The Most Dangerous Place for Your Diabetes Might Be the Hospital

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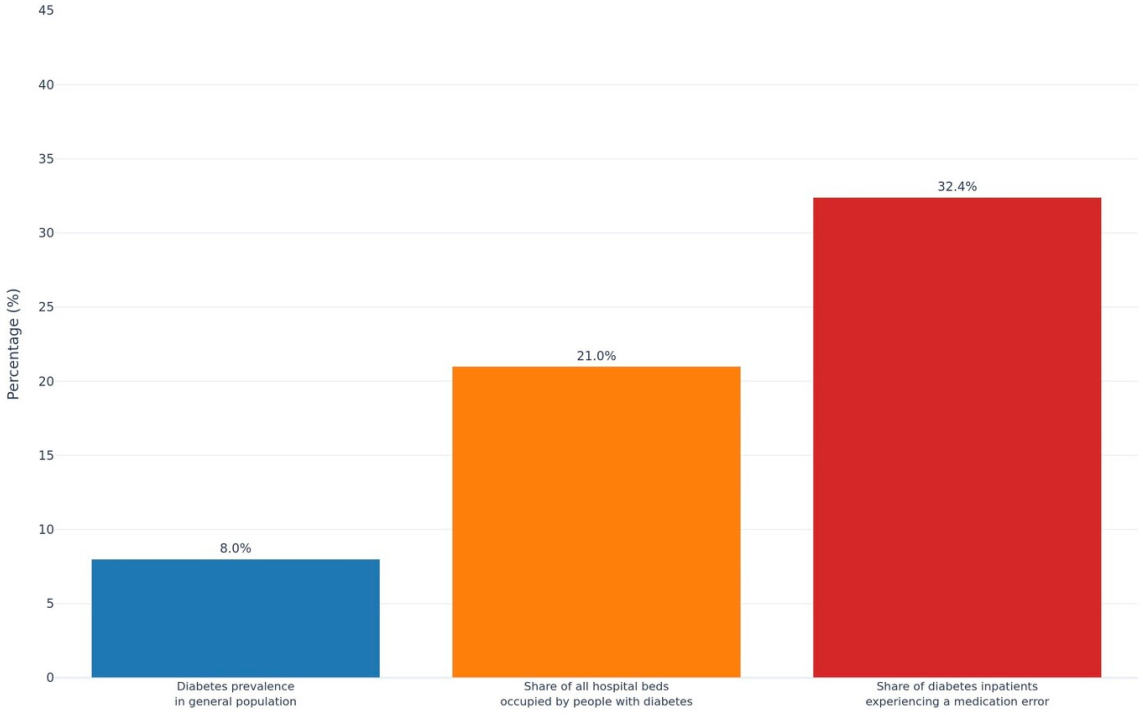
Imagine living with a condition where a few units of the wrong drug can literally kill you in hours – and then handing over all control to a hospital that proudly announces: **“Don’t worry, we’ve dealt with diabetes before.”**

Welcome to Hospital Diabetes Land

People with type 1 diabetes (T1D) go into hospital for all sorts of reasons: appendectomy, broken leg, childbirth, pneumonia – you name it. And far too often, they come out with one additional diagnosis: post-traumatic hospital disorder. Not from the disease, but from how it was managed.



Diabetes in Hospitals: Population vs. Admissions vs. Error Rates
I've heard stories of hospitals stopping basal insulin "because the patient is not eating," as if long-acting insulin were some kind of optional dessert. I've seen orders to "hold insulin, glucose is 280, we'll recheck tomorrow," as if diabetic ketoacidosis (DKA) politely waits for office hours. And then there are the classics: mixing up type 1 and type 2, treating a pump user like they're on premixed insulin from 1995, or the legendary sliding-scale insulin chart taped to the wall that looks like it was faxed during the Jurassic period.

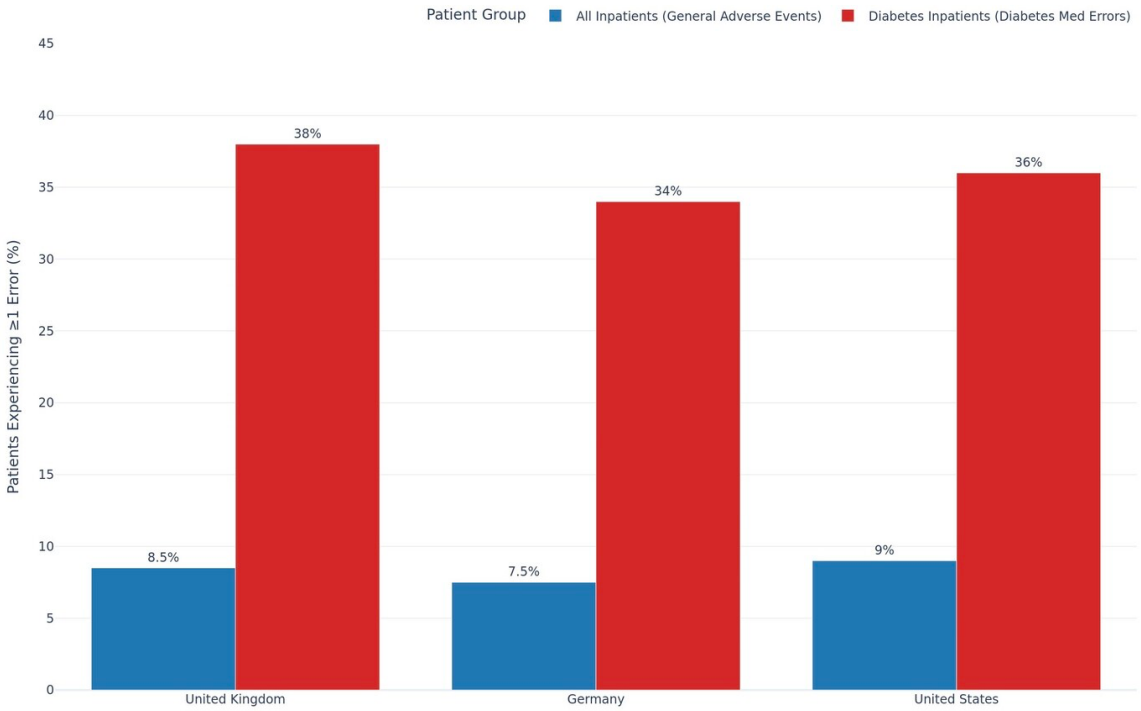
Real Stories That Shouldn't Be Real

Here's what people with T1D report from real-world hospital stays:

A young adult admitted for surgery, clearly documented as T1D, has their long-acting insulin "paused" without replacement because "we don't want you to go low during surgery." The team then spends the next 24 hours chasing blood sugars over 400 with small correction doses, visibly confused why things are getting worse instead of better. The patient, still groggy from anesthesia, ends up explaining basal-bolus therapy to the medical team.

Another person with T1D, admitted to a non-ICU ward, is told they must hand over their insulin pump because "devices are not allowed on our floor." The replacement plan? A nurse will come "three times a day" with insulin – for someone who normally fine-tunes micro-boluses every hour. Unsurprisingly, chaos ensues: sky-high glucose overnight, then massive correction doses, followed by spectacular hypoglycemia before breakfast. The medical chart calls it "labile diabetes." The patient calls it "what happens when you confiscate my brain."

Then there are the medication mix-ups: rapid-acting insulin used as if it were basal; double-dosed insulin because two shifts both "wanted to be safe"; carbs given without insulin "to keep energy up"; or the truly terrifying sentence: "We stopped all insulin because your glucose was normal." For a person with type 1 diabetes, "no insulin" is not a treatment plan; it's a slow-motion emergency.

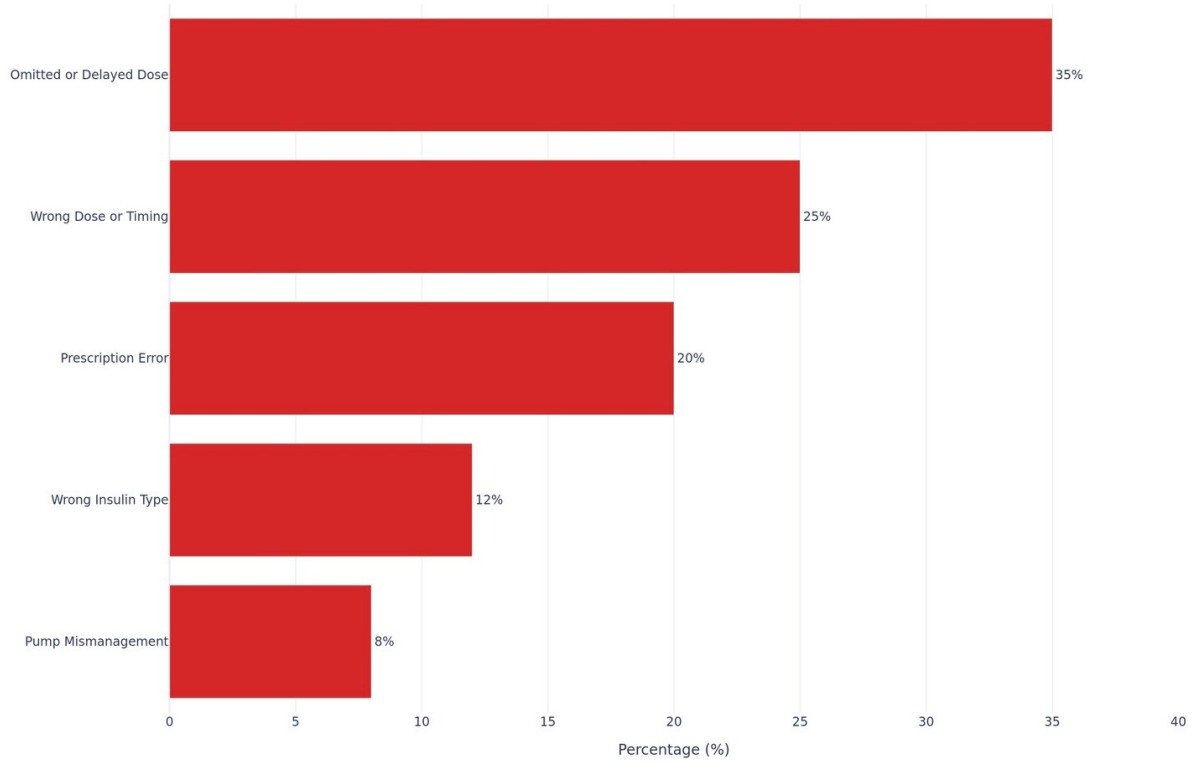


Hospital error Rates: All Patients vs. Diabetes Inpatients n the UK, Germany and the US

The ICU Paradox

Here's the absurd part: people with diabetes are significantly more likely to land in intensive care than people without diabetes. They have more complex infections, more post-operative complications, more cardiovascular events. In other words, diabetes is a frequent flyer in the ICU.

And yet, many hospitals still treat inpatient diabetes management as a side quest – something vaguely handled by a paper protocol and a nurse who "once did a diabetes course." We have elaborate algorithms for ventilator settings, multi-page SOPs for sepsis, and beautifully laminated checklists for central line insertion. But insulin dosing? Often reduced to "Give X units if glucose > Y" stuck on a clipboard last updated when pagers were cool.



Most common causes of Hospital Insulin Errors

The result is a bizarre paradox: the group most likely to end up critically ill – people with diabetes – is often managed by teams that don't feel particularly comfortable with the very drug that defines the condition: insulin. It's like an airline being great at in-flight entertainment but a bit shaky on how wings work.

Humor, Because Otherwise You Cry

Let's be honest: people with T1D survive hospital stays not rarely because of the system, but despite it. Many walk into hospitals with their own monitoring systems, pumps, algorithms, and years of finely tuned self-management – only to be told, "We'll take it from here," by someone who thinks basal insulin is just "the one you use at night."

If you listen to T1D patients, you hear the same pattern again and again:

- "I ended up hiding my CGM from staff so they'd stop trying to 'turn it off'."
- "I smuggled my own insulin into the hospital because the formulary didn't have what I needed."
- "I had to argue for three hours to keep my insulin pump on, then they asked me if it's 'like a nicotine patch'."

It would be hilarious if it weren't so dangerous. The dark joke writes itself: For many people with T1D, the riskiest part of a hospital stay is not the surgery, not the infection, not the injury – it's handing their insulin management over to people who treat it as a minor detail.

Looking Ahead to 2050

By 2050, we're heading towards about 1.3 billion people worldwide living with diabetes. That's not a niche; that's a global core business. Diabetes will be as common in hospitals as IV lines and antibiotics. You would think that by now, every hospital, every ward, every training program would treat diabetes management as a fundamental core competency.

And yet, if you talk to people with diabetes – especially those with T1D – you get a different impression. We have more technology than ever: CGM, closed-loop systems, decision support, AI-driven dosing tools. But a lot of inpatient care still looks like: "We use this insulin scale because we've always done it this way."
So here we are, on track for 1.3 billion people with diabetes by 2050, and I still have the uncomfortable feeling that a scary number of hospital providers don't really understand diabetes and are even less confident with insulin dosing. We built rockets that land themselves on drone ships, but in many hospitals, a safe basal-bolus regimen is still considered advanced magic.

Maybe it's time we flip the script: instead of T1D patients teaching staff how to manage insulin at the bedside, hospitals should treat inpatient diabetes care like what it actually is – a high-risk, high-prevalence, absolutely non-optional core skill. Until then, people with T1D will keep doing what they've always done: walking into hospitals with their own devices, their own experience, and a small but justified dose of fear. And frankly, given what they've already lived through, who can blame them?

For further Reading:

Patient stories and real-world errors

"Making hospitals safe for people with diabetes" – Diabetes UK Overview of how often hospital-induced DKA and insulin-related errors occur in the NHS, with patient examples

and concrete recommendations for safer inpatient care.
https://www.diabetes.org.uk/sites/default/files/2018-10/Making%20Hospitals%20safe%20for%20people%20with%20diabetes_FINAL.pdf[org]

"Diabetic patient died after hospital overdose" – BBC - News report about a patient who died after receiving ten times the prescribed diabetes medication, illustrating how lethal inpatient dosing errors can be. **https://www.bbc.com/news/uk-england-lincolnshire-54109068[bbc]**

"Anyone else had bad experiences at hospitals?" - Thread collecting T1D patients' hospital horror stories, from withheld insulin to pump removal and dangerous misunderstandings of type 1 management.
https://www.reddit.com/r/Type1Diabetes/comments/1572wzs/anyone_else_had_bad_experiences_at_hospitals/[reddit]

"Challenges of Diabetes Management and Medication Reconciliation" – Case-based discussion of inpatient diabetes medication errors, focusing on admission/discharge gaps and how wrong or missing insulin orders harm patients.
https://psnet.ahrq.gov/web-mm/challenges-diabetes-management-and-medication-reconciliation[psnet.ahrq]

"Errors of insulin therapy: Real-life experiences from a developing country" – J Family Med Prim Care - Clinical paper sharing concrete insulin error cases (e.g. wrong syringes, dose confusion) and what clinicians should learn from them.
https://pmc.ncbi.nlm.nih.gov/articles/PMC5848387/[pmc.ncbi.nlm.nih]

Inpatient standards and typical mistakes

"16. Diabetes Care in the Hospital: Standards of Care in Diabetes" – Authoritative guideline chapter describing how inpatient diabetes should be managed, with a section on common insulin dosing and timing errors in hospitals.
https://diabetesjournals.org/care/article/47/Supplement_1/S295/153950/16-Diabetes-Care-in-the-Hospital-Standards-of-Care[diabetesjournals]

"Challenges and Strategies for Inpatient Diabetes Management" – Review of why hospitals struggle with diabetes care, including data that insulin is one of the top drugs involved in hospital medication errors.
https://pmc.ncbi.nlm.nih.gov/articles/PMC7428658/[pmc.ncbi.nlm.nih]

"Common mistakes concerning diabetes management in clinical practice" – Broad review of frequent diabetes management errors, including medication and monitoring issues that directly translate into inpatient pitfalls. **https://pubmed.ncbi.nlm.nih.gov/39299897/[pubmed.ncbi.nlm.nih]**

"Type 1 diabetes perioperative care: Preventing harm to patients" – Focuses on surgical/perioperative T1D care, including the UK finding that 1 in 25 inpatients with T1D developed hospital-induced DKA due to undertreatment. **https://www.journal.acorn.org.au/cgi/viewcontent.cgi?article=1097&context=jpn[org]**

"Lived experiences of Type 1 diabetes patients visiting a hospital" – Qualitative study on T1D patients' hospital experiences, highlighting gaps in counseling, communication, and feeling unsafe or misunderstood.**https://journals.plos.org/globalpublichealth/article?id=10.1371/journal.pgph.0005810[plos]**

Some additional publications on treatment errors in hospitals:

Insulin Errors and Inpatient Danger

ISMP (Institute for Safe Medication Practices) / US Medicine *Summary:* Highlights that insulin is consistently one of the most high-risk medications in hospitals, involved in up to 16% of all high-alert medication errors. Often, errors stem from wrong dosing, incorrect timing, or using the wrong insulin product. *Link:* **https://www.usmedicine.com/clinical-topics/diabetes/insulin-errors-potentially-plague-hospitals-treating-diabetes-patients/**

General Hospital Adverse Event Rates

International prevalence of adverse drug events in hospitals (BMJ Quality & Safety / PubMed) *Summary:* A major systematic review analyzing routine data from England, Germany, and the USA. It establishes the baseline that general adverse drug events affect approximately 5% to 10% of all hospital inpatients across these Western healthcare systems. *Link:* **https://pmc.ncbi.nlm.nih.gov/articles/PMC3984698/**

The National Diabetes Inpatient Audit (NaDIA)

National Diabetes Inpatient Audit (England and Wales) *Summary:* The most comprehensive rolling audit of hospital diabetes care globally. It repeatedly demonstrates that up to 38% of diabetes inpatients experience at least one medication error during their stay, and around 1 in 25 type 1 patients develop hospital-acquired DKA. *Link:* **https://www.hqip.org.uk/wp-content/uploads/2018/02/national-diabetes-inpatient-audit-england-and-wales-2016.pdf**

Causes of Insulin Errors in Hospitals

Insulin errors and contributing factors affecting people with diabetes (King's College London / ScienceDirect) *Summary:* A qualitative and quantitative analysis showing that the vast majority of insulin errors occur during prescribing and administration. The most common specific causes include omitted/delayed doses (e.g., stopping basal insulin), wrong dose timing, and prescription/documentation mix-ups. *Link:* **https://kclpure.kcl.ac.uk/portal/en/publications/insulin-errors-and-contributing-factors-affecting-people-with-dia/**

Insulin-Related ED Visits and Hospital Errors (USA)

Insulin-Related Hypoglycemia and Errors (JAMA Internal Medicine) *Summary:* A detailed US study exploring why insulin errors happen, noting that taking the "wrong insulin product" (mixing up rapid and long-acting) accounts for over 22% of insulin-related emergency incidents, highlighting the severe risk of "look-alike" medication errors. *Link:* **https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1835360**