 passage three about 1,200 people died in public hospitals in britain last year because of mistakes in prescribing and administering medicine, according to a report published today by a government watchdog group.outlined in a report by the audit commission, the errors included administering the wrong medicinein one case, a breast cancer patient was given the sleeping drug temeazepam instead of the cancer drug that caused a fatal reaction.the death toll was five times higher than that in 1990, according to the report. in addition, thousands of patients who survive medicine-related mistakes each year invariably become sicker, requiring more treatment that creates an extra expense for the national health service, the report said. “ the health service is probably spending half a billion pounds ($725 million) a year making better people who experienced an adverse incident or errors, and that does not include the human cost to patients, ” said nick mapstone, an author of the report.mr. mapstone said that many of the most common errors are avoidable and could be rectified if the health service introduced computerized patient record and prescription systems.the government has promised to introduce computerized prescriptionswhich could include a standard national system for coding medicines and the use of bar codes to support development of electronic prescribing systemsby 2005, but mr. mapstone said he did not think it would meet the

deadline.addressing the issues raised by the report, dr. trevor pickersgill, a spokesman for the junior doctors ' committee of the british medical association, said that understaffing in hospitals and the increasing complexity of modern drug therapy have created a culture " where mistakes unfortunately do happen. " " the number of drugs is increasing, the effectivenessand therefore often the toxicityof drugs is increasing, the number of people on multiple medications is increasing, and that increase the risk of interaction, " dr. pickersgill told the bbc. " we must also remember that one in six pharmacy posts in hospitals are unfilled, and new doctors who are doing the work on the wards are overworked as well, " he said.a number of highly publicized cases of drug-related errors in recent months have brought home the problem. in one case, a cancer patient was prescribed and administered a drug at 1,000 times the recommended dose, according to the report.41. which of the following is not an error cited in the report by the audit commission?a. administering the wrong medicine.b. giving out the wrong dosage of the right medicine.c. unknowingly prescribing a drug that caused a fatal reaction.d. administering tamoxifen where temazepam is required.42. according to mr. mapstone, many of the most common errors can be avoided if _____.a. computerized patient record and prescription systems are adoptedb. patients ' notes are illegible, incomplete or missing altogetherc. doctors and nurses are provided with correct informationd. bar codes are used by 200543. according to dr. pickersgill, reasons why hospitals become a culture " where mistakes unfortunately do happen " includes

_____.a. overstaffingb. the fact that there are too many doctors and nursesc. the increasing complexity of modern drug therapyd. the increase of toxicity of modern drugs44. in paragraph 8,“ that ” in “ that increases the risk of interaction ” refers to _____.a. the increasing number of drugsb. the increasing effectiveness of drugsc. the increasing of the number of people on multiple medications d. all of the above45. what will probably be discussed after the passage?a. other cases of drug-related errors. b. unfilled beds in hospitals.c. overworked doctors. d. publicity of medical errors.