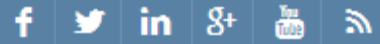


Hi, just a reminder that you're receiving this email because you have expressed an interest in Patrick Malone & Associates. Don't forget to add [pmalone@patrickmalonelaw.com](mailto:pmalone@patrickmalonelaw.com) to your address book so we'll be sure to land in your inbox!

You may [unsubscribe](#) if you no longer wish to receive our emails.

Call Us Today 202-742-1500



## Better Healthcare Newsletter from Patrick Malone

### Medicine's dirty secret: tens of thousands suffer injury and death from preventable error



Dear Jessica,

Each year tens of thousands of Americans are killed by medical mistakes and errors. These avoidable deaths and the many more injuries that happen in hospitals, nursing homes, surgery centers and medical offices are the dirty secret of U.S. medicine.

There's some dispute over the numbers but only about whether the magnitude adds up to a lot or a whole lot. Multiple researchers have reported that roughly **685** Americans die each day due to medical errors, with the

#### IN THIS ISSUE

Medical care comes with great risks

M.D.s, hospitals slow to disclose errors

Cleaning up an 'epidemic' of harms

Time to rethink hospital care?

Resources on patient safety

#### BY THE NUMBERS

**685**

Estimated daily deaths of Americans due to medical errors.

**250,000**

Estimated annual American death toll due to medical error.

annual toll as many as 250,000. Health care professionals expressed shock almost two decades ago when the Institute of Medicine issued a landmark study calling preventable medical errors an “epidemic,” with experts estimating then that they caused 100,000 deaths annually.

The nation has made headway on patient safety since. But with medical services booming and so many Americans dying due to preventable harms—more than die of respiratory disease, accidents, stroke, and Alzheimer’s—aren’t we past due in confronting costly causes of adverse medical care?

## Medical care comes with great risks



How do they hurt thee? Let us count the ways.

Some patients aren’t properly identified so doctors and nurses know who they are and what they’re supposed to be treated for. Or their lab tests get mishandled, so they get incorrect therapies. They’re given wrong drugs or too little or too much of the right drug. Kept awake night and day by hospital din and woozy from illness and medication, patients injure themselves severely when they tumble on hard floors while trying to negotiate a short trip to a hospital bathroom with IV and other equipment hanging.

They acquire nasty infections from bugs that breed only in hospitals. Some occur at patients’ surgical sites or when

## No. 3

Estimated ranking of preventable medical error as cause of Americans' deaths, more fatalities than attributed to respiratory disease, accidents, stroke, and Alzheimer's.

---

### \$17.1 billion

Estimated annual cost of measurable medical error in 2008.

---

### \$45,814

Estimated added cost to treat one patient with a common, preventable, hospital-acquired infection (HAI) via central-line and into the bloodstream.

---

## QUICK LINKS

[Our firm's website](#)

[Read an excerpt and order Patrick Malone's book](#)

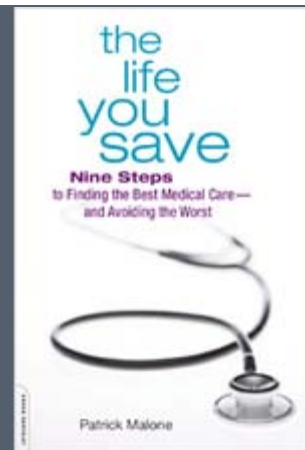
[The Life You Save](#)

[Nine Steps to Finding the Best Medical Care — and Avoiding the Worst](#)

caregivers break the skin for catheters and [intravenous lines](#). Others may be due to the failure of doctors (especially) and nurses to [wash their hands](#). Hospitals, surgical centers, and nursing homes—caring for large numbers of the sick—teem with viruses and bacteria, many of which have [grown in deadly virulence](#) and resistance to routine medical cleaning. Many of these infections increasingly can't be dispatched with a range of familiar, overused, and [powerful antibiotics](#). They will make you feel terrible, may extend your hospitalization, [add hundreds to tens of thousands of dollars to the costs of your medical care](#), and worse.

If you're undergoing surgery, your risks may be greater. Your doctor [may operate on the wrong limb or in the incorrect area](#). Surgeons may damage organs or cause excessive bleeding. They [may spread infections and cancers internally](#) while operating. Their actions, or those of an anesthesiologist, may be detrimental to your circulation and breathing. And if humans do not err in operating suites or patient treatment spaces, complex medical devices may be tainted or malfunction. They may burn patients with heat or radiation or spread infections. Their components, like batteries, may be injurious or failure-prone.

Then, you may think you're on the road to recovery and that you've escaped caregiving without injury, [only to be caught up in a poor transition](#). When you're released, you may get unclear information—or even none at all—about your next medical steps. Your medications may be messed up. Did you get released too early? Did bureaucracies and medical finances lead your doctor and hospital to put you out the door in less than optimal shape?



---

## LEARN MORE



Read our Patient Safety Blog, which has news and practical advice from the frontlines of medicine for how to become a smarter, healthier patient.



---

## PAST ISSUES

Read this before you get a metal joint put in your body  
Medical testing can be harmful to your health  
Spring clean your meds to save costs and health  
Our vehicles are killing us - and we can do a lot to stop it  
Diabetes: The new and the tried-and-true for coping

[More...](#)

Are you going home with medical issues undetected or untreated and ready to boomerang you back to a hospital or skilled nursing facility, this time more fragile than before?

To be sure, most doctors, nurses, and hospitals do their best. But medical care has become a high-pressure, high-stakes concern with complex and costly treatments. Caregivers work under huge time and resource constraints with ailing, unhappy, and uncomfortable patients, some in dire shape. Still, the evidence mounts that avoidable injury and deaths are too common.

“It boils down to people dying from the care that they receive rather than the disease for which they are seeking care,” Martin Makary, a professor of surgery at the Johns Hopkins University School of Medicine, told the Washington Post about the results of a 2016 study he led that found faults in everything from bad doctors to systemic issues, like communication breakdowns when patients are handed off from one hospital department to another.

He and other researchers estimated that 9.5 percent of all deaths in this country can be blamed on medical error. The findings caused discomfort among caregivers and questions if they were overstated. But they have been supported by other studies, including by the annual surveys of the Leapfrog Group, a well-known hospital safety advocate.

If anything, critics say, medical errors may be understated. Although legally required in many states to record and report adverse incidents, doctors, hospitals, nursing homes, and other caregiving institutions control many of the ways that the public might learn about problems. They can tweak negative circumstance, notably via the key document of a death certificate. Doctors may decide a frail, elderly patient succumbed to old age, not the ravages of a preventable infection. A medication error may go in the books as the patient dying of natural causes. It may take a long time to detect that a drug given to very sick patients, or a procedure performed on them, creates as much harm as the condition it was supposed to

remedy.

Meantime, the deaths rise—and we may not know it.

## M.D.s, hospitals slow to disclose errors



The disturbing headlines pop up regularly:

- A 52-year-old man dies after he gets a dozen infected teeth pulled so he can qualify for a liver transplant. A hospital clinic, which should have known the patient's blood-clotting is compromised and that he must be hospitalized at least overnight for observation, pulls his teeth, watches him for an hour, and then discharges him to his home 3.5 hours away. A surgical trainee botched the care but the hospital tries to blame a seasoned oral surgeon and teacher for it. Details of the incident emerge only due to lawsuits and journalistic investigation.
- An untold number of patients who are recovering so well they're moved out of intensive care and into regular, "low risk" hospital units die suddenly, sometimes just after visits by families and friends. Hospitals refer to the fatalities as "dead in bed." But a TV investigation finds evidence the deaths are linked to opioid drugs. The patients, who all showed signs of respiratory depression, may have died due to a side effect of powerful, much-abused prescription painkillers: They can slow breathing to fatal levels. Researchers long had warned of this risk in piecemeal

publication. Hospitals can reduce patient dangers with inexpensive monitoring devices, but most do not.

- A neurosurgeon with a background in cancer research moves to a new state and reestablishes himself as a spinal specialist. He [hopscoches around a big city, going from hospital to hospital and amputates a patient's spinal nerve](#), causing paralysis; cuts another patient's vertebral artery and ignores the major bleeding that occurs; installs a too-long screw so it punctures a big vein, causing extensive bleeding and nerve damage; slashes a patient's esophagus and a neck artery, leaving the man struggling to eat and breathe. After news reports and multiple, settled lawsuits, prosecutors step in. They take the rare step of filing criminal charges against the doctor because they say the medical establishment has failed to safeguard the public.

Why does it take investigative journalism and crusading patient advocates, including lawyers, to get hospitals to fess up to problem cases like these and many more? As [Healthnewsreview.org](#), the health information watchdog site, explains, doctors and hospitals “for the most part ... have circled the wagons to make sure that the public is kept in the dark when mistakes are made.”

It isn't easy or satisfying for doctors to blow the whistle on bad colleagues. Indeed, some even may be willing to lie in court for a colleague. It doesn't make sense to rely, as we do now, on practitioners to self-police—and it doesn't work, as a [U.S. Senate committee found after digging into why it took doctors and hospitals so long to get wise to dirty intestinal scopes that sickened dozens and killed as many as 21](#).

As for hospitals, they operate under extensive, supposedly rigorous laws and regulations. But when it comes to patient safety, these clearly get worked around—and they're not working as well as they should. Many states have legal oversight of doctors and hospitals. But only [about half of them require medical staff and institutions to report cases involving major](#)

patient harm, also known as “never” incidents (as in: They are never supposed to occur). Regulators get much of their pertinent information from the very targets of their supposed supervision. They also [keep it confidential or make it public slowly and only in ways that don't help patients](#). They, for example, issue aggregated numbers and not reports of problem individuals or institutions. Regulators—often thinly stretched, poorly resourced, and outmatched in knowledge and experience by those they are supposed to oversee — [also may be too predisposed to negotiate resolutions to problems they uncover](#), especially with big, wealthy, and politically powerful doctors and hospitals. But these settlements, experience has shown, may not fully address woes. They also likely will be kept secret, sometimes preventing discovery of wider, major issues.

It's also true that industry groups now handle the heavy lifting in overseeing safety and quality issues in hospitals, nursing homes, and surgical centers. Federal Medicare and Medicaid regulations permit hospitals, ambulatory surgery centers, home health agencies, and hospices to pay private accrediting groups to determine if they meet minimum requirements to participate in and receive funding from these key federal programs. The self-policing groups, which carry great prestige and considerable clout, theoretically put institutions through rigorous paces, conducting periodic, detailed site visits, interviews, and inspections. As demanding and fearsome as reviews by groups like the Joint Commission may seem to be, details of their findings aren't publicly shared. Further, the respected organizations use a lot of their sway in standards-setting and sharing of best practices and ideals, not necessarily in enforcement. Its reviewers give extensive notice of when they will conduct major reviews, though they occasionally do conduct surprise site visits. The reviewing teams can be toothless watchdogs, with [Pro Publica](#), the Pulitzer Prize-winning investigative site, reporting that: “Of the 4,018 hospitals listed on The Joint Commission's website [as participants in its programs], more than 99 percent have full accreditation and only seven are on track to lose their ‘gold seal of approval.’ ” [The Chicago Tribune](#), in a 2002 investigation, found that the commission

“frequently serves the interests of the hospital industry over those of the public, giving its seal of approval to medical centers riddled by life-threatening problems and under-reporting of patient deaths due to infections and hospital errors.”

## Cleaning up an 'epidemic' of harms



Let's be clear: Doctors, hospitals, and nursing homes have made progress in improving patient safety with [health care-acquired infections \(HAIs\)](#), for example, falling [17 percent](#) between 2010 and 2014. It's still not enough, especially as the volume and complexity of treatment has risen.

Modern medicine, in brief, has struggled with the challenge of safeguarding patients' safety because it isn't easy and it requires a commitment that's tough to sustain. Doctors and nurses are human. They make mistakes. These can be reduced and minimized with steps that include [relentless vigilance](#), [transparency](#), [culture change](#), and [persuading and reminding well-intentioned medical professionals](#) that their everyday tasks can cause harm.

Hospitals have cut HAIs, for example, with [robust campaigns](#) to get caregivers to wash their hands every time they're in contact with patients. They've improved results by getting rid of [germy fabrics in patient-privacy curtains](#) and asking doctors to [forgo dressy but dirty](#)



neckties, as well as stepping up the cleaning of their facilities, sometimes with new UV-emitting hygiene equipment. They're re-examining admission procedures to triple-check that patients get properly identified and given legible ID bands. They're using dyes and marking pens to label areas of patients on which surgeons are supposed to operate. Newer, electronic health systems and records have clarified doctors' drug prescribing (no more scrawled scripts), as well as allowing institutions to triple check that M.D.s' prescriptions and treatment plans generally adhere to evidence-based standards. Doctors, to their credit, are researching, too, how to improve patient safety, including by using, as aviation and other industries have, quality-control checklists to ensure medical staff don't let the routines of their work lull them into error.

If you look at medical journals, trade publications, and even popular press coverage of health care, it could seem as if the medical establishment is making huge strides in improving patient safety. Don't sell the farm for that idea. Reformers say they fight daily with the ingrained culture of medicine to protect patients. That's because doctors still like to see themselves as professional paragons. They're slow to change. Too many still react poorly to peers, much less nurses, giving them the least hint that they're doing something imperfectly much less in ways that are wrong and injurious. A colleague says a major academic medical center keeps up high compliance with its handwashing campaign only because the chief of staff named scofflaw doctors in a monthly staff meeting and took away their coveted parking privileges. It doesn't make sense or help the sick if nurses and other medical staff can't speak up to safeguard them. Some doctors and hospitals deserve credit for their steady, thankless internal activism on quality improvement committees to protect patients. To be fair, they're not like the mortality and morbidity sessions chronicled in the short-lived TV drama, "Monday Mornings." Safety checklists will fail in

operating suites if cantankerous surgeons can throw instruments and berate others during surgeries. If hospitals can keep secret their deaths, infections, and other adverse care, bad doctors and nurses will keep harming patients. Hospitals, surgical centers, and nursing homes also won't see and fix systemic issues that might be injurious, even fatal.

Uncle Sam, of course, has tried to crack down on medical error and patient safety. The government now declines to pay hospitals and doctors if Medicaid and Medicare patients are found to have suffered “never” events—that is they have suffered due to egregious medical errors that are more common than the incident title might suggest. Federal regulators also, under the much-derided Affordable Care Act, aka Obamacare, have developed penalties and incentives for doctors and hospitals to improve the quality and safety of patient care, including in such areas as HAIs, readmissions, and transitions from hospitals to skilled nursing, rehabilitation, and other caregiving facilities, including nursing homes. These programs are showing some good signs.

Most of us, though, aren't clinicians, so let's be clear: There are some fine medical efforts under way on patient safety and they can't all be detailed here. But patient safety is an issue that demands data and transparency so patients, families, taxpayers, policy experts, and lawmakers can best grapple with the full depth and scope of medical error. As mentioned, Uncle Sam has stepped up federal efforts. U.S. officials now collect more and better data on hospital performance, and they're publicly sharing it and improved ways, notably through a scoring system targeting lay consumers' convenience by summarizing information in star ratings. Key data, however, from industry accrediting organizations has stayed out of public view. Regulators proposed a change in this in a plan put forth by the Center for Medicaid and Medicare to release hospital inspection information. Alas,

federal officials have just pulled back from this proposal. It's a good and needed step, as would be more efforts to get states—including Virginia and Maryland— and the District of Columbia to provide better oversight of doctors and hospitals, to require them to report adverse care, and to release as much information as possible. Across the country, we also need to pay more attention to how doctors, hospitals, and states determine and record patients' causes of death. We can't let superbug outbreaks be kept out of regulator and public view by saying, instead, that a patient died of a perforated ulcer. We can't, say, let the frail elderly be deemed casualties of age, when they die due to medical error. As a patient-safety advocate noted in a study on the too-high incidence of adverse care has observed: "Medicine does not have the moral authority to discount or disregard days, weeks, or months of life" for patients.

Of course, here's hoping you simply stay healthy enough so you keep far from doctors, hospitals, or nursing homes and any attendant of their medical errors or safety woes!

## ***Resources on patient safety***



Interested in learning more about patient safety issues, particularly how various hospitals stack up?

The firm offers lots of resources on patient safety on our site or that you can find on our newsletters and our [Protect Patients blog](#).

## Time to rethink hospital care?



Is it time to disrupt the hospital-based model of care, which due to its size and complexity, carries with it ample chances and places for medical error and harm?

Researchers at Johns Hopkins have studied for some time a radical alternative that doctors say can provide many patients with improved

Patients, for example, may appreciate ideas about [ways to find a good doctor](#) or how to pick [their safest, best hospital](#).

Also, we plan to unveil soon a new interactive website that gathers performance data on Washington, D.C. area hospitals. Stay tuned for that.

It may be worth the time to check out the Centers for Medicare and Medicaid Services hospital comparison web site. [Click here](#).

U.S. News and World Report publishes hospital ratings, too, including a lot of safety data. [Click here](#).

Or you may wish to look at information provided by the patient safety advocates of Leapfrog. [Click here](#).

Obamacare boosted a part of the federal government known as the Agency for Healthcare Research and Quality. It seeks to provide robust, independent, and evidence-based information to the public. Its fate is uncertain, dependent on the continuing efforts of the Republican members of Congress to repeal and replace the ACA, as well as to fund Uncle Sam's various health-related programs. [Click here](#).

Locally, you may wish to scrutinize the output of the Armstrong Institute for Patient Safety and Quality at Johns Hopkins. [Click here](#).

outcomes, lower costs, and better experiences. How? By seeking to keep them out of hospitals and, instead, in their homes.

They can be safer and happier there, according to researchers at Johns Hopkins and the nationwide Presbyterian health system. Independent analysis by experts at the Commonwealth Fund, a nonpartisan foundation dedicated to health care's improvement, found that the chief downside of initiatives to treat patients more at home rather than in hospitals rests in [how insurers and the government pay to support them](#). [Not great at present](#).

Might that change? Other researchers have found benefits in Medicaid and Medicare allowing outpatient procedures for two of the most commonly performed surgeries these days: knee and hip replacements for older adults. With good preparation and follow-through, [patients do fine, may suffer fewer harms like infections, and can save money by getting out of the hospital faster and avoiding stays in skilled nursing care centers](#).

Stand-alone, specialty treatment centers are becoming more key in health care. Surgical centers and now rising emergency care units can have significant economic advantages over hospitals, which must carry big staffs, buildings, and overhead. They may not offer the same array of services, nor the depth of prospective care.

But they can be faster, more convenient, and cheaper—say by targeting just knee and hip

work or by dealing with emergency patients.

[Free-standing emergency departments](#)

[\(FSEDs\)](#) also may serve as navigators for the medical needs of many patients, most of whom now drive up to them. They can handle many patients' most timely woes (though not a hospital bed, for example), then send them to doctors or hospitals that excel in providing the exact care they need. Combined with urgent care, pharmacy- and community-based health clinics, FSEDs may be an option to better safeguard our health, especially if insurers and the government can figure how to reimburse them appropriately.

Specialty centers, in economic and other terms, also may help push hospitals away from being like America's troubled giant department stores, offering a range of services and options but not necessarily being the best in any. Hospitals, instead, [may become more like boutique malls](#), [bringing together and coordinating various, somewhat autonomous specialty practices](#). They also may shift their [leafy campuses into healthful hubs](#), working with public and private organizations to offer not just medical care but social services that research indicates can be beneficial to patients' well-being, including nutrition and employment counseling, as well as health education.

## Recent Health Care Blog Posts

Here are some recent posts on our patient safety blog that might interest you:

The nation's long war on one of its leading preventable killers has taken a surprising tactical turn, as the head of the federal [Food and Drug Administration](#) has declared that [tobacco companies will face new regulations aimed at slashing nicotine in cigarettes](#). FDA Commissioner Scott Gottlieb argues that cutting the addictive nicotine will help Americans unhook themselves from tobacco use, prompting less cigarette smoking, and, potentially increasing the use of possibly less harmful health vices, like nonburning "e-cigarettes" for vaping. Gottlieb, at the same time, put further off a planned FDA crackdown on e-cigarette makers, delaying for several years requirements that they disclose ingredients in their colorful, flavored vaping liquids and demonstrate that they and other e-cigarette products do not cause health harms.

- Americans each year [needlessly throw away drugs worth hundreds of millions of dollars which are still potent](#). It's a wasteful practice driven by a "myth," the mistaken belief in and scrupulous adherence to already debunked product expiration dates. Drug discards, including of medications that may be in short supply nationwide, occur all along the distribution chain, from corner druggists up to giant health system pharmacies. The practice flies in the face of known evidence, much of it developed, verified, and shared by the same force that presses for expired meds to get tossed: Uncle Sam.
- Pathologists are the medical specialists whom few patients ever meet, but they play increasingly important roles in treatment decisions. [Some new reports raise concerns about systematic errors in the path lab](#). The New York Times painted a surprisingly distanced picture of the work of pathologists in a recent report on these medical doctors who are trained to interpret an array of laboratory tests and often microscopic materials to determine the care for complex diseases. The paper found that the specialists and their labs mislabeled and mixed up patient samples and results, as well as sometimes contaminating them—yes, rarely, but with potentially significant harms. Erroneous results could lead to misdiagnoses, resulting in patients getting wrong or ineffective treatment, especially for cancers, experts say.
- This fall's National Football League games will be markedly different in an unexpected way that also offers insight into the nation's skyrocketing costs of medical care. The makers of the erectile dysfunction drugs [Viagra and Cialis are yanking \\$50 million in advertising from TV broadcasts of NFL games](#), their top contact point with male consumers. Indeed, the makers of both drugs are going dark with their costly ads across a variety of sports programs, including summer pro golf and tennis. After billions of dollars in revenues reaped every year for their manufacturers, Viagra and Cialis both are Big Pharma hot shots no longer. They may have erased any remaining decorum on TV over the years with their advertising and marketing hype. But they cannot outrun a typical drug's economic life cycle. Their patents are expiring, and their makers are trying to figure how best to exploit

their profitable, branded drugs when generics—already regulator approved and ready to go—saturate markets and drive prices down, perhaps as early as next year.

- Some of the very [medical specialists who are supposed to put patients to sleep experience big problems themselves staying awake](#), with more than half of anesthetic trainees reporting in a new national survey in Britain that they had crashed their cars or nearly done so while headed home after long night shifts. American doctors' social media responses to this new research indicate that work weariness and drowsy driving are perils for practitioners on this side of the Atlantic, too. The doctors' complaints also underscores the irrationality of recent decisions by American medical educators to reinstate long shifts for interns and residents, trainees who play important—and sleep-deprived— front-line roles in providing medical services to too many patients in academic medical centers and hospitals nationwide.

HERE'S TO A HEALTHY 2017!

Sincerely,

A handwritten signature in black ink that reads "Patrick Malone". The signature is fluid and cursive, with the first letter of each name being significantly larger and more stylized.

Patrick Malone

Patrick Malone & Associates

*Copyright © 2017 Patrick Malone & Associates P.C., All rights reserved.*

MailChimp