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enough of them, and because we don't take enough time, (we're) not killing germs. There is a study in Britain that came out six months ago that shows if you hire one extra housekeeper, on a Monday-to-Friday shift, you reduce the amount of hospital acquired infections by 38 percent. I was in the hospital taking care of a friend last week, at Virginia Mason. On her ward, the (nurse-to-patient-ratio seemed high). We're supposed to have a ratio bill in this state, but it's not being applied. (The Nurse Staffing Law, passed by the state legislature in 2008, requires hospitals to develop a nursing staff plan for each unit and shift.)

The third systemic cause would be shift work: health care workers working too many hours. After a certain amount of hours you lose your cognitive ability, your rational thought. And on a shift in any health care institution, you need your cognitive ability. You need your rational thought. Yet we still are working too many hours because we don't want to hire enough people to do the job.

The fourth, health care working conditions. Health care workers are working under too much stress, under conditions that are not ergonomically suitable. One out of 10 health care workers applies for workers' compensation every year. And when you injure a health care worker, you have a downstream negative patient effect.

Bullying is huge.

R.R.: *When you say bullying, I think, "Don't bully people in school."*

W.C.: Well, one form is being dressed down by your superior, being yelled at, being ganged up on by your peers. It's very similar to bullying in the schoolyard. The studies show that it lowers cognitive capacity. Doctors dressing down nurses, nursing supervisors dressing down nurses, nurses dressing down licensed (practical) nurses or orderlies. There's a pecking order in hospitals, a class system that's very clear. But each time a health care worker gets bullied, they lose their ability to do their job. We can't get health care workers to wash their hands when they come out of the bathroom. Systems are not being accountable through the basics of health care delivery and infection control.

R.R.: *But there are always those signs that say, "Employees must wash hands."*

W.C.: They don't do it. There's no peer pressure. There was just an article in The New York Times, where during operations, doctors have their cell phones in the OR ("As Doctors Use More Devices, Potential for Distraction Grows," NY Times, Dec. 14, 2011). And during an operation, they're making calls to their travel agents to book vacations. Nurses were doing the same thing. So there's a lack of accountability.

R.R.: *One of the hot topics a couple years ago was MRSA (Methicillin-resistant Staphylococcus aureus) How's MRSA tied into this?*

W.C.: MRSA is a bacterium, and it becomes a problem when health care workers and hospitals aren't diligent enough to prevent transmission, either from a patient or a surface in the hospital, which has not been cleaned properly to eradicate the MRSA. Then they touch another patient who's immuno-compromised. Most people in the hospitals are immune compromised. The germs, the bacteria, the viruses, the pathogen will spread. And they'll spread because the basic infection control paradigms are not being rigidly enforced. So MRSA – Methicillin-resistant Staphylococcus aureus – has been killing patients for years now in hospitals.

These are not easy bugs to kill. You can, if you clean properly. In America we don't know how to clean hospitals. We're letting the housekeeper in a room for 20 minutes or 15 minutes or 10 minutes, and then they gotta go to the next room. That's not enough time. They're not using the right kinds of products that actually kill them. We don't understand survival times of these germs, these pathogens. We're not cleaning nursing stations where they can accumulate. You know, about 100,000 people are dying every year of hospital-acquired infections and MRSA is one of them. Not the only one, but certainly one.

R.R.: *This might sound a little naive, but hospitals are projected as this place where you go to get better. But I know so many people who are terrified to go into a hospital.*

W.C.: Well, we have to keep in mind the denominator. The number of cases they treat are in the billions; number of people they harm are in the millions. They're only harming about maybe a third or more patients, according to some studies. One out of three has an adverse affect, according to Health Science, which is a journal that's published. So you justify the epidemic in terms of the good that they do to two-thirds of the population that they don't harm. However, when you look at the number of fatalities and the number of people they hurt, but don't kill, it's really becomes an epidemic of harm.

R.R.: *Is there somewhere where the harm isn't as extreme?*

W.C.: I think European hospitals tend to have lower medical error rates. Scandinavian hospitals have lower rates. That's a guess on my part. I've seen some comparable data.

But we don't want to turn this into a numbers game because Europe may be counting differently than the U.S. is counting. And that's one of the big problems we have: In 27 states in the U.S. – Washington is one of them – we have laws that say they have to report medical errors. Twenty-three states don't have rules. But we don't know how they're counting, we don't know what they're calling a medical error or what they're not. There's no standardization of approach of epidemiology, which tells you events that are supposed to be reported. We don't really have a mathematical way of comparing the numbers.

R.R.: *Why did you start researching this data?*

Somebody has to radicalize the process, somebody's gotta get out there and shout from the rooftops and the treetops that this is untenable. And patients, especially patients of color, poor patients — we're killing 134,000 Medicare patients a year in this country through medical error.

W.C.: Well I became horrified when I saw the data. I got angry. I know so many people who, in my own life, have sustained a medical error, who will never be the same. And the more I researched it, the more I realized there was an epidemic. (Then) I realized that the people who are in charge of fixing it are also the people in charge of breaking it. And that's a relationship that never works. It just never works.

The Society for Actuaries, which is a national society that actually counts money, says – and this is a very low figure – we're spending $20 billion a year on medical errors. So if you take the number of hospital beds we have in this country, which are about 1 million, and you divide those numbers – $20 billion by 1 million – you get $20,000 per bed that we're spending on medical errors. Even before a patient is put in the bed. And nobody's taking responsibility for that kind of cost. I mean, we can't afford to insure 50 million people in this country, and there's millions of others who are under-insured, who are making medical decisions because they can't afford it. Somebody has to radicalize the process, somebody's got to get out there and shout from the rooftops and the treetops that this is untenable. And patients, especially patients of color, poor patients – we're killing 134,000 Medicare patients a year in this country through medical error.

R.R.: *So many statistics point to how people of color, poor people, are adversely impacted in law enforcement, educational opportunities, unemployment. So how does it happen with medical errors? How would it be any different, if I were black or poor, that I might undergo more medical errors? I mean, we're in the same hospital, theoretically.*

W.C.: Well, in terms of social approach to medicine, the U.S. is behind Brazil and a lot of other third world countries, second world countries, in how we apply the umbrella of medicine. And certainly, people of color, people of poverty, receive the lowest amount of any type of intervention than people who are more able to pay for whatever intervention they are trying to receive. And that's true in medicine. If you go into the same hospital and you're black and you have no insurance, you're going to get a certain quality of care. I mean, they'll deny this 'til they're blue in the face, but that's what the data shows: that you will not get the same care as somebody who is fully insured. You may get fewer tests, you may get fewer interventions, you may get less personal care. The metrics of the care become lower for people who have less money or are people of color.

R.R.: *Earlier you mentioned someone needs to radicalize (health care). Let's say you're that radical individual. What do you decide to do?*

W.C.: One of the things I've decided to do is publish this book. It's a conversation changer, because we're saying that (medical errors are) the leading cause of death. And nobody knows that. I mean, Americans are dumbed down in practically every category you can think of at this particular moment in history, which is one of the reasons the empire is declining. Some people see that as a good thing and some people don't. But in health care it's never a good thing. So, we want to change the conversation. We want to change how we approach this.

The second thing is we're gonna try and create a North American alliance and social movement around trying to create the change. If every state had a law, every hospital had to apply a ratios bill – like Kaiser (Permanente), in California, which is a big HMO. They're doing it voluntarily, their rates have really come down. They're a leader in this field. So we're gonna introduce legislation. And we're gonna try to get people angry. Because hospitals are literally getting away with murder.

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Systemic factors in medical errors

Profit motive: The Journal of General Internal Medicine published a study in March 2000, titled "Hospital Ownership and Preventable Events." It showed that patients in for-profit hospitals are 2 to 4 times more likely than patients at not-for-profit hospitals to suffer adverse events such as post surgical complications, delays in diagnosis and treatment of an ailment.

Staffing: Ratios are not at acceptable levels. Only California and Washington have regulations calling for a ratio guideline. Patients in a hospital with a 1:8 nurse-to-patient ratio, have a 31 percent greater risk of dying than patients in hospitals with a 1:4 ratios.

Shift work: Longer shifts translate into more errors. Physicians who are scheduled to work long hours make 36 percent more errors with five times as many serious diagnostic errors.

Injury to workers: Injury contributes systemically to medical error and compromises patient safety.

Working conditions: Poor working conditions, such as ergonomics, patient developmental flows, staffing, workload, scheduling and autonomy contribute directly to medical errors. In 115 studies included in a 2003 review, working conditions affect patient safety, the rate of medication errors and the rate of recognition of such errors after they occur.

Behavior: A study of 1,700 nurses, physicians, clinical care staff and administrators found fewer than 10 percent address behavior by colleagues that routinely includes trouble following directions, poor clinical judgment or taking dangerous shortcuts. Specifically, 84 percent of MDs and 62 percent of RNs and other clinical care-providers had seen coworkers taking shortcuts that could be dangerous to patients … fewer than 10 percent said they directly confront their colleagues.

Non and Under Reporting: There are 27 states in the U.S. with reporting regulations and none in Canada.

Accountability: Studies have shown even getting healthcare workers to wash hands between patients or after leaving bathrooms is not enforced and there are low compliance rates.

Technology: Smart technologies in health care are being designed to intervene in administration errors. But according to a recent study, 98,000 people end up in emergency rooms every year (mostly elderly) due to medication error.

Cost-Benefit Analysis: The Society of Actuaries has stated that medical errors are costing $20 billion a year. Bedsores alone account for a cost of $3.9 billion annually. The cost per patient of medical error can be as high as $20,000 per bed (using the American Hospital Association's data of 1 million hospital beds in the U.S.).

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