I DIDN’T KNOW, I DIDN’T KNOW

AVOIDABLE DEATHS AND HARM DUE TO MEDICAL NEGLIGENCE

Aubrey Milunsky, M.D, D.Sc.

It is startling to realize that the third most common cause of death in the U.S. is medical negligence, third only to heart disease and cancer. That translates to about 250,000 deaths per year! That is a catastrophe equivalent to 12 full jumbo jet crashes per week. Serious harm is estimated to be 10-to-20-fold more common than lethal harm due to medical negligence.

Contrary to common expectations, it is good and usually competent doctors who make medical errors and contribute to most defendants in claims of medical malpractice.

In this book, Dr. Milunsky describes the poignant stories, recounted in litigation, about the causes and consequences of medical errors, culled from his extensive experience in medicine and as an expert witness on both sides of the bar. His focus is on how and why error(s) occurred and what lessons about anticipation, avoidance, and prevention could be learned to assure patient safety. Given his expertise, many of the cases involve possible genetic issues, a matter of importance since only 29% of physicians reported training in genetics in a 2012 survey. In this context, given the great sadness and long-lasting grief following serious errors in pregnancy care, labor and delivery, those planning childbearing would be well advised to heed the lessons from the cases described.

Dr. Milunsky examines the pathogenesis of error and the many anticipatory and remedial steps that can be taken to avoid catastrophes. His discussion incorporates the categories of negligent failures in all specialties and how, once recognized, they can be prevented rather than remedied after the fact.

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This book is for everyone who will become a patient (that is all of us). The aim is to provide knowledge and insight that enables proactive anticipatory and preventative actions. This book is especially important for physicians in all specialties, midwives, nurses and family doctors, those in public health, federal and state legislatures, professional and medical societies, professional colleges, deans of medical schools, safety organizations, and hospital CEOs. All are collectively responsible for not taking drastic action to halt the carnage in which 250,000 patients die each year in the U.S. This is a national crisis that requires everyone’s attention. The cases described vividly illustrate the nature of medical error and what can be done to remedy this long-ongoing tragic problem.