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Hospital errors kill 750 patients a year

The deaths of two patients, in Canterbury and Wellington, from untreated infections are only the public face of a "chilling" 750 potentially avoidable deaths each year in New Zealand hospitals.

Canterbury's leading doctor is calling for greater awareness of the rate of "adverse events" in the health system before a national meeting of senior doctors and nurses on patient safety.

Canterbury District Health Board chief medical officer Nigel Millar said it was important for the health service and the public "to understand the scale of this" and realise the cases that became public were only the "tip of an iceberg".

Tragedies such as the death of 25-year-old Dean Carroll 12 hours after he was sent home from Christchurch Hospital's emergency department with an undiagnosed infection could make the public think the hospital or health system was deteriorating, he said.

"It is not something new and dreadful, but it is something really serious and we need to get to grips with it," he said.

He told yesterday's hospital advisory committee meeting that research in comparable countries had found the level of harm induced by health services was "unacceptably high".

Research indicated that of 600,000 hospital admissions in New Zealand each year, about 5000 suffered preventable, serious harm and an estimated 750 died.

"That's a chilling thought," said Millar. "We need everyone on board – the public, patients, relatives, health professions, health managers, this committee and board members – to accept the reality of this and realise the gravity of what has been in health services for as long as we know."

The apparent "inevitability of harm" should not stifle action to make a difference, he said.

A national meeting of senior medical and nursing representatives, including Millar, on patient safety would be held next week.

The meeting was called after a public inquiry into the death of a 50-year-old Wellington Hospital patient from a treatable chest infection.

Health and Disability Commissioner Ron Paterson said the case should be a wake-up call for other district health boards.

His investigation found several failings by the hospital, including inadequate communication, documentation and monitoring of the patient's condition. He also found a lack of dignity and respect for the patient and his family.

This week, the CDHB apologised to the Carroll family and promised an external inquiry. Millar said Canterbury had begun a "safe-patient journey" initiative to streamline patient movement at the hospital.