

TOP SCREWUPS DOCTORS MAKE AND HOW TO AVOID THEM, by Joe Graedon, M.S., and Teresa Graedon, Ph.D. Book Report and Commentary by David G. Schwartz, M.D. October 28, 2019

## Part I

We have visited this problem previously in “Questioning the Overall Benefit of Medical Care,” in the Archives in 2010, and in Deadly Medicine and Deadly Psychiatry, both by Peter Gotzsche.

This thoroughly researched and referenced work tells the shocking story of how medical errors kill and maim people of all ages and classes.

Granted, the human body is a complex organism, and it isn't easy to make diagnoses. There are no “cut and dried” answers, and we have to have the humility to face uncertainties and complexities. We run into trouble many times precisely because we try to oversimplify diagnoses and treatments, which is what modern medicine often does. We often reduce health care to a single drug or surgical procedure for a single disease or symptom. Recall The Disease Delusion, by Jeffrey Bland, also in the Archives. The above is my introductory comment.

The Graedons have written several books on health, some bestsellers, and have hosted a long lasting radio show, “The People’s Pharmacy.” I get inspiration for most of my article from the books written by the speakers they interview in The People’s Pharmacy.

The authors describe errors in diagnoses, prescriptions, and communication, drug interactions, generic drug disasters, and screw-ups that pharmacists and patients make, and they cover several disease conditions in which screw-ups and controversies abound.

The death toll in this country from health care errors is around 500,000 annually, the equivalent of about 3 jumbo jets crashing every day of the year, the 3<sup>rd</sup> leading cause of death after heart disease and cancer. But many of the bodies are not counted. Many death certificates list the basic disease, not the medical mistake or complication. The American Medical Association, the American Hospital Association, and other special interest groups blocked any organized system for reporting errors, spending \$81 million lobbying Congress in 2001 and 2002. Without a compulsory reporting system, hospitals may miss or ignore 93% of events that injure patients. A study in 2011 estimated that 6.1 million people are harmed by errors. In the 20 states that require medical error reporting, hospitals report a very small per cent of mistakes, and enforcement is almost non-existent.

The Institute For Healthcare Improvement, developed a standardized method of reviewing patient records, called the Global Trigger Tool. Out of 800 records, 350 medical errors were found, and a computerized record review found only 35. Voluntary reporting revealed 4. Deaths related to misdiagnoses are estimated to be 133,000.

Deaths resulting from properly administered treatment (no known errors) were 656,000, with a total of 788,000 iatrogenic (caused by medical treatment) deaths.

No-fault systems of reporting with some compensation to patients, with apology, actually reduce liability. Patients most often sue when they think the error is being covered up, when transparency and communication are poor, and no apology is issued. “Patients are not stupid. They know when something bad has happened...”

In my opinion, most of these adverse events are related to the overall question of “How much medical care do we need?” The corporate takeover of medicine with the main goal of making the most money in shortest period of time by doing more medical care, more procedures, more tests, and more drugs has become the norm. Unfortunately, a large part of the public has bought into this paradigm of a pill for every ill, aided and abetted by direct to consumer drug advertising. Every drug has its toxicity, and the more drugs we take, and the more doctor visits we make, the higher the chance for errors, even when people are doing their best, forced to do everything as fast as possible. Why wouldn’t they make more mistakes than if they could take the time they need to listen to patients, talk to patients, and look at everything carefully, check and double check everything, as the airline industry does? Errors would not be so dangerous if the playing field wasn’t so hazardous to begin with, toxic drugs, surgery, and invasive procedures. Making errors with supplements or herbs or lifestyle counseling does not have such dire consequences.

The authors present Top 10 tips to stop screw-ups in hospitals. There is at least one medication error per hospitalized patient per day.

1. Expect mistakes. Every hospitalized patient needs to have someone at bedside as advocate at all times to speak up, ask questions, and to verify everything that is done. We shouldn’t have to do this. This is foreign to our thinking. We would expect that we trust the system that is caring for us for safety first. “First do not harm.” Not so. Buyer beware.
2. Drug check. Check for drug incompatibility and be sure each drug is meant for that patient.
3. Be assertive. The squeaky wheel gets the grease. Being nice can get you killed.
4. Say No. When in doubt, object.
5. Track transitions. When shifts change, responsibilities are “handed off” to the next people in charge. Be sure an advocate is included in team handover conversations.
6. Condition H – Help. If something bad may be happening suddenly, call for help.
7. Deal with discharge. Get medication instructions, possible adverse effects, and medical records.
8. Cultivate communication. Take medical records to next doctor’s appointment.
9. Double-check everything. Be sure to get copies of lab reports and question anything that looks unexpected. Don’t assume that no news is good news.
10. Take a family member to doctor visits.

Then they list top 10 screw-ups that doctors make.

1. Not listening to patients. Be assertive, be sure your story is heard and understood. Ask for a recap from the doctor.
2. Misdiagnosing. When things don't add up, ask for a second opinion or a consultant.
3. Providing too little information. Repeat back to the doctor what you think you heard, and ask for more explanations if unsure.
4. Not dealing with side effects. Doctors fail to address adverse effects 25% of the time. Call attention to it if it is ignored.
5. Under treating or ignoring evidence. Go to [www.cochrane.org](http://www.cochrane.org) or get Joe and Terry's book, Best Choices From People's Pharmacy, for help in drawing attention to evidence of a problem that needs attention.
6. Over-treating. Ask about the "number needed to treat," and the "number needed to harm," for any drug to be used preventively over a lifetime. That is, how many patients need to take a drug in order for one person to benefit, or for one person to be harmed.
7. Overlooking drug reactions. Approximately half of doctors can identify unsafe combinations of drugs. Some resources are [www.webmd.com](http://www.webmd.com), Epocrates.com, [www.Mediguard.org](http://www.Mediguard.org), and <https://reference.medscape.com>. to look at drug combinations that could be problematic.
8. Failing to revise the plan. Don't accept another drug in the same category as the one you couldn't tolerate if the 2<sup>nd</sup> one also gives you problems.
9. Overlooking lab results. One out of 14 patients with abnormal lab results don't hear about them. Call the office if 1-2 weeks have passed and no word.
10. Not addressing lifestyle issues. If you have a chronic condition or are at high risk for one, search the literature yourself for things you can do to improve your odds. Get a health coach. Don't count on the doctor for this education, but you can ask.

The authors describe diagnostic disasters. Diagnosing is not simple and easy. Doctors have to use statistics and probabilities and multiple tests, and intuition and educated guesses are sometimes necessary. Autopsy reports indicate that doctors misdiagnose fatal illnesses 20% of the time. Dr. Peter Pronovost, MD, PhD, a leading expert on medical safety, says misdiagnoses in hospitals lead to 100,000 deaths annually. The top 10 conditions most often misdiagnosed are 1. Blood clots in lungs, 2. Drug reactions or overdoses, 3. Lung cancer, 4. Colorectal cancer, 5. Heart attack, 6. Breast cancer 7. Stroke, 8. Congestive Heart Failure, 9 Fractures, 10. Abscesses.

They then discuss the top 10 reasons doctors misdiagnose. 1. Overconfidence. What we said before about humility and recognizing the complexity of the human body holds true here. As Mark Twain commented, "It's not what you don't know that gets you into trouble, but what you know for sure, that ain't so." You have a right to question anything that looks questionable. 2. Information overload. 3. Going it alone. 4. Tunnel vision. 5. Time pressure. 6. Missing test results. 7. Ignoring drug side effects, and poor reporting to FDA. 8. Follow-up failure. 9. Hurried handoffs. 10 Communication break down.

Now, these are the top 10 questions to ask to reduce diagnostic disasters.

1. What are my primary concerns and symptoms?
2. How confident are you about this diagnosis?
3. What further tests might be helpful to improve your confidence?
4. Will the tests you are proposing change the treatment plan in any way?  
Sometimes simple curiosity motivates the ordering of many tests.
5. Are there any findings or symptoms that don't fit your diagnosis or that contradict it?
6. What else could it be? Even if the doctor seems very confident in that diagnosis.
7. Can you facilitate a second opinion by providing me my medical records?
8. When should I expect to see my test results? Will you call me with them, or will they come by mail or electronically?
9. What resources can you recommend for me to learn more about my diagnosis?
10. May I contact you by e-mail if my symptoms change or if I have an important question? Or how else can I best reach you? In one practice, email reduced the amount of time the doctor spent answering questions compared to the telephone. Remember though, that unless the communication is well encrypted, health information sent over the internet may not be protected from security breach. Recognize that your email becomes part of the medical record. Be concise. Don't write paragraphs. Never use email for emergencies.

Then, they describe the top screw-ups made when prescribing. Some of these repeat items on previous lists. Leading patient safety experts concluded that 7.8 million Adverse Drug Events (ADE's ) could be prevented or ameliorated if patients and their physicians communicated better, and if physicians acted more reliably to address medication symptoms.

1. Failing to disclose drug side effects
2. Creating obstacles to the reporting of symptoms. Patients may not know what to look for or recognize drug related symptoms if not forewarned, and phone trees make it difficult to get through to report symptoms or questions.
3. Ignoring drug-induced symptoms. Doctors may fail to recognize symptoms to be drug related about 40% of the time, and patients are unaware.
4. Overriding medication alerts. Electronic drug interaction warnings were dismissed by prescribers 90% of the time, and allergy warnings  $\frac{3}{4}$  of the time.. The large number of potential interactions can lead to "alarm fatigue," as it may be hard to distinguish between minor and major interactions. Children and seniors are most vulnerable to drug reactions.
5. Since doctors don't pay or know the cost of drugs, patients may be surprised and may take less than prescribed due to cost.
6. Not knowing actual effectiveness. A vast majority of medications work on only 30-50% of patients, and FDA approval may be based on a very small margin of efficacy over placebo. The FDA does not define what "safe and effective" means.
7. Relying on surrogate markers. For chronic, potentially fatal conditions, we want to know if a drug reduces overall mortality, not just whether it lowers B.P. or lipids or glucose (surrogate markers). Some drugs can lower B.P., for example, and cause increase in death rates.

8. Not checking for drug interactions, as mentioned before.
9. Not keeping up to date with new drug research.
10. Not reporting drug problems to the FDA. Patients may need to pressure their prescribers to report adverse events to the FDA's MedWatch system.

The authors also give top 10 questions to ask the doctor when getting a prescription

1. Is there another way to treat my condition besides this drug?
2. What is the evidence that this drug will produce a meaningful outcome, and not just change some numbers on a test?
3. How likely am I to get a benefit from this medication?
4. What are the most common side effects?
5. What are the most serious side effects?
6. What symptoms require me to contact you immediately?
7. How can I get through to you promptly?
8. How long do I need to take this medication?
9. How should I take this drug – with food or without, morning or evening, any foods to avoid? (You may get more answers from the pharmacist)
10. Are there any special instructions on how to stop this medicine?

The book devotes a whole chapter on drug interactions. Years after a drug is approved for sale, dangerous interactions may be discovered. After enough bodies have piled up and enough random reports to the FDA accumulate, the agency pays attention, and warnings come out. One study found that prescribers correctly categorized drug-drug interactions only 44% of the time. This shows to me that more continuing medical education (CME) programs are needed so that doctors have a better understanding about the drugs prescribed. Unfortunately most CME is sponsored by the pharmaceutical industry, whose incentive is to promote prescribing of drugs, not to issue more warnings, that may decrease prescribing. CME seminars that are not connected to the industry are needed, for more judicious prescribing. Direct to consumer advertising of drugs is false and misleading advertising and should not be allowed. Only 2 countries in the world allow it. We don't need it. It does not provide valuable education to improve patients' health. Only the pharmaceutical companies need it to increase revenue.

Tips for preventing dangerous drug interactions: Take a list of medications to every appointment, ask the doctor about interactions, ask the pharmacist about interactions, ask about over-the-counter drugs, go to the internet and check on them yourself, beware of drug-alcohol interactions, ask about drug-disease interactions, and potential effects of drugs on laboratory tests.

Part II will cover mistakes that pharmacists make, generic drug problems, special hazards for seniors, screw-ups that patients make, and more of my comments on the whole medical industry, with some references to Shannon Brownlee's book, Overtreated.