

Editorial

Unacceptable Losses: Hospital-Caused Deaths

Find medicine is the best of all trades because whether you do any good or not you still get your money.

(Moliere: "A Physician in Spite of Himself" 1664)

The harmful effects of conventional medicine are alarming and increasing.¹ A patient entering hospital has about a one in 25 chance of suffering an adverse event.^{2,3} By 1992, over 17% of surgeries in the United States were based on unconfirmed diagnoses, and 2.4 million unnecessary operations were performed annually with approximately 11,900 deaths at a cost of \$3.9 billion.⁴ This large surgical death rate is small in comparison with the problem caused by drugs in hospitals. A person hospitalized in the United States had a 6.7% chance of suffering a serious adverse drug reaction.⁵ Yes, this figure excludes minor reactions, as well as excludes therapeutic failures, overdose, and drug abuse. It also leaves out errors in drug administration, non-compliance, and unconfirmed adverse reactions that could be explained by other causes. Despite this, a minimal estimate is that between 1,721,000 and 2,711,000 (mean 2,216,000) people suffered adverse reactions in just the year 1994 alone.

That is grim, but it gets worse: three in 1000 hospital patients were killed by adverse drug reactions. In 1994, between 76,000 and 137,000 (mean 106,000) hospital patients died in this way. These reactions were thus estimated to be between the fourth and sixth leading cause of death in the United States. Unsurprisingly, considering both the preeminence and profitability of the pharmaceutical industry, these figures have been challenged⁶ but adverse drug reactions have been confirmed to be a major international health issue in other studies.⁷⁻⁹

Indeed, it is likely that adverse reactions are systematically under-reported.¹⁰

If we now consider the results of medical error, the figures provide increased concern. In the United States, medical errors result in between 44,000 and 98,000 unnecessary deaths each year, and one million direct injuries.¹¹ Note that these deaths are in addition to those from adverse drug reactions indicated above. Similarly, in Australia medical error results in about 18,000 unnecessary deaths, and disabled more than 50,000 patients.¹²

A reasonable (low) estimate for medical deaths per year in the United States is between 225,000 and 284,000, making medicine at least the third largest cause of death in the United States.¹³ However, this estimate is conservative. Some authors estimate the number of deaths to be far higher, about 780,000 deaths per year, which would make conventional medicine the number one leading cause of death in the US.¹⁴ Compare this with all deaths from cancer, numbering 553,251 in 2001.¹⁵ It is clear that "the toll of medical injury is truly appalling."¹⁶

When Doctors Strike

An objection to pointing out the high incidence of medical-related deaths is that doing so ignores the benefits provided. It is frequently suggested that the number of lives saved greatly outweighs the number of deaths.¹⁷ However, in developed countries, mortality increases with the number of doctors.^{18,19}

When conventional doctors withdraw their services in a strike, there is a brief but dramatic lowering of mortality rates as surgery for elective operations is suspended.²⁰ Such a decrease (about 18%) occurred in Los Angeles in the 1970s.^{21,22} When the strike ended, the death rate returned to more normal values. At about the same time, a strike

occurred in the Colombian city of Bogotá and the mortality was reduced by about 35%.²³ A strike in Israel produced a reported 50% drop in deaths.²⁴ A later strike, in 2000, produced a similar result (93 funerals compared with 153), and lead to complaints by funeral parlors. The director of Jerusalem's burial society reported "the number of funerals we have performed has fallen drastically."²⁵ The *British Medical Journal* suggested the strike might be beneficial to health. A recent study of a strike in Croatia showed no effect on mortality figures.²⁶ It seems strange when a study showing no increase in deaths during a physicians' strike is reassuring.

Treatment or Prevention?

Filling hospital beds is much like filling hotel rooms or airline seats: maximum occupancy means maximum profitability. Treating illness is profitable. Often treatments are cost insensitive, as a patient with a severe or life-threatening disease has a profound impetus to pay whatever is necessary to become well again. A person in good health has less motivation to pay out-of-pocket to maintain wellbeing, but is often insured either directly or indirectly against sickness.

For decades conventional medicine has espoused the benefits of preventive medicine, but the immediate economic benefits to the medical providers are not apparent. Indeed, a declining proportion of sick people in a population means a reduced role for the most profitable medical interventions. Hospitals stays are not for preventive care.

There are ready alternatives to continued tolerance of iatrogenic deaths. History more than suggests that most gains in public health arise from sanitation, hygiene, and nutrition. Hospital food, long mocked for poor quality, has been just as long tolerated. This too could be radically and promptly improved. One

cost-effective way to enhance nutrition is with routine vitamin supplementation to institutional diets. Adding suitable supplements with a patient's meal would add only pennies to a hospital's costs, but greatly enhance the patient's healing. A healthier patient means a shorter hospital stay and a lower bill. Shorter stay? Lower bill? A cynic might perceive a vested interest in hospital undernutrition.

Hospital stays have always been dangerous, and they remain dangerous. Hospitals collect our very sickest people into close proximity. Very sick patients require optimum nutrition. Even a glance at what is served up on any hospital food-service tray indicates a pressing need for orthomolecular supplementation. Delay is unjustified at best and fatal at worst. Let us provide patients with superior hygiene, and actively protect them from unnecessary surgery and excessive drug therapy. In not doing so, hospitals are clearly breaching their duty of care, and the death toll is horrendous.

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References

1. Phillips DP, Christenfeld N Glynn LM: Increase in US medication-error deaths between 1983 and 1993, *Lancet*, 1998; 351(9103): 643-644.
2. Leape LL, Lawthers AG, Brennan TA, Johnson WG: Preventing medical injury, *QRB Qual Rev Bull*, 1993; 19(5): 144-149.
3. Brennan TA, Leape LL, Laird NM, et al: Incidence of adverse events and negligence in hospitalized patients *Results of the Harvard Medical Practice Study*, 1991; 324(6): 370-376.

4. Leape LL: Unnecessary Surgery, *Ann Rev Public Health*, 1992; 13: 363-383.
5. Lazarou J, Pomeranz BH, Corey PN: Incidence of Adverse Drug Reactions in Hospitalized Patients A Meta-analysis of Prospective Studies, *JAMA*, 1998; 279: 1200-1205.
6. Kvasz M, Allen IE, Gordon MJ, et al: Adverse drug reactions in hospitalized patients: A critique of a meta-analysis, *Med Gen Med*, 2000; 2(2), E3.
7. Impicciatore P, Choonara I, Clarkson A et al: Incidence of adverse drug reactions in paediatric in/out-patients: a systematic review and meta-analysis of prospective studies, *Br J Clin Pharmacol*, 2001; 52(1): 77-83.
8. Moore N, Lecointre D, Noblet C, Mabile M: Frequency and cost of serious adverse drug reactions in a department of general medicine, *Br J Clin Pharmacol*, 1998; 45(3): 301-308.
9. van der Hooft CS, Sturkenboom MC, van Grootheest K, Kingma HJ, Stricker BH: Adverse drug reaction-related hospitalisations: a nationwide study in The Netherlands, *Drug Saft*, 2006; 29(2): 161-168.
10. Lugardon S, Desboeuf K, Fernet P, Montastruc JL, Lapeyre-Mestre M: Using a capture-recapture method to assess the frequency of adverse drug reactions in a French university hospital, *Br J Clin Pharmacol*, 2006; 62(2): 225-231.
11. Kohn LT, Corrigan JM, Donaldson MS eds: To err is human: building a safer health system, 1999. *National Academy Press*, Washington, DC.
12. Weingart SN, Wilson RM, Gibberd RW, Harrison B: Epidemiology of medical error, Education and debate, *BMJ*, 2000; 320: 774-777.
13. Starfield B: Is US health really the best in the world? *JAMA*, 2000; 284(4): 483-485.
14. Null G, Dean C, Feldman M, Rasio D, Smith D: *LEF Magazine*, 2003; 11.
15. US National Center for Health Statistics: *National Vital Statistics Report*, 2003; 51(5): March 14.
16. Leape LL: *Am J Law Med*, 2001.
17. Laidler JR: The Null Hypothesis, Comments on Gary Null's *Death by Medicine*, www.wquackfiles.com accessed April 2nd 2008.
18. Cochrane AL, St Leger AS, Moore F: Health service 'input' and mortality 'output' in developed countries, *J Epidemiol Commun Health*, 1978; 32: 200-205.
19. Leger SS: The anomaly that finally went away? *J Epidemiol Commun Health*, 2001; 55(2): 79.
20. Bunker JP: The role of medical care in contributing to health improvements within societies, *Int J Epidemiol*, 2001; 30(6): 1260-1263.
21. Roemer MI: More data on post-surgical deaths related to the 1976 Los Angeles doctor slowdown, *Soc Sci Med*, 1976; 15C: 161-163.
22. James JJ: Impacts of the medical malpractice slowdown in Los Angeles County: January 1976, *Am J Public Health*, 1979; 69(5): 437-443.
23. Mendelsohn R: *Confessions of a Medical Heretic*, 1990; McGraw-Hill.
24. Steinherz R: Death rates and the 1983 doctors strike in Israel, *Lancet*, 1984; 107, 1561.
25. Siegel-Itzkovich J: Doctors' strike in Israel may be good for health, *BMJ*, 2000; 320: 1561.
26. Erceg M, Kujundzic-Tiljak M, Babic-Erceg A, Coric T Lang S: Physicians' strike and general mortality: Croatia's experience of 2003, *Coll Antropol*, 2007; 31(3): 891-895.