Doctors Confess Their Fatal Mistakes

Doctors, nurses, and pharmacists hold your life in their hands. Here, their shocking stories of what can go wrong—and what has to improve to keep us safe.

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“It was more than 20 years ago, but it still haunts me,” says Bryan E. Bledsoe, a clinical professor of emergency medicine at the University of Nevada School of Medicine. “I made a

mistake that may have cost a woman her life."

Bledsoe's oversight, which you'll read about later, has driven him throughout his career. To this day, he is an outspoken advocate for health care safety, teaching physicians-in-training to treat patients as individuals, not as numbers at a deli counter. It sounds like an obvious message, but an overemphasis on speed is just one of the reasons that, every day, Americans in hospitals around the country are injured or die because of a medical error. "Any physician who says he or she never made a mistake is a liar," Bledsoe says.

The problem of avoidable medical error burst into the news in 1999 when the Institute of Medicine published To Err Is Human: Building a Safer Health System. Highlighting an estimated 98,000 unnecessary deaths every year, the report inspired a patient-safety movement—but over a decade later, not nearly enough progress has been made, say many experts.

What's still needed: more thorough approaches to investigating errors, support systems that help doctors admit to and learn from their failings, and better methods of adopting proven solutions. In the meantime, people are still dying needlessly.

"If we don't talk about the problem of hospital error, there's no way to fight it," says Peter Provonost, MD, PhD, a

professor at Johns Hopkins University School of Medicine, whose own father died because of medical errors at age 50. “Whenever I’ve worked up the courage to share a personal mistake, my colleagues listen raptly. But most don’t say anything, even though I know they’re just as guilty. The culture of medicine still won’t allow it.”

But that’s changing. When Reader’s Digest first considered approaching health care professionals to ask them to confess their biggest mistake, we worried that few would speak up. We were wrong.

Doctors, nurses, and pharmacists all stepped forward. Each of these professionals welcomed the chance to say “I’m sorry”—and, more important, to address the weaknesses in the health care system that continue to make errors like theirs possible.

Read their stories and see if you, too, don’t entertain some hope that a better, safer health care system is on the way.

“I Could Have Caused Permanent Brain Damage”
By Peter Provonost, MD, PhD

I was a young doctor doing specialty training in critical care, and I was exhausted. Partway through a 36-hour shift at Johns Hopkins Hospital, I was hungry and hadn’t slept for 24 hours, but I was facing an overflowing intensive care unit and

somehow needed to discharge five patients to make room for more. Mr. Smith,* who'd had esophageal surgery, was a borderline call. But because of the pressure I was under, I decided to remove his breathing tube and transfer him to another unit.

**Name changed to protect privacy*

That turned out to be a very bad decision.

Before long, his breathing sped up as his oxygen levels dropped dangerously. I needed to reinsert his breathing tube. But what I didn't know was that he had severe swelling in his throat—in fact, the anesthesiologists in the operating room had had difficulty placing the tube in the first place. When I looked into his mouth and tried to identify his vocal cords in order to insert the tube, all I saw was a swollen mass of dark pink tissue, like raw hamburger meat.

I took the instruments out and started to bag him, breathing for him, but he vomited, making that almost impossible. I finally got the tube in—but quickly realized it was in his esophagus, not his airway where it belonged. Understand that when you insert a breathing tube, you give the patient medication to stop his breathing. You have about four minutes before he suffers brain damage. It took me between three and five minutes to get the tube properly placed.

I waited anxiously for the medication to wear off, which usually takes about 15 minutes. But after an hour, Mr. Smith was still asleep. After six hours, I was panicked. I explained the situation to the patient's wife—well, I sort of explained it. Fighting back tears of shame and guilt, I told her I'd had difficulty reinserting the tube, but I didn't mention that it was the wrong decision to remove it in the first place. Doctors, especially Johns Hopkins doctors, didn't make mistakes. If you did, you suffered your shame silently.

Luckily, Mr. Smith regained consciousness shortly thereafter and recovered with no ill effects. I still remember my overwhelming feeling of relief.

How to Fix the Problem

Many medical errors occur because hospitals lack standardized checklists for common procedures designed to minimize the chance of bad judgment. Airline pilots and NASCAR teams have them—why don't doctors? I think it's partly because it's so important for us to believe in the myth that doctors are perfect.

Before I pulled that tube, I should have had to complete a checklist that included input from the patient's senior physician and nurse. If anyone had disagreed, I wouldn't have been able to act. A simple system like this not only protects patients but also promotes honesty, respect, and

teamwork among hospital staff.

A few years ago, I helped develop such a checklist for doctors and nurses in more than a hundred ICUs in Michigan. It focused on a common intensive care procedure: inserting a catheter into a vein just outside the heart for delivery of intravenous fluids. It ticked off five steps everyone had to follow, and in 18 months, it lowered the rate of catheter infection by 66 percent and saved 1,500 lives.

Mr. Smith taught me a lesson I never forgot. It's time we let him teach us all.

Peter Provonost, MD, PhD, is a professor at Johns Hopkins University School of Medicine and the coauthor of Safe Patients, Smart Hospitals: How One Doctor's Checklist Can Help Us Change Health Care from the Inside Out.

"The Wrong Medication Dose Killed a Toddler"
By Eric Cropp

It was a busy Sunday in the pharmacy at Rainbow Babies & Children's Hospital in Cleveland. The hospital's computer system had been down for about ten hours before I started my shift, and because I was teamed with a pharmacist who was fairly new to the department, I had additional responsibility. But I'd been in busy situations many times before. In fact, I had 14 years of experience and had been

president of the Northern Ohio Academy of Pharmacy.

But on this day, I made the mistake of not thoroughly checking a saline-solution base that a technician had prepared for a child's chemotherapy treatment. She mixed it more than 20 times stronger than ordered, and I didn't catch it. When a nurse administered it, the high concentration of the sodium chloride flowing through the child's veins made her brain swell and put her in a coma. Three days later, she died. Her name was Emily, and she was two years old.

I was eventually convicted of involuntary manslaughter, for which I received six months of jail time, six months of house arrest, three years of probation, a $5,000 fine, and 400 hours of community service. I also lost my license, career, reputation, and confidence. But most devastating of all is that I have to live every day with the memory of that little girl.

I accept full responsibility for what happened. I should have checked the solution more carefully. But there are some facets of hospital and retail pharmaceutical work that desperately need fixing if similar tragedies are to be avoided.

How to Fix the Problem

Pharmacy technicians need better training. Most people don't realize that techs have something to do with approximately 96 percent of prescriptions dispensed in

pharmacies, according to the National Pharmacy Technician Association (NPTA). Yet 92 percent of us live in states that do not require them to have any formal training. (The tech in my case had a high school diploma.) Ohio recently adopted Emily's Law, which requires that all techs undergo training and pass a competency exam. The NPTA is currently working on a bill that would institute Emily's Law nationwide.

We should also take advantage of technology. There are lots of look-alike, sound-alike medications that come in small vials with tiny labels. A bar-code scanning system, like the ones in supermarkets, would supply an extra layer of safety.

But technology isn't enough; pharmacists and techs need better working conditions. Pharmacies can be cramped and the workload is often heavy. But studies suggest that crowding and dim lighting make mistakes more likely. So do interruptions, and the need to fill too many prescriptions. Believe me, a lot of pharmacists say a little prayer on their way home that an error didn't slip through.

Finally, I wonder what would have happened if I had talked Emily's family right away and said I was sorry. I was advised against doing that. That's the way it is in the medical world when a mistake occurs: Hospital management may meet with the family, but the health care worker is often advised not to make a personal apology. Too much of a culture of silence still exists and must change. Doctors, nurses,

pharmacists, and others need to be able to come together to confess their mistakes, clear their consciences, be supported, and, most important, work together to make the system safer.

Eric Cropp, 42, is currently unemployed

"My Patient Had a Life-Threatening Clot, But I Didn't Know the Symptoms"
By Robert M. Wachter, MD

I was a second-year medical student at the University of Pennsylvania, and on my second day of rounds at a nearby VA hospital. Penn's philosophy was to get students seeing patients early in their education. Nice idea, but it overlooked one detail: Second-year students know next to nothing about medicine.

Assigned to my team that day was an attending—a senior faculty member who was there mostly to make patients feel they weren't in the hands of amateurs. Many attendings were researchers who didn't have much recent hospital experience. Mine was actually an arthritis specialist. Also along was a resident (the real boss, with a staggering mastery of medicine, at least to a rookie like myself). In addition, there were two interns. These guys were just as green as I was, but in a scarier way: They had recently graduated med school, so they were technically MDs.

I began the day at 6:30 a.m. with a “pre-round,” a reconnaissance mission in which an intern and I did a quick once-over of our eight patients; later, we were to present our findings to the resident and then to the attending. I had three patients and the intern had the other five—piece of cake.

But when I arrived in the room of 71-year-old Mr. Adams,* he was sitting up in bed, sweating profusely and panting. He’d just had a hip operation and looked terrible. I listened to his lungs with my stethoscope, but they sounded clear. Next I checked the log of his vital signs and saw that his respiration and heart rate had been climbing, but his temperature was steady. It didn’t seem like heart failure, nor did it appear to be pneumonia. So I asked Mr. Adams what he thought was going on.

**Name changed to protect privacy*

“It’s really hot in here, Doc,” he replied. So I attributed his condition to the stuffy room and told him the rest of the team would return in a few hours. He smiled gamely and feebly waved goodbye. At 8:40 a.m., during our team meeting, “Code Blue Room 307! Code Blue 307!” blared from the loudspeaker. I froze. That was Mr. Adams’s room.

When we arrived, he was motionless. The resident immediately began CPR while yelling: “Wachter! What did he look like this morning?”

I stammered, then lied: “He was a tiny bit short of breath, but he was okay.”

The autopsy later found Mr. Adams had suffered a massive pulmonary embolism. A blood clot had formed in his leg, worked its way to his lungs, and cut his breathing capacity in half. His symptoms had been textbook: heavy perspiration and shortness of breath despite clear lungs, with the right interval between his major hip surgery and the onset of respiratory symptoms. The only thing was, I hadn’t read that chapter in the textbook yet. And I was too scared, insecure, and proud to ask a real doctor for help.

This mistake has haunted me for nearly 30 years, but what’s particularly frustrating is that the same medical school education system persists. Who knows how many people have died or suffered harm at the hands of students as naïve as I, and how many more will?

How to Fix the Problem

What’s needed is this: Students and residents should participate in teamwork training, just like commercial airline pilots do. Such training stresses the importance of speaking up when they see something they don’t understand.

What’s more, before they start working on the wards, students should do exercises with computers or actors to

help them better recognize the symptoms of common clinical syndromes.

Finally, attending physicians should be up-to-date in hospital care, and should have undergone special training to help them balance the amount of supervision needed for patient safety with the graded independence that will help trainees become practitioners.

Robert M. Wachter, MD, is associate chairman of the Department of Medicine at the University of California, San Francisco, and author of a blog and six books on health safety and policy, including Internal Bleeding*, from which this story is adapted.*

"I Unknowingly Discharged a Patient Having a Stroke"
By Bryan E. Bledsoe, DO

I'll never forget her—in fact, I still have dreams about the look on her children's faces after she died. Her name was Claire,* and she came into the ER where I was working as an emergency physician. She had an old neck collar on upside down and was complaining of neck pain and a bad headache. She was about 60 years old, and I thought she might have had a mental handicap because she had difficulty describing her symptoms. Her son and daughter were with her, and they also seemed a bit slow.

**Name changed to protect privacy*

This ER was always busy, and the administration had been pressuring us to move patients through more quickly. I examined Claire briefly and saw no worrisome signs. X-rays of her neck showed nothing wrong; I assumed she had slept wrong or pulled a muscle. So I discharged her with some pain medication and picked up the next chart in the bottomless stack.

The next morning we received a call from an ambulance transporting a female who had suffered cardiac arrest. She was brought into the resuscitation room, where we continued CPR. I didn't recognize her at first, but then I noticed a familiar-looking son and daughter sobbing in the hallway. I looked at the lifeless patient and almost broke into tears myself. In my rush the day before, I hadn't listened carefully to Claire's complaint of severe headache. Now it seemed clear to me that I'd overlooked a symptom of an impending stroke.

We did everything we could, but I knew our efforts were hopeless. After I pronounced her dead I met her son and daughter in the small chapel near the emergency department. I started to explain—in way too technical terms—what happened. Then I paused, and tears came to my eyes.

“I’m so sorry,” I said. “I wish I had ordered a CT scan yesterday. I must have missed something. I’m so sorry.”

“That’s okay,” Claire’s daughter replied. “We know you did your best. Mom said you were a good doctor.” I couldn’t stop my tears now. A few days later, I went to the funeral, where I sat with Claire’s children. Even thought 20 years have passed and I’m now a medical-school professor, I haven’t forgotten.

How to Fix the Problem

I try to impress upon physicians-in-training that medicine is more than using advanced technology to move an endless flow of patients. Every person in the exam room, regardless of social status, is a human with a family, and our duty is to act in that person’s best interest—not in the best interest of insurance companies and hospital administrators, the way I did.

We also need to erase the burden on the ER. Between 1997 and 2006, emergency department visits increased by 32 percent, while reimbursement to hospitals hasn’t kept up. We need more retail health clinics and urgent-care centers. And we need to educate people so they trust these new clinics and use them for all but the direst emergencies.

Until these things occur or other solutions are found,

unfortunately what happened to Claire will happen again—and again.

Bryan E. Bledsoe, DO, is a clinical professor of emergency medicine at the University of Nevada School of Medicine in Las Vegas.

"I Didn't Question a Doctor I Knew Was Wrong"
By Sunnie Bell, RN

I was the nurse in charge of the evening shift at a small hospital. I was enthusiastic and experienced—a top graduate of a prominent nursing school. I had come on duty at 3 p.m. and met 85-year-old Mrs. Owen,* who had been admitted by Dr. X, her long-time family physician, because she had a suspected bowel obstruction. She was alone.

**Name changed to protect privacy*

Around 5:30, her condition worsened dramatically. She was in increasing pain, and I became convinced she needed emergency surgery—obstructions can be deadly. I called Dr. X at home immediately. He was a highly regarded doctor, and his photo was displayed in the lobby along with those of the hospital's other physicians. I passed it every day on my way to work.

But despite my concern, Dr. X said surgery could wait until the morning. He told me to increase her pain medication, but

the drugs didn't help, nor did anything else I tried.

Over the next five hours, I called Dr. X three more times, asking that he come to see her or at least call in a consulting physician. I always got the same instructions delivered in an ever more irritated way. And because nurses never questioned doctors, I bit my lip and followed orders.

Toward the end of my shift, Mrs. Owen was so weakened by her pain she could barely speak. She motioned me over to her bed and whispered, "When is my doctor coming?"

"Soon," I lied. That word has echoed in my head for quite some time.

Mrs. Owen died the next morning. Whether she had a heart attack, stroke, or ruptured colon, we'll never know, because an autopsy was never ordered. Dr. X completed the paperwork just as if he'd done everything right, and no one questioned him.

I could have, though. I could have submitted a report, carefully documented and supported by my supervising nurse. But I didn't. Challenging a doctor may not get a nurse fired, but it'll often get him or her publicly chastised, reassigned to a different floor, or moved to the graveyard shift. I'd seen it happen.

After Mrs. Owen died, I could no longer stand to look at Dr.

X's photo in the lobby. But this is more than a complaint against one man—bullying and disrespect occur every day in every hospital throughout America. Most of the time the behavior is petty and only hurts the workers involved, but sometimes, as I witnessed firsthand, it can take the life of an innocent person.

How to Fix the Problem

As nurses' unions have been saying for many years, hospital patient-to-nurse ratios sometimes get too high to keep people safe. We don't have a shortage of nurses, though, just a shortage of nurses who are willing to work under current hospital conditions. More respect will bring them back.

We also need whistle-blower protections to safeguard nurses who speak up for the safety of patients. If I had such assurances of protection and support, I wouldn't have thought twice about challenging Dr. X.

Each nurse must take it upon herself or himself to stand up to and report physician intimidation and abuse. Nurses are not second-class citizens in the health care system. In fact, in the increasingly busy and sometimes heartless hospital world, we are the patient's primary protector.

Sunnie Bell, RN, is a Certified Diabetes Educator and was

National Diabetes Educator of the Year in 1995.

Patient Safety: 5 Fresh Ideas

Offer a "guarantee." Pennsylvania's Geisinger Health System offers a 90-day warranty for coronary-artery-bypass grafts and other treatments. Patients pay a flat fee up front; if an avoidable complication develops within three months of a procedure, patients are not billed for any required medical care. Instituted in 2006, Geisinger's warranties create a powerful incentive to do things right the first time—and have reduced the 30-day readmission rate by 44 percent.

Keep an eye on things. In industry, a number of companies use video cameras, motion sensors, and other devices to monitor operations. Now some medical centers are testing hospital video auditing to ensure workers wash their hands before entering and leaving a patient's room. Performance scores are posted on an electronic "scoreboard." Early results show the technology substantially boosts hand-washing.

Scan it. One study showed that about 20 percent of medication doses given to hospital patients involve some sort of mistake. So nurses at Parkview Medical Center in Pueblo, Colorado, carry small bar-code scanners that read patient wristbands and wirelessly link to the pharmacy and doctor records to ensure that the right medication is given at

the right time and in the right dose. The error rate has dropped by more than half.

Take a walk. Senior executives at Brigham and Women's Hospital in Boston conduct weekly "WalkRounds" in which the president, CEO, or chief medical or nursing officers emphasize safety and listen as staffers discuss concerns. This high-profile advocacy of patient-safety is not only economical but has been shown to change behavior.

Practice, practice, practice. The Banner Simulation Medical Center in Mesa, Arizona, uses computerized mannequins to re-create emergency, surgical, and everyday-care scenarios for medical professionals-in-training. Though the program started less than a year ago, improvements in patient care are already being seen, a spokesperson says.

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