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Report Cites Deadly Medical Errors

By LAURAN NEERGAARD
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WASHINGTON (AP) Medical mistakes **kill anywhere from 44,000 to 98,000 hospitalized Americans a year**, says a new report that calls the errors stunning and demands major changes in the nation's health care system to protect patients.

The groundbreaking report by the Institute of Medicine says there are ways to prevent many of the mistakes and sets as a minimum goal a 50 percent reduction in medical errors within five years.

The problem is less a case of recklessness by individual doctors or nurses than it is the **result of basic flaws in the way hospitals, clinics and pharmacies operate**, the report says. The institute cited two studies that estimate hospital errors cost at least 44,000, and perhaps as many as 98,000, lives, but research on the topic is unable to pinpoint fatalities more precisely.

Doctors' notoriously poor handwriting too often leaves pharmacists squinting at tiny paper prescriptions. Did the doctor order 10 milligrams or 10 micrograms? Does the prescription call for the hormone replacement Premarin or the antibiotic Primaxin?

Too many drug names sound alike, causing confusion for doctor, nurse, pharmacist and patient alike. Consider the painkiller Celebrex and the anti-seizure drug Cerebryx, or Narcan, which treats morphine overdoses, and Norcuron, which can paralyze breathing muscles.

Medical knowledge grows so rapidly that it is **difficult for health care workers to keep up with the latest treatment or newly discovered danger**. Technology poses a hazard when device models change from year to year or model to model, leaving doctors fumbling for the right switch.

And **most health professionals do not have their competence regularly retested** after they are licensed to practice, the report said.

Indeed, **health care is a decade or more behind other high-risk industries in improving safety**, the report said. It pointed to the transportation industry as a model: Just as engineers designed cars so they cannot start in reverse and airlines limit pilots' flying time so they're rested and alert, so can health care be improved.

"These stunningly high rates of medical errors ... are simply unacceptable in a medical system that promises first to 'do no harm,'" wrote William Richardson, president of the W.K. Kellogg Foundation and chairman of the institute panel that compiled the report.

As the report's title - "To err is human" - implies, no one will ever eradicate medical mistakes.

But **"errors can be prevented by designing systems that make it hard for people to do the wrong thing and easy for people to do the right thing,"** Richardson concluded. Unfortunately, he continued, medical mistakes usually are "discussed only behind closed doors."

In recent years, however, researchers have begun coming up with **ways to avert medical mistakes**. Some hospitals now use computerized prescriptions, avoiding the handwriting problem and using software that warns if a particular patient should not use the prescribed drug. Many hospitals now mark patients' arms or legs - while they're awake and watching - to prevent removal of the wrong limb.

Anesthesiologists made their field safer by **getting manufacturers to standardize anesthesia equipment from one model to the next**. The Food and Drug Administration is trying to prevent new drugs from hitting the market with sound-alike names.

But the Institute of Medicine concluded that reducing medical mistakes requires a bigger commitment, and **recommended some immediate steps:**

1. Establish a **federal Center for Patient Safety** in the Department of Health and Human Services. Congress would have to spend some \$35 million to set it up, and it should eventually spend \$100 million a year in safety research, even building prototypes of safety systems. Still, that represents just a fraction of the estimated \$8.8 billion spent each year as a result of medical mistakes, the report calculated.

2. The government should **require that hospitals, and eventually other health organizations, report all serious mistakes to state agencies** so experts can detect patterns of problems and take action. About 20 states now require such reports, but how much information they require and what penalties they impose for errors varies widely, the report said.
3. State licensing boards and medical accreditors should **periodically re-examine health practitioners** for competence and knowledge of safety practices.

"Any error that causes harm to a patient is one error too many," said Dr. Nancy Dickey, past president of the American Medical Association, which already has started a National Patient Safety Foundation designed to address some of these issues.

But she cautioned that **some of the changes will be difficult** because doctors do face large liability for any mistake. **"We may know to talk about a culture of safety, but we still live in an environment of blame,"** she said.

The Institute of Medicine is part of the National Academy of Sciences, a private organization chartered by Congress to advise the government on scientific matters.



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