September 1, 2001

PATIENT POWERline from the desk of Marie Savard, M.D.

RE: Power to the Patients: Patients who take charge of their health can save their own life, and sometimes the lives of countless others.

Dear Friends,

Believe it or not, it was a Patient who discovered the critical laboratory mistake involving the blood thinner Coumadin at a local Philadelphia hospital that caused the death of at least two people and injured countless others.

Background to the story
Last fall, following the report of up to 100,000 medical mistakes each year, a patient safety hearing was held in Washington. Fox news in Philadelphia chose to do a weeklong story on patient safety. The Mother Cabrini nuns who I have cared for during the last twenty years were following my system and together we were featured in the series. The Savard System emphasizes the importance of collecting and reading one's medical records and tracking test results, carrying an emergency health information card and using a "health buddy" or advocate (the nuns call them guardian angels) for every doctor visit and hospital stay.

Local Philadelphia Hospital Story
About 900 patients taking the blood thinner Coumadin were tested to adjust their Coumadin dose. The laboratory reported erroneous results, leading their doctors to prescribe more Coumadin than was actually needed. This lead to two or more deaths and untold numbers of bleeding complications.

The blood test result that determines the Coumadin dose is called the INR. The INR was calculated using an incorrect formula leading to results much lower than they actually were. Doctors trusted the lab results and increased the Coumadin doses in a number of patients. Too much Coumadin (also called warfarin, the ingredient in rat poisoning) can lead to bleeding and even death.

On the evening that the story first broke I was called by Fox news and later our ABC affiliate to be interviewed. According to Fox news a patient was using my system and collecting original copies of test results and charting them over time along with changes in the Coumadin dose. This patient alerted the hospital to her suspicion that there was something wrong with the INR test as her clinical picture had not changed, yet her recommended dose of Coumadin continued to increase as each test came back with an INR result lower than expected.

Because it was a patient rather than a physician or the hospital lab that discovered the error it made big news and gave me the opportunity to describe on the two stations the importance of patients trusting their instincts, asking questions, asking for copies of test results and keeping their own test-tracking system.

Conclusions
Patients and their families can help play a role in protecting themselves in the chance of a laboratory error simply by asking for a copy of all their test results, including x-ray reports, and learning to track the results together with changes in their treatment regimen. Patients should know and record their physician recommended treatment goal for therapy as well. For example: patients who take cholesterol-lowering medication should know what the treatment goal is for their particular circumstances. Patients who already have heart disease should have their LDL cholesterol levels below 100. If you are taking Coumadin, do you know what your target goal INR level should be for your condition? If you don't know, ask your doctor, and then keep track of your test results.

On a slightly different note, I have received countless stories from patients who alerted their physicians to laboratory/x-ray abnormalities that were previously undetected. One woman was diagnosed with Stage III breast cancer despite routine mammograms. It was not until she went to my book signing this summer and heard me

speak about the importance of getting test results and mammogram reports that she asked for her test results from her gynecologist and found reports of previously abnormal mammograms. No one had brought the abnormal results to her attention and she believed that "no news is good news"? She has since encouraged me to tell her story and use her name as well. How many of us grew up with a similar notion, trusting that our doctors will tell us if something is wrong? Remember, lab and x-ray reports can be lost, misplaced, or even misinterpreted. No news is simply that, no news!

Doctors' failing to alert patients to an abnormal PSA test is another common occurrence. Often patients discover the abnormality themselves when they request their medical records upon transfer to another doctor or practice. Sometimes it's too late.

Not only can patients help to identify lab errors, they can become more fully informed and involved in all aspects of their care. I talk about my system and how you can manage your health information and protect yourself in my two books, How To Save Your Own Life (Warner, 2000) and The Savard Health Record (Time-Life 2000). To learn more about the system and to print out free forms that will help you stay safe, visit my web site at www.drsavard.com.

Next month I will talk more about the important and potentially lifesaving medication, Coumadin and what you can do to stay safe and get the maximum benefit as well.

I will answer the following questions:
What is Coumadin used for? Who should take it?
How can you monitor the medication yourself to be safe?
Why does vitamin K interfere with Coumadin?
If you are taking Coumadin, how can you avoid extra vitamin K in your diet?
What other medications can affect the INR level and dose of Coumadin?

Keep safe and thanks again for doing your part,

Marie Savard, M.D.
To learn more about how to get involved more fully in your own health care please visit my web site at http://www.DrSavard.com.
Please feel free to share this message with your friends and family. I would also welcome your stories and questions, http://www.info@DrSavard.com.

Warm regards,

Marie Savard, M.D.

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