to come.

In this latest survey:

- 40% of the respondents believe that the quality of U.S. health care has declined in recent years.
- 55% said they were dissatisfied with the overall quality of their care.

52% of patients say they are "worried" or "somewhat worried" about the quality of health care they or their families receive.

More than 20% of those who have experienced their own or a family member's medical errors say that the mistakes caused serious consequences.

- 16% said the mistake caused severe pain or significant lost time at work.
- 8% said the error caused death.
- Only 17% of those surveyed said the quality of their health care has improved.

Nearly all of the patients surveyed said hospitals should be required to report medical errors and 63% said that the information should be made public.

Commentary: Sadly, hospitals have resisted public reporting of error occurrences, fearing (rightly so in our humble opinion) that it would unleash a torrent of lawsuits and negative publicity. Since the problem has continued unabated since first reported in 1999, it would appear that rather than resolve the preventable medical error problem, hospitals are simply pushing to keep them a secret from the people they serve.

They call it Health Care. We don't consider it healthy or caring.

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■ 80% Of Doctors Witness Mistakes

Reuters Health news service reported on January 26, 2005 that a recent survey finds that 80% of U.S. doctors and 50% of nurses said they had seen their co-workers make mistakes. Disturbingly, the survey also found that only 10% of them ever spoke up about it.

The study was conducted by Vitalsmarts, a consulting group of nursing experts. 1700 nurses, doctors and hospital administrators were surveyed for the study.

According to Joseph Grenny, president of VitalSmarts, the study also reported:

- "50% of nurses said they have colleagues who appear incompetent."
- "84% of physicians and 62% of nurses and other clinical care providers have seen co-workers taking shortcuts that could be dangerous to patients."
- 88% of doctors and 48% of nurses and other workers felt they worked with colleagues who showed poor clinical judgment.
- The 10% of workers who spoke up about the problems they saw felt good about it and were more satisfied with their workplace.
-

A 1999 study by the Institute of Health estimated that 98,000 Americans die every year from medical errors that occurred in hospitals. Other estimates place that number closer to 195,000.

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Doctor Owned Specialty Hospitals Faulted

The April 7, 2005 issue of the New England Journal of Medicine says that doctor owned specialty hospitals, such as those that offer cardiac procedures, are no better than the local community hospitals.

Lead author Dr. Peter Cram, assistant professor of medicine at the University of Iowa, says even though the specialty hospitals have produced studies showing lower death rates and shorter hospital stays, those studies are deceptive.

Cram cites the fact that specialty hospitals only admit patients who are healthier, wealthier and have better insurance coverage leaving the sicker patients for the community hospitals.

He also says that after accounting for differences in patient health and a higher volume of patients seen, there are no statistical differences in outcome. He goes on to say that while specialty hospitals do discharge the patients faster, "they do not have lower costs for Medicare patients than community hospitals."

A Congressional moratorium on construction of new specialty hospitals is set to expire in June, 2005. Experts say this report is timely since they anticipate many new facilities being set up after the moratorium expires.

Ellen Pryga, policy director for the American Hospital Association says this study reinforces the idea "that there aren't any really significant contributions coming from this particular delivery model that would warrant the kind of extreme treatment they get under government regulatory and payment policy."

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Medical Errors Worsening

A May 2, 2005 report issued from Colorado-based Health Grades Inc. finds that deaths from medical errors, particularly those from hospital acquired infections, are on the increase even though the problem is much more recognized than in previous years.

According to the report, “Hospital-acquired infection rates worsened by approximately 20 percent from 2000 to 2003 and accounted for 9552 deaths and $2.6 billion, almost 30 percent of the total excess cost related to the patient safety incidents.”

The report found that more than 300,000 patients died after experiencing some kind of hospital-related incident between 2001-2003. More than 80 percent of those deaths could be directly attributed to the incident.

A hospital’s infection rate “correlated most highly with overall performance…suggesting that hospital-acquired infection rates could be used as a proxy of overall hospital patient safety.”

“For patients, it’s important to know which hospitals meet this standard, as they are nearly 200 percent less likely to have an incident at hospitals in the top 10 percent.”

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U.S. Leads The World In Medical Errors

The November 3, 2005 issue of the internet journal Health Affairs reports that patients in the United States reported higher rates of medical errors and more disorganized doctor visits than people in other countries around the world.

The study was a phone survey of patients who had experienced some kind of serious health issue that required "intense" medical treatment or hospitalization.

Thirty-four percent of U.S. patients reported that they received the wrong medication, improper treatment or incorrect or delayed test results during the last two years.

Thirty percent of patients in Canada reported similar results along with 27 percent of Australian patients, twenty-five percent in New Zealand, 23 percent in Germany and 22 percent in Britain.

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