How Common Are Medical Errors?



In my 30+ years as a contract artist I have provided services to a multitude of different industries which, more often than not, operate with an extremely high-efficiency. Errors are typically not tolerated for long, especially in the film, theme park and toy industries, where everything is on a rushed schedule. Other than government, I have never seen as many blunders committed daily as I experienced in hospitals. I'm not sure anyone outside of government or hospitals would stay in business long with such inefficiency. To illustrate what the iatrogenic rate would compare to when applied to other businesses, I refer to a paper published by Dr. Lucian L. Leape in his 1994 JAMA paper, "Error In Medicine". Leape calculated that the error rate in hospitals would translate to:

- Two unsafe plane landings at O'Hare airport per day
- 16,000 pieces of lost mail by the U.S. Postal Service per hour
- 32,000 bank checks deducted from the wrong accounts

every hour

With industries of commerce, profits are at stake; in government and hospitals it's only human lives lost – the profits continue to roll in even in spite of rising failures. It boggles my mind that our priorities can be so misplaced in this nation. Though I am an advocate of the capitalist model, I believe it has become quite perverted when commerce can be placed a much higher priority over the "life, liberty and the pursuit of happiness" promised in the earliest document signed by our nation's founders. The only reason that the medical industry continues to thrive within a flurry of errors and inefficiency when any other business would flounder, is because medical professional can collect fees irregardless of how miserably they fail. Few other businesses have that luxury.

America, being the only remaining superpower with leading technology, is only ranked 37th in health care on the world stage according to the last WHO ranking in 2000. In 2006, the United States was number 1 in health care spending per capita, but ranked 39th for infant mortality, 43rd for adult female mortality, 42nd for adult male mortality, and 36th for overall life expectancy, according to the New England Journal of Medicine.

Anyone who has read my blog for any period of time knows about the royal blunder that started all of my problems – an injury from a colonoscopy and the inability of the doctors to diagnose the problem for the three days I was in critical condition. The excessive delay in treatment ultimately cost me all of my intestines and should have cost me my life. But the mistakes and negligence didn't stop there – far from it. In this article I will give some of the accounts of avoidable mistakes made by doctors and nurses that should have taken my life had my wife, sister or I not intervened. Prepare for a very long article. Rather than listing a lot of random statistics, I felt that personal stories may have more impact.

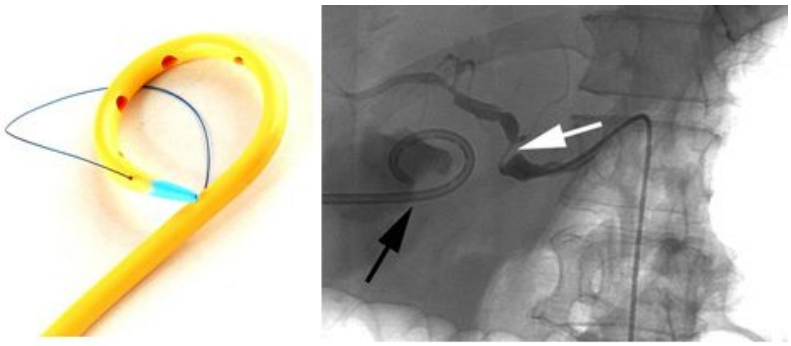
Because of the high frequency of errors, I have listed a lot of them. Everything that follows happened in less than a 12-month period of time, between September 2009 to September 2010 (with the exception of the reversal which was January 2011). I hope you find the stories interesting enough to read them all. These are only the life-threatening mistakes. I could write volumes if I listed all of the clerical and non-life threatening mistakes.

Medical Errors Made On Wolverine

- September 20, 2009 – It didn't take long after the first mistake before the second took place. The surgeon failed to get a pathology on the bowel tissue remaining and left a section of necrotic tissue inside of me (he even wrote in his surgical notes that the tissue appeared compromised, but used it to form a stoma anyway). Even in light of an obviously dying and inactive stoma, he continued to ignore all the signs of sepsis for 5 days. As a result, the necrosis spread to the existing jejunum and I succumb to septic shock and seizures. At this point, I still had enough small bowel to possibly live on and not require a transplant. But because he left some necrotic tissue behind, I was ultimately rushed in for surgery for a second time. All of the remaining small intestines had to be removed, giving me a very remote chance of survival. This became less inexcusable when I later discovered that this same surgeon had been reprimanded by the Florida Medical Board and had his license revoked in California less than a year earlier for doing the exact same thing – only in that case it did cost the patient their life. Until now, I didn't know that hospitals could hire surgeons who had their license to practice revoked in other states nor was the hospital required to inform the family of that fact. Certainly my family would not have let that surgeon work on me had they been given that

information. I plan to cover this in great detail in a future post.

- On November 18. 2009, I was admitted to the hospital for a fever. Blood cultures revealed a gram negative blood infection called; Enterobacter cloacae and CT imaging showed an abscess in the abdominal cavity. In these cases, use of the infusion port should always be suspended, because it is often found to be colonized quickly from a blood infection. (the human body does not defend a plastic catheter the way it would the arteries). The nurses continued to access the mediport for two days to infuse TPN and antibiotics, thereby flushing the infection straight into my heart where it was circulated throughout my system. The high sugar, vitamin and mineral content of TPN feeds pathogens and increases their rate of reproduction. The gram negative infection was later found to be colonized in the port catheter, and as a result of using the port, I was sent into septic shock with severe rigors, a temperature of 105.8º and a resting heart rate in excess of 198 bpm (I was at very high risk for cardiac arrest). I was rushed to surgery to remove the port and then sent to the ICU, where I was place on pressors to elevate my crashing blood pressure. This mistake could have possibly killed me. Septic shock is often lethal and I was lucky to survive.



Pigtail Catheter

- On November 29, 2009, while still in the ICU, a pigtail

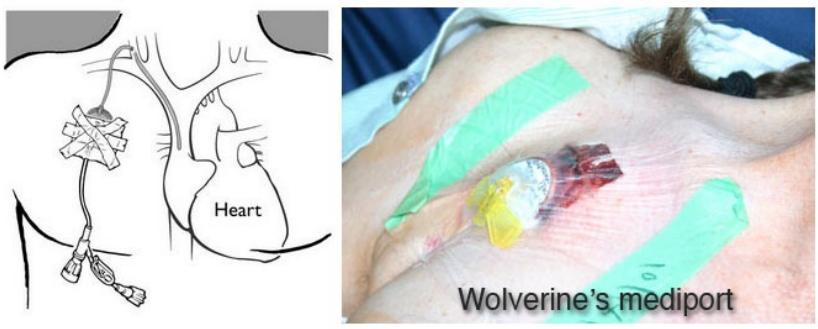
drain had been surgically implanted in my abdomen to release the infection from the abscess. The drain line was evidently annoying the night nurse, so she decided to place tape around the line and pin it to my gown while I was sleeping. She forgot to unpin the line or inform the day nurse who replaced her. The day nurse came in to change the gown and violently ripped it off of me and rushed out the door to get a new gown. The last thing I remember seeing was the pigtail end of the line flying through the air and knew I was in trouble. Besides being extremely painful, I was rushed back to interventional radiology to have the drain replaced before the wound closed with the infection inside. It took a tremendous amount of force to withdraw that pigtail from within my abdomen *(the pigtail is designed to prevent it from coming out and requires a surgical procedure to remove)*. A nurse once told me the story of a man who accidentally stepped on his line while standing up from being seated on the toilet. The catheter was ripped from his chest, tearing a hole in the superior vena cava and he bled out before they could get him to surgery. The force needed to pull out that pigtail would have been plenty enough to tear the port from my chest.

- By December 3, 2009, after two weeks of very aggressive antibiotic treatments to kill the bacteremia, my sister requested that the infectious disease doctors administer a prophylactic treatment of antifungal agents. She predicted that I was at high risk for a fungal infection because so many of the probiotics *(many of our good bacteria protect us from fungal overgrowth)* had been destroyed by the antibiotics. The doctors argued and refused the treatment. One of the doctors actually said that I was not at risk for a fungal infection because; “men do not get yeast infections – only women do”. This is just one of many experiences

where I learned that doctors are not necessarily very smart just because they're educated. I was released from the hospital and was not home for more than two days before my fever would skyrocket again. We opted to make the longer trip into Orlando to admit me to a better hospital, because we refused to ever go back to a hospital (South Lake Hospital) where doctors don't know that candida can breed in places other than vaginas.

- On December 7 2009, I was admitted to the other hospital. We explained to the ID doctors what had happened and why we believed it was a fungal infections. As usual, the doctors rolled their eyes and ignored what we said *(typical cynical nature of doctors to believe whatever the patient says is always wrong)*. Of course all cultures for bacteria came back negative *(duh, little surprise given the two weeks of massive antibiotics I had just had)*. It took us three days to finally convince them to run fungal cultures and of course, they came back positive for a systemic candida infection. Systemic candida infections are the single most killer of TPN patients, because the fungus thrives on the high sugar content of the TPN and these ID doctors just wasted five days *(it takes several days for the cultures to grow and fungal cultures take longer than bacterial)* because they refused to listen to us. It was hardly rocket-science, as fungal growth had already become apparent around the follicles of my facial hair. At this point, we didn't feel like we were in any more competent hands than at South Lake. Whenever the doctors suspended the use of the port, my condition would improve. As soon as they began using it again, my fever would spike to over 105º F. It was pretty obvious to even a novice that the port was infected, but the doctors refused to remove it because they claimed the port continued to test negative for candida. After several weeks of this, my wife asked how

they could have possibly tested the port because there was a clot in the line and the nurses were unable to draw blood from it? Instead they were drawing blood from each arm and telling me that was equivalent to a port draw. It turns out the nurses were reporting the right arm draw as a port specimen and sending it to the lab. They continued to perpetuate this lie for more than six weeks, while I continued to suffer the deadliest sepsis known to TPN patients. Upon my wife's insistence, the doctors questioned the nurses and learned what they had done. A heparin lock was performed on the line to clear the clot and a successful draw was achieved. The cultures came back positive for a massive candida colonization. This bone-headed chicanery from these lazy nurses could have easily cost me my life. The nurses simply did not want to take the time to perform the heparin lock and defrauded the paperwork. Of course, no disciplinary action was taken on the nurses involved. As a result, I spent over six weeks with a sepsis and was sent home with the infected port a couple of times, only to return a day or two later with a high fever. In Jackson Memorial in Miami, the doctors have a policy to immediately remove any and every port or PICC line if a patient is presented septic and will not wait for a pathology and culture, which can take days. I believe this is a much better policy that all hospitals should be forced to adopt.



- During the same stay in that hospital, around December 12, 2009, a night nurse once entered the room late one

evening to hang the TPN. She was very hurried because she had showed up late for work and was behind schedule. She quickly primed the line and attached it to the lead from my port, then realized that she had forgotten to place the in-line filter between the pump and my port. We were a bit confused, because she had an extremely thick asian accent and kept calling it a "pilter", so we had no idea what she was talking about. She finally grabbed a filter, which comes out of the package with about 2 feet of line. She placed the line between the pump and my port catheter. She began to reach for the start button on the pump. My wife yelled to her and grabbed her hand. In her haste, she had not primed the new line and would have pumped the entire line full of air directly into my heart had my wife not stopped her. Remember, I had a port catheter that delivered the infusions straight into my heart as shown in the image above. An air embolism in the heart is a quick ticket to the grave (think of the Bends). Had she started the pump, I would certainly be dead. I seriously doubt my death certificate would have reported the error had my wife not been there. My death certificate would have probably read: "cardiac arrest due to sepsis". This is an example of how quickly you can die from an accident from a sloppy nurse and just how awesome my wife is. The anal retentiveness of my wife can be trying at times, but while I was in the hospital it saved my life on many occasions.

- December 24, 2009 – The doctors had ordered an ethanol lock to be performed on my port line, because doctors were still refusing to remove the port. In this procedure, ethanol is injected into the line and it is capped and locked for several hours to sterilize it. It is later drawn back out and is not intended to ever be infused into the patient. The line had been fitted with a red cap and then taped over and labeled; "do not use".

A nurse entered to administer medication. Rather than detach the other lead from the TPN to inject the medication (it was a two lead port), he removed the tape and the red cap and attached the syringe to the line. My younger sister asked him what in the hell he was doing? This line had been capped because it was infected. A red capped line should have never been used. Had this been a heparin lock, he would have pushed the high dose of heparin into my heart. Any nurse should know that a red cap means not to use.

- After my transplant, on March 23, 2010, all of my future hospital stays would be restricted to Jackson Memorial Hospital in Miami. I was released from the hospital on May 7, 2010, after my transplant, but was not allowed to leave Miami. I was sent to a place called the Transplant House across the street from the hospital. On May 12 2010, I came down with a fever (I had been infected from an ileoscopy two days before). I was rushed into the ER by ambulance with a serious sepsis and was literally beginning to flatline. I was hurried to the SICU where my blood pressure had reached 35/28 and I was in shock. While being intubated, my right lung was perforated and collapsed, making a critical situation even more severe. Lung punctures during intubation is very common and not actually a mistake or error, but a known risk of the procedure. I am not listing this as an avoidable error but only to preface the next point on the list which was quite avoidable.

- The error came in the following days. I was placed into a drug induced coma between May 13, to May 27, 2010. I continued to come out of the coma fighting for air. My wife insisted that I was not able to breathe, but the nurses confidently claimed that I was just fighting the respirator. To appease my wife, they took x-rays of the lung and claimed that the lung appeared completely

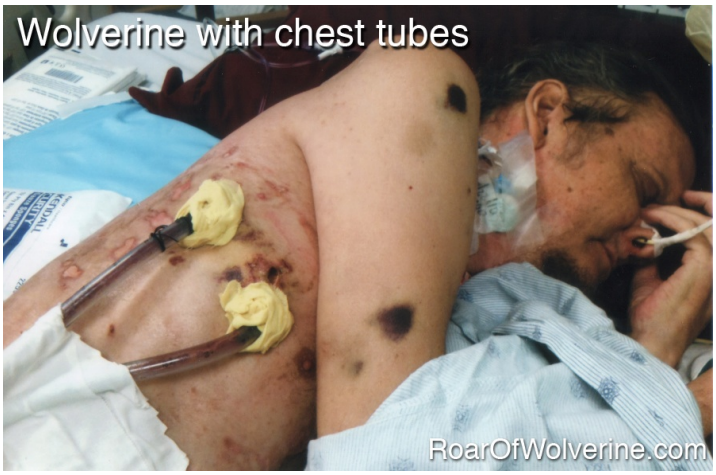
inflated and all was fine. I continued to come out of the coma and attempt to get out of bed fighting for air. My wife continued to insist that a CT be performed because the water on the chest tube canister was no longer showing bubbles, but the doctors thought it would be too much trouble to transport all of the gear and life support I was hooked to down to radiology. Her persistence paid off and the doctors finally ordered the CT imaging on May 23rd, one day before I was scheduled to get a tracheotomy. (If a patient is unable to come off a respirator within a couple of weeks, they are required to have a tracheotomy placed). The CT revealed that the pneumothorax was behind the lung and the lung was being crushed from the back to the front. In a two-dimensional x-ray the lung appeared full, but in the 3 dimensional images from the CT it was as flat as a pancake. The three ineffective chest tubes that had been placed were removed and a proper one was finally placed. The lung inflated and I was able to have the respirator removed. A pneumothorax is a life threatening condition and yet I had to survive one for more than five days because of this mistake (It's a wonder I'm still alive).

- While I was in the coma, between May 13 to May 27, my wife was at my side the entire time. At one point, my monitor began to alarm because I had stopped breathing (I had the collapsed lung at the time). My wife looked around for the ICU nurse and he was nowhere to be found. ICU nurses are not to leave critical patients unattended for any reason. She had not seen the nurse for over an hour and was frantically calling for help, but none came. She finally had to run from the SICU (where I was) and over to the ICU and grab a nurse, who then came over, bagged and resuscitated me. (at that point I was clinically dead for a few moments). The original ICU nurse did not return for more than another

half hour. My wife had seen my SICU nurse over in the ICU standing around chatting with some other nurses while I was dying. She removed that nurse from my service forever. Had my wife not been there, I would surely have become permanently dead. To my knowledge, no disciplinary action was given to this nurse, who I'm sure is still working in the SICU. I wonder how many patients he will have to kill before someone advises him to seek a new career?

- On July 2, 2010, I underwent a lung resection to fix the pneumothorax, I was in ICU recovering the day after the surgery. Some ICU doctor walked in (I had never seen him before) and told me he would be back in a few minutes to lance the abscess on my back. I wasn't aware of any abscess and refused to allow him to touch me until I had spoken to the surgeon. He was very insistent, so I asked him to leave the room. Later, when the surgeon stopped by, I asked her about the abscess, which she claimed was a hematoma at the point of the surgical incision (surgery was done through a scope, similar to laparoscopic). She also added that had he lanced it, the infection would have made a straight path to the lung she had just operated on. The only entertainment came when this diminutive woman (5'4″) took this six-foot doctor out in the hall and gave him a verbal spanking he will never forget. Most people would have probably permitted him to go on with the procedure, and I might have many months earlier. By this time I had become quite suspicious because of all the errors I had encountered. This was all post transplant, so I was on immunosuppressant medication and an infection in that lung could have been lethal. To this day I don't know who that bozo was, just some ICU doctor that wanted to do an unauthorized procedure on a post operative patient. This goes on a lot in ICU. The ICU doctors have little regard for the surgeons and

other doctors, so never allow them to administer non-emergency procedures on you without first consulting your doctor or surgeon.



- On July 14, 2010, I had been released with a chest tube still implanted. They cannot release you with a chest tube still attached to the rather large container it drains into. So they replaced the container with a device called a Heimlich Valve on the end of the tube, which allowed the release of fluid, but would not allow anything to back up into the tube. *A funny side note: The hospital typically used a surgical glove taped on the outlet, but I found a standard party balloon fitted with a rubber band worked better and was easier to change (the Thoracic surgeon thought it was ingenious and now recommends it to all chest tube patients). Whenever I would begin to cough, the balloon would blow up. My sister had bought a bag of balloons with smiley faces on them. I began having a coughing fit in the waiting area at clinic and this bright yellow smiling face balloon inflated so big we were afraid it was about to pop – which would have slung all of the infected fluid and pus on everyone in the waiting area – it was sort of frightening and funny at the same time.* But on to the point of the deadly error. On August 31 2010, my wife noticed that the valve seemed to be hanging very low when I exited the shower. It was normally at my

mid-thigh level and now it was below my knees. My wife immediately rushed me to the ER and it was late in the evening and my surgeon was not available. Two of her assistants were on duty and came down to the ER to look at the tube. One of them grabbed hold of the tube and braced himself against my body. He was obviously preparing to push the tube back in. My wife and I both simultaneously asked if they had lost their minds! Pushing that tube, which had now been exposed to every germ in that ER where I had been waiting for the last hour, back up into my pleural cavity would be suicide, especially in an immunosuppressed patient. They continued to insist it was safe and the right thing to do, but we stood our ground and not only refused, but asked them to leave the room (you can do that by the way, I don't think most people know that). The next morning, the thoracic surgeon came in and removed the tube and told us we were right in stopping them from pushing it back in. She agreed that pushing that filthy tube back inside of me most likely would have caused an infection, which in my case could well be deadly. No new tube was placed. To every doctors surprise, I didn't go into respiratory distress, because obviously the hole in the lung had healed prematurely (my Wolverine powers at work).

- The final deadly mistake I am going to list concerning myself happened a year later on January 14, 1011, when I went to have the ostomy reversal. Every intestinal transplant patient is required to have an ileostomy for the first year following the transplant. They leave the colon and ileum separated, so the colon is not in use for the first year. The only reason they do this is so they can scope inside the ileum for signs of organ rejection. It was now time for my bowels to be reconnected, which meant I would no longer have an ostomy bag and would be normal once again (take a dump

like everyone else). Shortly after the anesthetics wore off from the surgery, I began to experience a tremendous pain deep within the incision. By now, I had enough surgeries to know the level of pain to be expected and this was far beyond the typical pain post surgery. I was given a shot of dilaudid, but it wouldn't touch the pain. I buzzed for the nurse and she went looking for a doctor. Instead of listening to me, the surgical assistant she found began to lecture me about pain-killers – even though I had not requested more pain-killer, but was inquiring why I still had so much pain even after the pain shot (typically dilaudid, which is about 8 times more powerful than morphine, can knock out any pain – and if it doesn't, you have a serious problem). Rather than investigate, he continued to lecture me and my wife and accused me of having a low-threshold of pain. His attitude was extremely cynical, which really angered me because it was that exact same attitude that the doctors gave me which cost me my intestines in the first place. They also never investigated to find the source of my pain (which was from ischemic and dying bowels) but allowed me to suffer for three days while telling me I had a low threshold of pain. Had I not been incapacitated by the intense pain, he would have been incapacitated because I would have leaped out of the bed and beat the living shit out of him. Instead, I yelled to the nurse to remove him from my room and never allow him back in (you can do this – I did) and get me a competent doctor. I guess the racket I was raising drew the attention of the Fellow who had assisted in the surgery and he entered the room. Rather than leap to the theory I was simply a wimp, he suspected there actually may be a problem and instructed the nurse to bring him a surgical kit and reopened the incision. We were all shocked when he withdrew a 4 x 4 piece of gauze which had been sewed into me. The gauze was extremely infected and he immediately irrigated the

wound. By this time, a large bulge was noticeable on my side. It looked like I was pregnant over on the right side of the wound. Cellulitis had set in and I had to spend an extra week in the hospital on antibiotics to clear all the infection. Being an immunosuppressed patient, any infection has the potential to kill me. How I survived these type mistakes is beyond me. Unfortunately, many of the friends we made there were not so fortunate and died from similar mistakes.

- I would like to list a medical error that happened to a young woman we met, who had lost nearly her entire digestive tract to Crohn's Disease. Onset of the disease began when she was only 9 years old. When we met her, she was 26 and had undergone over thirty surgeries, which ultimately left her with no intestines. She required a six organ multivisceral transplant and was so small, that her donor had to be a 6-year-old child who had passed away. From so many years of living with Crohn's and all of the resulting fistulas, she required very high doses of methadone to control her pain. A doctor once told us that the doses of methadone she received would kill a normal person, but she had built up a resistance to the drug. After her transplant, a night nurse came into her room to hang her medications. Her intestines were not yet working well enough to absorb the prograf (the anti-rejection medication all transplant recipients require) orally, so it was being infused intravenously. Prograf is a highly toxic drug to the organs, especially the kidneys. If we don't take enough, we will die from organ rejection and if we take too much we will die from toxicity. Her nurse screwed up and hooked her prograf and methadone to the wrong pumps. She set the methadone to infuse at 10 ml and the prograf to infuse at 100 ml and then left the room. The young woman awoke initially because she was not getting enough pain medication and buzzed for the

nurse for her pain. Of course the nurse immediately began lecturing her on the dangers of pain-killers and accusing her of being an addict and all the other cynical crap we must deal with when we're in pain in a hospital. Had the nurse investigated before launching onto her soapbox sermon and fumbling for her DEA badge, she may well have noticed her error sooner. An error that could have cost this girl her life and has certainly damaged her kidneys beyond repair. As a result, she spent the next three days with profuse vomiting and dehydration.

High Risk Decisions Derived From Power-Plays

There are some deaths due to power struggles between doctors. There are times when a doctor will simply flex their professional muscle and usurp the consensus of other doctors, just to exercise their power to do so. Medicine is not a democracy in a hospital. There are certain legendary doctors who can override the diagnosis or treatment options decided by even a team of doctors. It seemed at times, that some of them did it just to prove they could. The reason it felt this way was because they would not consider or examine any of the evidence or concerns given by the other experts, who were more involved in the case, but simply fly in and make a decision and force it to be carried out, even at the protest of the other doctors. You, as the patient are the only one who have the power to override the super-doctor. Chances are, if several other doctors disagree with superdoc's decision, you may want to reconsider his suggestion and opt for the treatment decided upon by the doctors more familiar with your case. Here are a couple of examples.

- This same young lady who had the Crohn's Disease once received several doses of thymoglobulin, rather than campath for an organ rejection issue. The thymoglobulin started a series of seizures, ultimately ending in a grand mal seizure which cause her to become blind in her

right eye (thymoglobulin is notorious for creating seizures). It also created a lesion on one side of her brain. She sustained a lot of organ and brain damage from this decision, not to mention the blindness in her right eye. The reason I list this is because the decision stemmed from a power struggle between two competing surgeons. Surgeon B knew that the standard treatment for such rejection by surgeon A would be campath. He took advantage of it being a weekend when surgeon A was not on-call and decided to try an older, less aggressive approach by ordering the thymoglobulin. I too had been caught as a pawn in their chess game when surgeon A's order for tobermycin usurped the requests from the ID doctors and thoracic surgeon, but more importantly – it overruled the competing surgeon B's suggestion.

- There was a gentleman who had many complications from a liver transplant because he also suffered from severe diabetes. Because of his diabetes, his stomach had shut down and was no longer working. He was also fighting a systemic infection from an obstruction in one of his bile ducts, where a stent had been improperly placed. All of the doctors agreed that the safest course of action would be to feed him with TPN infusions until the infection could be cleared. Their decision was overruled by the chief transplant surgeon who insisted that a stomach tube to be placed. The other doctors protested because all of his visceral organs (pancreas, spleen, liver, etc.) were inflamed, making the high risk procedure many times more dangerous. The spleen was infected and as a result, his blood platelets were below 30 (normal range 150-400), making him a high risk for bleeding. The chief surgeon convinced his wife to sign for the procedure and his liver was perforated. He began to spontaneously bleed internally and continued to decline for several weeks before the decision had to be

made to remove him from life support.

- He was one of two of our friends that died from infections acquired from perforations. They both died very slow, painful deaths, which took many months and the slow shut down of organs. Both ultimately had to be removed from life-support before perishing. There was a lot of debate and power-plays instigating the final decisions to perform the high risk procedures. Many of the same type of mistakes I encountered had happened to them, according to their families – the only difference was they didn't survive them, whereas somehow I did. But I never lose sight of the fact that I could have just as well suffered the same fate and taken much more damage to my other organs.

- I did suffer damage to my kidneys as well as my hearing as a result of a completely unnecessary treatment of a very dangerous antibiotic called Tobramycin (both nephrotoxic and ototoxic) started on September 10 2010. After my lung resection, Pseudomonas was found in the fluid draining from the chest tube. The thoracic surgeon and every doctor from infectious disease refused the use of this medication. They said that the infection was isolated to the pleural cavity and was little threat of going systemic and the drain was adequate. Because of the destructive nature of this highly toxic antibiotic, it is better reserved as a "last resort" medication, rather than a prophylactic. They didn't want the pseudomonas to become resistant to the tobramycin, so it could still be of benefit if the bug ever did go systemic. But the chief transplant surgeon (a rock star of the surgical world) who personally performed my transplant and is treated like a god in that hospital (for good reason, he has performed more transplants than any surgeon in the world and was one of the pioneers of intestinal

transplants), overrode the other doctor's opinion and in a panic, ordered the medication to be administered for eight weeks as a prophylactic. I finally refused the treatment after the first week, on September 14th, because my entire face and throat went numb and the ringing in my ears was so bad that I couldn't sleep. The medication was stopped and I healed just fine, so the usage was completely unnecessary and had I have gone the entire eight weeks, I'd be completely deaf and would have suffered total renal failure.

- I had taken over 55% hearing damage in both ears and the ringing was driving me insane (this was really upsetting because I am a musician). My wife did some research and found a doctor who had a treatment for damage sustained by tobramycin, which had been successful if applied soon after the event. The problem was that the equipment necessary for the procedure could not be transferred to the hospital, so I couldn't undergo the treatment until I was released from the hospital and everyday I didn't get treatment, the deafness became more permanent. I was finally release a week later and was able to get the treatment which was miraculous to say the least. Unfortunately, the procedure required three steroid shots directly into each eardrum (6 in all). He would only do one ear at a time, because of the risk of causing me to go completely deaf and the severe vertigo following the procedure. It took six appointments to get all of the treatments, but my hearing is near normal again and the ringing is very minimal. After getting just one of those painful shots in the eardrum makes it very difficult to line up to get five more. That was a dreaded three weeks. We did meet a woman who had gone completely deaf as a result of this medication.

- The damage I sustained to my kidneys is irreversible, which puts me at a huge disadvantage because the prograf

> I have to take is known to damage kidneys over time. Because of the doctor's knee-jerk use the tobramycin prematurely (and against the advice from all other doctors), I could eventually need a kidney transplant at some time in the future. Had I continued the eight weeks he prescribed, I would have already been in need of a new kidney and probably be on dialysis at this time. *Kidney transplants are a much easier and less risky operation, but many people die waiting to get a kidney. Because kidney transplants are so common and so many hospitals perform them, the supply is much lower than the demand and you can be on the waiting list for years. Only six hospitals in the world are capable of performing intestinal transplants, so I was able to get an organ after only six days of being on the list.*

It seems that a lot of the errors and delay in treatment today stems from an excessive amount of cynicism that many doctors and nurses have regarding patients and pain medications. I will cover this in further detail in my post; "The Cynical Attitude Of Doctors". There also seems to be a lot of mistakes that stem from cynicism that doctors have towards each other and the competition that arises as a result.

We can see that medical errors are quite common and not as rare as most people would believe. Aside from the notes on the young lady and the other unfortunate gentleman, these are all errors that happened on just me. I could write an article ten times longer if I wanted to included all the errors that happened to others that we met – some died as a result. Medical errors are in fact the third highest killer of people in the United States and that is only based on the mistakes that are reported. I do not believe that any of the mistake that I listed here were ever reported, because no one forced them to be. If we could include all of the mistakes that go unreported, medical errors could well rival, if not surpass, pharmaceuticals as the number one killer of human beings in

the U.S.. If you tally them all together (drugs and errors), hospitals are without a doubt the biggest killer in America. [source] It kills more people than AIDs, breast cancer, and automobile accidents.[source] Each year in the U.S. there are:

- 12,000 deaths due to unnecessary surgeries
- 27,000 deaths due to medical errors (that's only what's reported, I'm sure it's much higher)
- 80,000 deaths due to hospital borne infections (many of these are due to sheer sloppiness by the staff)
- 106,000 deaths due to negative effects from drugs

The source for this is found here.

Another note on the 80,000 deaths due to infections. It was all too common that my wife or I caught nurses attempting to access my port line without first cleaning it. Port leads dangle from the patient and make contact with the bed sheets, patient's body (often time in their armpits) and all of the transplant patients had ostomies that could leak intestinal contents (crap, stool or whatever you want to call it) onto the bed where the leads were lying. Hospital protocol, set forth by infectious disease experts, demands that the lead be scrubbed with chlorhexidine wipes for a minimum of thirty seconds – because it is not just the chemical that destroys organisms, but also the heat generated by the friction of aggressive scrubbing. There were some occasions that nurses would attempt to access without cleaning the lead at all and when they did clean them, it was just a single quick wipe – not the 30 second scrub required to sterilize it. If you are a patient, don't feel like you are being a pest by pointing this out and demanding that it be done properly. Infection is the 2nd largest killer in hospitals. These rules are always posted around the hospital by law, so that the patients can understand and recognize when a nurse or tech fails to follow them.

A few times we asked a nurse why they were about to access a lead without cleaning it? There were a couple of the nurses who tried to fly the excuse that they didn't have any of the chlorhexidine wipes on them at the time – offered as if that was acceptable. My wife always kept a supply of them in the room so she would give those nurses (who thought my life wasn't worth their effort to walk back to the nurses station to get the supplies) no excuse for killing me in their haste. Hospital borne pathogens are some of the deadliest on earth, because they have been exposed to so many disinfectants and antibiotics that they have become resistant to nearly everything. Hospitals inadvertently breed superbugs.

I will admit that nurses work long hours (usually a 12 hour shift) and most hospitals are under-staffed with nurses, but these are humans lives we're talking about and hospitals make plenty of money to hire more nurses. There have been multitudes of studies that have proven that an employee's efficiency at their job begins to decline after an eight-hour shift [one study]. Other businesses that operate around the clock break shift rotations down to 3 eight hours shifts for this reason, but hospitals use two 12 hour rotations. Again, I will reiterate that those industries of commerce have profits at stake, whereas hospitals have only lives that can be lost to the mistakes of a tired and frustrated employee.

You can see why it is so important to have a loved one by your side. The patient is sedated (heavily drugged), confused and in pain most of the time and it is impossible for them to be attentive to everything going on around them. Nurses enter the rooms at all hours of the night and access PICC and port lines while the patient is sleeping. My wife slept in a chair in my rooms for nearly 14 months. There were other transplant patients who had family members stay in their rooms (mothers, wives, husbands) and there were some whose families left them entirely in the hands of the hospital staff so they could continue on with their careers. All of the ones who were left

on their own also died. The ones who had family members all survived (except one) and those family members had similar stories of near fatal mistakes made on their loved ones that they had averted by being there. Those family members also declined many unnecessary and risky procedures that were offered by doctors. A heavily sedated patient may sign a paper authorizing a procedure that they otherwise wouldn't sign in a less stressful or sedated state. If you have no surrogate and are incapacitated (coma, sedated, etc.) then it only takes two doctors to agree that a procedure is necessary to legally perform the procedure. Don't believe that crap that your loved ones are in capable hands when left alone in a hospital – they're not. Yes, these professionals are competent in their training, but too often become complacent and sloppy at the end of a long shift.

Why does this one occupation seem more prone to errors than all others? It is because they have a greater protection under the law and are held less accountable for their actions than any other individual citizen of this nation. If anyone else had the legal impunity that medical practitioners have, they too would dissolve into the giant mess that modern medicine has become.

I have covered this very subject in a recent post entitled "Malpractice Law: Reserved For Only The Frivolous" where I hope to illustrate how the laws are constructed to make it nearly impossible to bring an action against a doctor or hospital and just how low the limits on damages are set as a deterrent to anyone who would seek to bring an action against anyone in the medical profession. I am not an advocate of increasing the amount of lawsuits against medical professionals, but reducing them properly. The way the laws are presently designed perpetuates the smaller, less significant malpractice cases and deters the catastrophic cases from being sought. It is exactly the opposite of what it should be and in fact promotes more frivolous lawsuits,

which I will explain in further detail in the upcoming post.

Another reason for the quantity of mistakes is because doctors get paid even if they fail at their diagnosis or treatment. If a plumber puts in a toilet and that toilet doesn't work, I have every right not to pay him. The doctors that failed to diagnose the problem and cost me my intestines still got paid. I cannot think of one other occupation, other than government, that can still expect to be paid when they fail so miserably at their job. In my occupation, I risked forfeiting payment if I didn't complete the job by a particular date, much less totally failing at the task.

A third reason for the elevating errors in medicine is something I have only recently learned of. Doctors who have their license revoked in one state can have a license to practice granted to them by another state. I do not see why a state medical board cannot be held accountable for the mistakes committed by a doctor that they allow to practice, who had lost their license in another state? This is a bad filtration system for sifting out the untalented doctors who should probably seek another career. I cover this in much greater detail in my post entitled "Is You Surgeon Licensed? Are You Sure?".

It is not my goal to simply trash the medical profession, but an attempt to improve it. There were many very competent surgeons, doctors and nurses who worked very hard to save my life and without their dedication, I would be deceased. It just appeared that there were a disproportionate population of incompetent, lazy and sloppy practitioners who made the job of the competent medical professionals that much harder. It was bad doctors that screwed me up in the first place and it took stupendously talented and dedicated doctors to put me back together. If these errors could be minimized, there is no reason that the U.S. is not the leader in health care. If these practitioners were held more accountable for their mistakes, we would see a reduction in needless deaths and

injuries.

I hope you will return to read more of these posts, or better yet, subscribe to be notified of new posts. I had to endure and survive a lot to bring you this information that few are willing to expose. I hope that you will take it in the manner in which it is presented – with your health and safety in mind. It is my hope that through this truth in information people will be better prepared and aware of the dangers that lurk within the U.S. medical system, so you can better protect yourself if you become in need of medical treatment. If you do not become your own advocate and understand your rights as a patient, your chances of survival decrease dramatically. Stay healthy, please.