The American Health Care System:

Saving or Killing Us?

When most people experience a state which they define as disease or illness, they expect one of two outcomes: either the condition resolves itself on its own, maybe with the aid of some over-the-counter medicine, or they will seek the care of their physician, who, will of course, “fix” them. Unfortunately, the reality of health and healing is far more complicated and, surprisingly, disputed, than this assumption. While most people have undoubtedly experienced many recoveries in their lifetime from trivial, to even severe, illnesses and injuries, many others have also experienced the dark side of medicine in the form of medical errors. The troubling reality of the healthcare system in America is that medical error is actually the fifth leading cause of death. This fact places it above diabetes, pneumonia, accidents, Alzheimer’s and many of the other top ten leading causes of death. However, “death by medical error” is not mentioned on any statistical analysis of the leading causes of death by the CDC.

This issue first gained national attention in 1999 when the Institute of Medicine published a report called To Err is Human. The findings of this report shocked and even enraged the medical community. The report estimated that 44,000-98,000 Americans die each year as a result of medical errors, and this may even be a
conservative number (Corrigan 1). Of particular importance is that the report only looked at hospital errors, and did not consider outpatient facilities, doctors’ offices or clinics, etc.

Following the publication of this report, the debate began. While most people, as well as physicians, do not dispute the fact that errors do indeed occur, the level at which they happen is subject to interpretation. In a study by the Harvard School of Public Health and the Henry J. Kaiser Family Foundation, it was found that 42 percent of the public, as well as one-third of American doctors, state that either they or their family members have experienced medical errors while receiving medical care (Robblee 1184). Despite this surprisingly high statistic, most people do not consider medical errors to be a serious problem.

Of all the problems present in today’s modern health care system, medical errors unfortunately raise few eyebrows. Physicians are most concerned with exorbitant medical malpractice insurance premiums, while the public is worried about the high cost of health care and lack of insurance to pay for it. In a recent study regarding this issue, it was found that only five percent of physicians and six percent of the public feel medical errors are a top concern (Medical 3). Physicians are blaming the nursing shortage and overworked health care professionals for the errors. The public, on the other hand, blame physicians for not spending enough time with patients (Patients 20). Obviously, there are very opposing poles on the cause of this problem, at the heart of which is the IOM report.
No sooner did the IOM report To Err is Human become published, than the debate and changes in public policy began. Within two weeks of the release of the report, Congress began hearings on the feasibility of implementing the recommendations of the report. One of these proposed changes included a national oversight body that was responsible for the expanded reporting and recording of medical errors nationwide. In addition, Congress also called for the development of patient safety programs, as well as intensified efforts by all involved in patient care to improve safety (Leape 95). Before these initiatives could begin, however, critics were already jumping to point out the flaws in both the study and in the data gathering techniques employed.

Critics argue that the figure of 44,000 deaths per year attributed to medical errors is outrageous. Their first argument is in relation to the two studies that were used as the basis for the report. The two studies, one by Harvard and the other done in Colorado and Utah using the same methods, were observational studies and not therefore designed to describe causal relationships. The authors of the studies use caveats such as “lead to death” and “died at least in part as a result of adverse event” (McDonald 94). They state that the IOM did not list these limitations as part of its report.

The fact that the data used in the report had limitations is not disputed. The nature of these limitations, however, is. The study was originally designed to assess the extent of injury that could lead to malpractice litigation. For this reason, the study excluded nondisabling injuries and instead focused on negligence. In addition, the
study was done in retrospect. As many patient care functions are not recorded in patient records, or at least were not at that time, many problems in patient care were never noted or even known. For example, studies of autopsies have found potentially fatal misdiagnoses in 20-40 percent of the cases examined (Leape 96). Due to these problems, in all actuality the data collected was far more likely to lead to an underestimate on the prevalence of harm and death, than an overestimate as the opponents argue.

This problem aside, the next argument focuses on the groups that were used to calculate the data. Opponents argue that the data was calculated on the premise that most patients admitted to hospitals have high disease burdens and are high death risks even before they enter the hospital; that those patients selected for chart review in the Harvard study were a high severity group and would of course reflect a higher mortality. Unfortunately, this misses the point completely.

Many items are overlooked by opponents of this study, including the following:

- The screened group contained many patients who were not very sick at all.

- A large proportion of the patients in the sample who were severely ill, had complicated conditions, or who were admitted for planned terminal care were not included.
Adverse medical events occurring outside the hospital (including the six percent of events discovered after discharge) were excluded from the study as well. (Leape 96)

In addition, opponents argue that statistically, the study did not use a baseline for comparison. Opponents argued for a baseline that included total admitted patients, as well as deaths, in high-risk categories. Realistically, this does not work. In fact, according to Leape, when you equate screening criteria with risk factors, “death becomes both a predictor and an outcome. One cannot predict an outcome with itself” (Leape 96).

The simple fact is that the study is valid. At best, its numbers are accurate. At worst, it severely underestimates the reality of medical errors. According to Dr. Anthony Rosner:

To set the record straight, the points are simply the following:

- In a study of patients lost to acute myocardial infarction, pneumonia, or cerebrovascular accidents (conditions found to account for 36 percent of all hospital deaths), 14-27 percent were deemed preventable.
- Up to 17 percent of invasive care unit patients had preventable serious or fatal adverse events in another study.
- The Centers for Disease Control and Prevention estimate 500,000 surgical site infections each year.
- Another large controlled study reported the excess mortality rates of surgical infections to be over four percent, suggesting 20,000 deaths
annually in the U.S. from this cause alone.

- Nonfatal medical injuries resulting in disability or prolonged hospital stay occur in 1.3M U.S. patients per year. (1)

It is apparent by the above data that the aforementioned at worst scenario may in fact be the reality of the situation, and therefore must be explored.

One of the arguments against the IOM study was that it listed 7,000 deaths as being due to medicine errors, and unfortunately made the mistake of including drug overdose among these errors. Since this report was published using data from studies in 1991, things have only spiraled downward on the prescription side of medical errors. In 1994, the Lancet stated that medication-error deaths are rising and reports that one out of every 131 outpatient deaths were caused by medication error and goes on to state that "patients must understand that and be warned about the potential dangers of prescription drugs" (Lancet 643). More recently, according to Pistolese, "Therapeutic drug use (not illicit drug use) each year; kills as many as 198,815 people, puts 8.8 million people in hospitals, accounts for 28 percent of all hospital admissions, and costs as much as $182 billion dollars" (1). These figures excluded errors in drug administration, noncompliance, overdose, drug abuse, therapeutic failures, and possible adverse drug reactions. The Journal of American Medicine has cited these same figures as well (Classen 1155). Amazingly, less than 200 death certificates show drug side effects as the cause of death. Instead, the physical ailment, such as hemorrhaging, that occurred is listed while failing to mention the medicine that caused the
hemorrhaging (Pistolese 1). In order to understand how this can be true, we must explore “the money trail.”

With the recent explosion of drug companies openly advertising their products in magazines, TV and radio spots, many people now openly go to their physicians seeking specific medications to cure what they have self-diagnosed as their ailment. The general public is neither trained, nor capable, of making such a judgment call. We are not privy to the thick pages of clinical trial reports that disclose all the adverse events that occur during testing, as well as even deaths. Nor are we privy to understand how a clinical trial occurs, or what the actual results are, without some serious research. For that matter, neither are the doctors who are prescribing them.

To illustrate this point, there is the example of the neurosurgeon and his wife on vacation in the Virgin Islands. His wife had been suffering from the hives, and was prescribed an antihistamine called Hismanal. Her prescription called for one tablet every morning. One evening while on vacation, her hives were especially bad. Although her husband had not been the prescribing physician, he was still a physician. She asked him if it would be okay to take a second tablet. He said, “sure, one tablet can’t kill you.” The next morning, he awoke to find her dead. The autopsy confirmed a heart attack, believed to be caused by the Hismanal. He was so traumatized, he has not practiced medicine since (Moore 16). Amazingly, even in cases like this, health professionals are under no obligation to file a report as to the occurrence of the event.

Another case in point is Procardia XL. Procardia XL (a calcium channel blocker) is typically prescribed for high blood pressure and the chest pains caused by heart
disease. It was tested for and approved based on its short-term clinical testing results: Procardia XL did in fact lower blood pressure, although the patients felt no difference. The hope was that over years of use, Procardia, as well as other calcium channel blockers, would lower the risk of heart attacks and stroke. With more than seven million people taking calcium channel blockers, the stakes are high financially. When reports began to surface that these products are actually causing heart attacks, as well as internal bleeding and cancer, the pharmaceutical manufacturers were quick to the defense. Referring to their initial studies of safety, they argued the effectiveness of their product. However, as mentioned earlier, no long-term studies had ever been done, and still haven’t. Even the American Heart Association refuses to address the issue, deferring patients to their doctors.

Unfortunately the doctors have also been fed the party line. There is no “proof” to substantiate that the pharmaceutical companies products are causing these deaths. Doctors were provided with brochures for their education, and to hand out to their patients on the safety and benefit of these medications. However, there is also no “proof” that these drugs are safe, since we lack long-term studies. Even if only .05 percent of the people who take calcium channel blockers are injured or killed by them, that is still 35,000 people per year for only this particular class of drug (Moore 26).

The costs of adverse drug events alone are astounding. One study states that they may cost $5.6M per year per hospital. In addition, preventable drug-related morbidity and mortality was estimated to cost $76.6 billion in the ambulatory care
facilities. The largest component of these totals is associated with drug-related hospitalizations. The estimated cost ranged from a conservative estimate of $30.1 to $136.8 billion in a worst-case scenario. However, this does not include malpractice or litigation claims, or the cost to the patient (Agency 1). According to the IOM study, 28-95 percent of these events are preventable through computerized monitoring systems. This can virtually eliminate errors caused by incorrect dose, frequency, and route errors. It is currently estimated that as many as 60 percent of drug errors alone are simply due to a miscalculation of dosage (Agency 5).

While all prescriptions carry risks, which are often times not predictable, much can be done to lower their incidence. Many hospitals are now using computerized programs that act as clinical identifiers to indicate that a drug reaction may be occurring. The computer program “watches” patient records for indications of an event in progress, such as sudden rash, fever, change in respiratory rate, seizure, or change in heart rate or mental status. The computer can also monitor lab results and alert hospital personnel of potential problems.

Another extremely useful benefit of computerized monitoring is automatic error reporting. Only nine cases of adverse drug events were reported in 1989 by hospital personnel in Salt Lake City, the hospital trying this new software. However, in 1992 the computer reported 529 incidents of adverse drug reactions (Agency 5). It is obvious from these figures that these adverse reactions had been occurring all along, albeit unreported. These 529 cases represent potentially $1.3M in additional costs to the hospital, not including lawsuits.
Given the high economic burden of medical errors, it is no great surprise that we spend more per capita than any other industrialized nation on health care. In fact, we spend 16 percent of our GNP annually on healthcare, the most of any industrialized nation. By comparison, one would think our system would also be superior. Unfortunately, this is not the case. The poor performance of the U.S. was recently confirmed by a World Health Organization study that ranked the United States as 15th among 25 industrialized countries. The World Health Organizations findings on the ranking of the US are presented as follows:

- 13th (last) for low-birth-weight percentages
- 13th for neonatal mortality and infant mortality overall
- 11th for post-neonatal mortality
- 13th for years of potential life lost (excluding external causes)
- 11th for life expectancy, at 1 year for females, 12th for males
- 10th for life expectancy, at 15 years for females, 12th for males
- 10th for life expectancy, at 40 years for females, 9th for males
- 7th for life expectancy, at 65 years for females, 7th for males
- 3rd for life expectancy, at 80 years for females, 3rd for males
- 10th for age-adjusted mortality (World)

If the problem of our nationwide health in relation to other countries isn’t startling enough, most medical practices used in this country, such as surgery, vaccines, and antibiotics are also questionable. Many have not been scientifically proven, as they regularly ask alternative practitioners to do with their methods of treatment. In fact, according to Dr. Eddy, only about 15 percent of all medical interventions are supported by scientific evidence. This is partly because only 1 percent of the articles written in
medical journals are scientifically sound (Smith 798). As pharmaceutical companies, which use clinical trials and often no control groups, fund and publish many of the articles in scientific journals their validity is highly questionable. In addition, many articles are written based off of isolated positive results from new procedures that have yet to be tested on a large scale. In effect, any physician who takes these articles as gospel is subjecting his patients to be nothing more than human guinea pigs, perpetuating the cycle of medical abuses.

Considering what we know about health care, our high level of technology and expert practitioners, and the amount of money we have available both for research and health care expenditures, we should be the top industrialized nation for the health of our population. However, it is easy to see why we are not when we consider in addition to medical errors, how our health care dollars are spent.

It is hard to get exact figures, but only 50 cents of every healthcare insurance dollar actually goes to the direct benefit of our patients. Ten cents is taken off the top by the insurers. About 25 cents goes to company administration, marketing, and profits. (A notable exception is Medicare, which is sustained on a 3 percent overhead) Another 15 cents is disbursed to brokers, lawyers, billing systems and a host of mandated regulatory functions. The administrative costs of hospitals have become as much as 25 percent of the hospital budget. (Bryan-Brown 6) However, we cannot make the error of blaming hospital administrators or insurance companies alone for this mess. We also cannot place the burden singly on the
shoulders of doctors and health care workers. We must accept responsibility for what our own culture, and we as its members, have done, and continue to do to drive the medical error machine.

As a general rule, when people go to the doctor they have several expectations. First, they expect their doctor to be knowledgeable enough to tell them what is wrong. Second, they expect the doctor to know how to fix it to enable them to feel better. Most of the time, this happens. Whether all that is needed is psychological reassurance that what we are experiencing is simply a cold, or whether we are told we need surgery, we are usually told not to worry- our “dis-ease” is fixable. Unfortunately, this simple picture is not always what really happens when we visit our physician.

Take, for example, the parent of a sick child. The child has been running a fever, is crying and is listless. The doctor knows it is only the latest virus, and that in a few days the child will make a complete recovery with no further medical interventions. The parents, however, ask for antibiotics. While the doctor knows they are not needed, he prescribes them anyhow to appease the family. This happens more often than people realize. In 75 percent of the cases where a physician prescribes antibiotics, it is solely for the placebo effect and not because the patient actually needs them (McTaggart 188). This practice alone has caused the introduction of super bugs that are resistant to all current antibiotics. In addition, 41 percent of doctors stated that they prescribe medicines that they do not feel the patient actually needs (Taylor 1). Regrettably, the overuse of medical interventions doesn’t stop with prescriptions.
If you have ever had a loved one in the hospital or been in the hospital yourself, you, or someone you know, have uttered the words, “Do whatever is necessary.” In our society, we have come to value medical tests, surgeries, and drugs to push the envelope of survival. As already stated earlier, only around 15 percent of these items we feel we cannot do without, are actually proven. However, doctors, fearing to be sued for malpractice if they don’t do everything, no matter how futile, will pull out all the stops. In a recent survey by Harris Interactive, physicians stated that due to the fear of liability, the following are common practice:

- 79 percent say they order more tests than are medically needed
- 74 percent say they refer patients to specialists more often that they would if based only on their professional judgment
- 51 percent suggest invasive procedures such as biopsies more often than they would if based only on their professional judgment

Overall, 94 percent of physicians, 66 percent of nurses, and 84 percent of hospital administrators believe than unnecessary or excessive care is provided due to fear of malpractice. In addition, 43 percent of doctors have stated they have considered leaving medicine because of the medical liability system. (Taylor 1)

It is a sad time when most of our society has come to prefer longevity of life, to quality of life, and our medical community fears treating us utilizing their training and judgment. Instead, there are held hostage by their patients and their patients’ families, who demand everything possible be done, no matter how futile or unnecessary. As a
society, we have come to feel that unless the doctor actually does something for us, he is neglecting his duties. Simply telling us it’s a cold and it will go away on its own is not enough. Instead, we insist on medications, tests, and procedures to fix us. The sad truth is that more often than not, we are truly not broken. However, we end up causing ourselves unnecessary harm by insisting on procedures we don’t need.

There have been numerous books recently written on what ails the health care system. They talk about unethical doctors who don’t tell you the truth about procedures and allow you to make an informed decision. They discuss the pharmaceutical companies and their pillaging of the American pocketbook with ineffective and potentially fatal medicines. We have all heard the news reports accusing the FDA of being paid off by pharmaceutical companies to overlook incomplete studies of their new prescription, or the prescriptions’ harmful side effects. A perfect recent example is the Phen Phen incident.

To make matters worse, every day through televised, print and radio media we are bombarded by ads from drug companies telling us to watch out. We may look healthy; we may feel healthy; but something is hiding that may kill us. Could it be cholesterol? Depression? Diabetes? Not to worry- they have a drug to fix that. In Disease Mongers, the author states, “We could become a nation of healthy invalids, crippled not by disease but by the idea of disease” (Payer 17). Regardless of whether drug companies believe that they can fix us, the problem begins when we as individuals first mentally assume and accept that we are broken.
Just as medicine and positive thinking can help us, negative thinking can also harm us. How many times have you been near someone sick and said, “Oh, now I’m going to catch their cold!” Then, a funny thing happens: a few days later you are sick. Compare this with doctors and nurses, who are bombarded with sick people on a daily basis, and yet to our amazement remain healthy and cold free most of the winter season. No, it’s not because they are privy to some wonder drug. It’s because they don’t worry about “catching” anything, and the mind responds in a like fashion and manufactures what they need to stay healthy. Despite the overwhelming evidence that placebos are as effective as most drugs, few people choose to accept this. Instead, they prefer what new technology has to offer in the way of the latest diagnostic tools and procedures.

While good at expensive, heroic care, Americans are very poor at the low-cost preventive care that keeps most other nations healthy. Instead of chasing our tails in the circle of blame, we must shift our focus to addressing and fixing the problem of medical errors. There is no longer doubt that these errors exist. Many can be traced directly to pharmaceutical errors, while others trace to us and our cultural way of perceiving medical care and our definition of illness and dis-ease.

It’s time we ask ourselves some tough questions about the value we place on health, as well as those who help us to achieve it. If physicians would spend as much energy in caring for their patients as they do treating them, many errors would cease to exist. In addition, patients are not free from blame. They must take the initiative to make a conscious effort to listen to their doctors’ advice on how to be and stay healthy.
Most importantly, we need to get away from the mentality that there is a pill or a procedure that will instantaneously fix whatever ails us.

Doctors are neither miracle makers nor gods, and we cannot hold them mercilessly accountable when they make every effort to use their best judgment: they are simply humans like the rest of us, doing their best, and yes, making some mistakes along the way. Instead, it’s time to open our eyes to the reality of this problem, and then will we find the solutions. Maybe, just maybe, if more people realized that medical treatment is the fifth leading cause of death in this country, we would all take a moment to really think about how we define both health and disease, and realize the true cost of our ignorance.
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