HealthManagement
Promoting Management and Leadership

Taking Responsibility for Avoidable Patient Deaths

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Unmonitored opioid deaths at home after surgery.

Primum Non Nocere. First, do no harm.

These wise words form the basis of the oath sworn to our patients. With the vast array of treatment models, administration, and decisions in medicine today, this oath is more poignant than ever. Medical Errors are the third leading cause of death in the United States. Courage is needed to find the causes.

Taking a fearless inventory of the way we practice, studying our mistakes, and making changes are the only remedies. The only way to achieve the goal is by individual accountability. Each person taking a stand, for each patient.

This is my contribution. Earned in the crucible of error and death. I now recognise a blind spot we have allowed to fester. Patients going home without monitoring when they use narcotics.

His name was Parker. He was a newlywed, aged 21 with a full life ahead. He died at home 2 days after surgery. Pain medication taken at prescribed doses killed him.

I sighed relief when the autopsy claimed pneumonia caused his death. His doctor was not to blame. During the sleepless nights that followed I could not deny the painful truth. My treatment must have killed him. He was healthy, took no medications, and spoke to his wife as they lay in bed hours before his death. Likely pneumonia? He didn't even have a cough.

How Parker died became clear:

I provided the path to his death: Pain pills. I withheld the device that would save him: Home pulse-ox monitoring. Cause of death: following doctors' orders.

Parker died from a small dose of painkillers. In a panic, I began sending all my post-operative patients home with pulse-ox monitoring. Cheap ones from the store were not enough. Hospital grade devices were needed to protect patients even while moving or being too cold (low perfusion). Responsibility to provide this level of equipment fell to me, not the patient. This device alarms when oxygen gets low, alerting the family of possible breathing difficulties. Respiratory depression is a major risk of opioids even at low doses. I was uncertain the device was needed, but also desperate to protect my patients. Two years have passed since his death.

I now know the machine would have saved him. I had the device; my ignorance clouded giving it to him.

This has happened before. In 1973, codeine was recommended for pain management. It is the most commonly prescribed opioid in the world. For over forty years, it was the mainstay for pediatric pain control. In 2013, the FDA issued a “black-box” warning regarding its use in children. Stating it should only be used in extreme cases. In 2016, United States experts recommended it not be used in children at all. The research discovered that some patients transform codeine to a lethal morphine derivative. Our children overdosed and died. Each death was beyond devastating but shuffled away, with the real cause not identified. Stunningly, it took almost half a century to realise codeine killed our babies. Medicine can be slow to recognise painful truths. To help, medical providers place safety nets in areas of danger until we better understand the problem.

In the opioid epidemic, we focus on addiction. We see addicts. Those we do not see are healthy patients who die taking pain medication at prescribed doses, after surgery or hospitalisation. Most of them have rarely taken opioids. They are the innocent victims, the civilian casualties, in the opioid war.

Similar to other wars, the unexpected death of bystanders is vastly under-reported. When a patient dies, medical providers seek reassurance that they were not to blame. We attribute these deaths to pneumonia, perhaps a heart problem, or the always-convenient category of ‘unknown.’ We are reluctant to discuss the painful losses with our colleagues; fear of litigation blunts our judgement. We sigh relief that it was not the surgery, and then we move on.

Parker did not take too many pills. In fact, he had never taken an opioid before. He was tough, preferred not taking narcotics, and died taking half of the prescribed amount.

For Parker, the missing safety net was home monitoring.

We practice inpatient medicine in an outpatient world. Medicine faces increasing pressure to treat patients at home. When it was suggested in the 1970s that tonsillectomy children did not need 3-5 days in the hospital, it was branded as unsafe and poor medicine. Today, tonsillectomy and other surgical patients are routinely discharged soon after surgery. In 1980, when arguments raged between patient safety protocols and outpatient cost savings, the technology did not exist to provide a level of inpatient care in the patients’ homes. Sending patients home puts them at risk, and home monitoring would have been mandatory. Instead, we accepted the risk. We gave concessions on patient safety.

The patient safety concessions can finally be repaired. Our ability to provide home safety nets is cheap, readily available, and easy to use. Tragically, these safety nets are almost never offered or even considered.

The only drug that rivals the lethal risk of taking opioids at home is insulin. Both can easily kill healthy people. It would be considered malpractice to send patients home on insulin without monitoring equipment. Shockingly, we do not require the same for pain medication.

Today, all my patients who take narcotics use alarmed pulse-oximetry at home. An alarming number are brought back with decreased oxygen. The data that demonstrates this is underway, but the safety net is ready now.

I urge others to put the safety net in place now! Policies are needed to protect patients like Parker and Amanda. National and state guidelines must be updated so every patient who is using these dangerous painkillers is continuously monitored for respiratory depression. Health insurance, Medicare and Medicaid, should make continuous pulse oximetry fully reimbursable for patients prescribed opioids. The technology is available, the results are proven, but there are no requirements for any patient to be monitored while on opioids. Lawmakers can prevent these tragedies from happening starting today.

Home oxygen monitoring while on opioids saves lives and should be a standard of care for all patients.

I lived the nightmare of learning that fact; I now zealously promote the prevention of these tragedies. Zero preventable deaths happen by each of us making the right decision. The opportunity for success and the responsibility of failure lies with us.

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