Medical Errors: The Third Leading Cause of Death in the U.S.

What can you do to help eliminate medical mistakes?

BY STEVE CHINN, DPM, MS, MBA

A patient admitted into the hospital falls out of the bed in the middle of the night trying to go to the restroom. In an attempt to prevent venous thrombotic embolism, his doctor had prescribed sequential compressive stockings for both lower extremities. Unfortunately, the patient forgot that he was still connected by tubing to the pump at the end of the bed. The result is a subdural hematoma when his head hit the floor with his legs tethered to the end of the bed. Miraculously, the patient survived the incident.

A doctor was running behind schedule and gave a phone order for an antibiotic to the nurse. The nurse questioned the nature of the order, but the doctor demanded that the medication be given to the patient. The patient was allergic to that antibiotic and subsequently had an anaphylactic reaction. The hospital's Code Blue team responded, and the patient recovered.

Another patient with multiple skin lesions on his neck came in to have one of the suspicious looking ones excised. Unfortunately, when the patient got home, his spouse pointed out that the doctor had taken out the wrong lesion. The patient had to return to the clinic to have the correct one removed.

Medical errors continue to plague healthcare. A 2016 Johns Hopkins study conducted by Martin Makary, MD and Michael Daniel determined that an estimated 250,000 patients are killed by medical errors every year.[1] Based on 2016 CDC data, medical errors would be the third leading cause of death behind heart disease and cancer.[2] Even though each of the above episodes resulted in the patient surviving a healthcare-acquired condition, the financial and emotional cost to the patient, staff, and doctors adds up.

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Organizations such as the Institute for Healthcare Improvement and Joint Commission are committed to decreasing medical errors. Joint Commission-accredited hospitals and surgery centers have requirements called National Patient Safety Goals, which were designed with the intent of preventing injuries from occurring. One goal is relevant to podiatry.

Universal Protocol for the Prevention of Wrong Patient, Wrong Site, and Wrong Procedures

A 2012 study from Minnesota determined that there were approximately 40 wrong patients, wrong sites, or wrong procedures done on patients in the United States every week.[3] The goal of the Universal Protocol was designed to prevent these events from occurring. The standards include:

1) Using a pre-procedural checklist. Just like pilots have a pre-flight checklist to make sure everything is in place and functioning, the intent of this standard is to make sure everything is in place, available, and working before a

Continued on page 44

Medical Errors *(from page 43)*

procedure is conducted.

2) Marking of the procedure site, especially if there are levels, laterality, or location. In podiatry, operating on the 3rd toe when the intent is the 2nd toe is unacceptable. The extra procedure and potential complaint or litigation could be avoided with a way to mark the right digit.

3) Performing a time-out prior to performing the procedure. This is a simple function of verifying that the procedure team is working on the correct patient, at the correct location, and doing the correct procedure. This does not prevent a surgeon from having to modify the procedure, but this makes sure that the team is on the same page.

It is possible that the hospital or surgery center where you operate may have more requirements. There are other pre-procedure checklists that have been circulated for years. Included in this list is the WHO surgical checklist, which addresses the pre-, intra-, and post-operative periods. These requirements may feel like extra work, taking up extra time, but if this process consistently is done, these steps can eliminate medical errors. **PM**

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References

[1] Makary M and Daniel M, Medical Error: The third leading cause of death in the U.S., BMJ 2016;353:i2139

[2] CDC Leading Cause of Death, https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm

[3] Rydrych D, Apold J, and Harder K, Preventing Wrong-Site Surgery in Minnesota: A 5-Year Journey, Patient Safety & Quality Healthcare (https://www.psqh.com/analysis/preventing-wrong-site-surgery-in-minnesota-a-5-year-journey/#)

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