OP-ED CONTRIBUTOR

Losing My Leg to a Medical Error

By FREDERICK S. SOUTHWICK
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LAST Fourth of July, during a day at the beach, I experienced a sudden pain in my left calf. Two months later, I required an above-the-knee amputation. Compounding my distress was the fact that my doctors had no explanation for why the blood flow to that leg had been cut off. I had none of the usual risk factors for atherosclerosis, the hardening of the arteries. I had low cholesterol and no evidence of diabetes, and I had never smoked. No blood vessels were blocked elsewhere in my body.

It took some further detective work to reveal what must have been the cause. Seventeen years earlier, in 1995, I had surgery on my left Achilles' tendon. To prevent bleeding during the procedure, a pressurized cuff was placed above my left knee to block the blood flow. Apparently, the cuff was left on too long, injuring the arteries. In the years since, the vessels progressively scarred and calcified, which eventually blocked all blood flow to my lower leg.

I lost my leg because of a preventable error. The loss of a limb is traumatic, and I experience waves of sorrow and regret. I struggle with continual pain in my residual limb, and am trying to learn how to walk with my prosthesis. My work as a physician has been put on hold.

For the past two decades I have been studying how to prevent errors in health care, and the irony of my present predicament strengthens my motivation to continue the quest. No one should ever have to experience such preventable harm.

And yet many people do. Exactly how many, we can't say, because there is no national registry for injuries or deaths caused by medical errors. Over a decade ago, in the best study of its kind, the Institute of Medicine estimated that there were 44,000 to 98,000 deaths per year because of preventable errors in the American health system. For every

death there are likely to be at least 10 serious injuries, so we can assume that roughly a million patients are seriously injured each year.

Despite calls to action by patient advocates and the adoption of safety programs, there is no sign that the numbers of errors, injuries and deaths have improved. Why? Because those responsible for the delivery of health care have been unable to change how they do things.

They could help themselves by embracing the lessons of great manufacturing companies to improve quality and efficiency. Automatic alarm systems and shut-off switches can be designed to make it nearly impossible for caregivers to do the wrong thing. Checklists and specific protocols based on best practices for each procedure can also help.

In my case, if an alarm had alerted the doctor to how long the cuff had been in place, if the cuff had automatically deflated after a period of time, or if a checklist had reminded the doctor to remove it, my leg might never have been injured. Better yet, if the doctors had not used the cuff, which evidence has shown can be dangerous to patients, I would still be walking on that leg today.

Most of all, perhaps, we need better coordination and communication among caregivers. Consider what happened to Mary, my former wife and the mother of our two children. In 1988, she was lying in an intensive care unit with less than a 10 percent chance of survival. Her first symptom, a pain in the sole of her right foot, had seemed so innocent. A neurologist said she had most likely injured a nerve during aerobic dance and the doctor ignored our requests for further tests. But when Mary's leg began to swell, we sought the help of an internist. She diagnosed thrombophlebitis, inflammation from blood clots. Mary was then admitted to the hospital for a blood thinner, but the medical team gave her too small a dosage. Her clots extended into her lungs. Next she suffered a heart attack, respiratory failure, renal failure and shock.

In desperation we transferred her care to another physician, who finally began treating her with corticosteroids for inflammation of the blood vessels. Over the next 24 hours, Mary's symptoms reversed and she fully recovered. But we nearly lost her as a consequence of delayed decision-making, poorly coordinated care and a medication error.

Eliminating errors has the added dividend of reducing costs. The cost for treating Mary's thrombophlebitis should have been $16,000; the complications pushed the cost nearly six times higher. The hospital bill for my leg amputation was approximately $150,000, my prosthesis cost more than $50,000, and I have lost months of work.

The Affordable Care Act has recognized this reality and is creating new reimbursement systems that reward the quality rather than the quantity of care. The act has also empowered an expert panel to create evidence-based treatment recommendations.

I wish I could go back in time and implement these changes before my surgery. But there is no way to turn back the clock. My life will never be the same, nor will the lives of roughly a million other patients who suffer similar preventable injuries each year. But we can make sure that future patients don't suffer the same life-changing harm.

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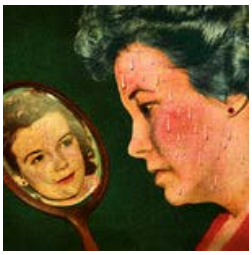

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