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A Newsletter about Truth and Integrity in Medicine and Medical Malpractice

The Most Dangerous Place in the Community

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According to the authors of Death by Medicine, a book released in April of 2010, the leading cause of death in the United States is not heart disease or cancer or automobile accidents but the healthcare system itself. If the book's statistical analysis is true, over 794,000 people die annually from inadvertent mistakes in hospitals, in nursing homes, or other areas of healthcare. It means that more people may have died in the past 10 years from healthcare mistakes than died during the Holocaust in Germany during World War II. The annual cost of these killings are a shocking 280 billion dollars ($280,000,000,000) plus. (See Death by Medicine, p. 26, Null, Freedman, Razio and Dean (2010))

Unfortunately, whether the above statistics are true or not, it is true that the most dangerous building in most communities is the local hospital. Each year thousands of patients are killed throughout the United States in hospitals from avoidable accidents that are designated as "unexpected events." In November 2010, the Inspector General of the United States released a report that estimated 180,000 Medicare patients were dying in hospitals from an adverse event that contributed to their death. On August 14, 2014, the Journal of the American Medical Association, (JAMA), published an online article about advocates calling for a "Patient Monitoring Board." In the article, a recent study was referenced that suggested the number of US deaths as a result of medical error may top 400,000 per year (more than 1,000 each day (James, J.T., J. Patient Safety 2013; 9[3]: 122-128).

The law in many states including Pennsylvania requires hospitals to ensure the safety and welfare of its patients; however, the statistics suggest that hospitals are not complying with that law.

In our experience, we have found that doctors who perform dangerous surgeries are not supervised closely so unnecessary and unsafe surgical practices continue to injure and kill patients. Nurses and other healthcare providers in the hospitals are not given detailed systems and instructions to avoid injuries from the delivery of drugs or the performance of other necessary procedures. The theme throughout hospitals is that "Hospitals do not tell doctors how to practice medicine," so there is little supervision or effort made to correct the unsafe practices of physicians and surgeons.

When a patient dies in an unexpected event, most hospitals do not enforce or have detailed and effective procedures to find out why the death occurred. More importantly, many hospitals do not use

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an “unexpected event” as a means of finding out exactly what happened so that policies and procedures can be put into place to ensure that such events will never happen again.

Hospitals do not require the recording of intraoperative conversations. Hospitals do not require monitors that generate actual time automatic recording of the patient’s vital signs during surgery. Hospitals do not require video recording of all laparoscopic procedures. When television equipment or monitors have the capability to record the events of surgery, there are no policies and procedures mandating their use.

When a patient dies, only rarely are autopsies performed. Hospitals view risk management as avoiding being held accountable in court. Patient safety, a priority under the law, is too often given mere lip service. Avoiding liability and fear of successful lawsuits largely control policies and procedures that determine how care is delivered in the hospital. So this inherently dangerous enterprise, whose purpose is to save lives, is, rather, the leading cause of foreseeable and avoidable deaths.

The airline industry, another inherently dangerous enterprise, provides an enviable record of passenger safety. Information from unexpected events is carefully studied. A black box is placed in every airplane so if a crash occurs the information can be recovered to facilitate finding the cause of the crash. Then procedures can be put in place so that a similar crash will never happen again. However, failure analysis has not been adopted by the health care industry. Patient deaths are justified as “known risks” or “known complications” of the procedure. Careful review of the philosophy and manner of the delivery of healthcare is appropriate. There is a better way.

The law provides that hospitals have the obligation to ensure the patient’s safety and well being while in the hospital. In Pennsylvania, for example, hospitals have a non-delegable duty:

1. To use reasonable care in the maintenance of safe and adequate facilities and equipment.
2. To select and retain only competent physicians.
3. To oversee all persons who practice medicine within its walls as to patient care.
4. To formulate, adopt, and enforce adequate rules and policies to ensure quality care for patients.

But hospitals have been unable to assure safe practices by physicians and surgeons, in part, because of a strongly held belief that the practice of medicine is an art. As long as medicine is viewed as an art based on the talent and judgment of the doctor, compliance with the above obligations that the law imposes upon corporations cannot be satisfactorily accomplished.

Utilizing safety engineering principles, hospitals must change the concept that medicine is an art to the view that the delivery of healthcare is a scientific discipline. They must utilize scientific engineering principles to develop rules of safe practice. The rules should be written. These rules must establish the “shoulds” and “should nots” that are needed to be followed to provide safe care to patients. The concept that hospitals do not tell doctors how to practice medicine must be changed.

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Over the past 50 years various authoritative sources have questioned the safety of healthcare methods and procedures. Perhaps the most stunning revelation occurred in 2000 when the Institute of Medicine published a report which carried this message on its cover: First, Do No Harm: **To Err is Human:** Building A Safer Healthcare System. The report, however, revealed the failure of hospitals to comply with medicine's prime directive. The report disclosed that up to 98,000 people a year were dying in hospitals from preventable medical errors. The report called for a 50% reduction within 5 years. It did not happen.

On August 9, 2009, the Hearst Corporation published a wide ranging national investigation report concerning medical mistakes. The investigation revealed that an estimated 200,000 Americans would die needlessly in 2009 from preventable medical mistakes and hospital infections. The investigation included interviewing 20 of the 21 living authors of To Err Is Human. Of those, 16 believed that the United States hasn't come close to reducing medical errors by half, the primary stated goal of the report.

The Hearst Corporation reported in "Dead by Mistake" that "more people die each month of preventable medical injuries than died in the terrorist attacks of September 11, 2001... The annual medical error death toll is higher than that for fatal car crashes."

In 2007 an article that appeared in the New Yorker Magazine by Dr. Atul Gawande established the benefit of safety engineering using checklists as applied to medical care in hospitals. Quoting a physician from Johns Hopkins Hospital whose use of safety checklists in preventing PICC line infection was astoundingly successful, Dr. Peter Pronovost stated:

> The fundamental problem with the quality of American medicine is that we fail to view delivery of healthcare as a science. The tasks of medical science fall into three buckets. One is understanding disease biology, one is finding effective therapies, and one is ensuring those therapies are delivered effectively. The third bucket has been almost totally ignored by research funders, government and academia. It's viewed as an art of medicine. That's a mistake, a huge mistake and from a taxpayer's perspective, it's outrageous. We have a 30 billion dollar a year National Institutes of Health he pointed out which has been a remarkable powerhouse of discovery but we have no billion dollar national healthcare delivery studying how best to incorporate those discoveries into daily practice.

Why has there been no dramatic and meaningful change in the unsafe manner healthcare is provided? In ten years since the Institute of Medicine's report, while some strong and innovative efforts have been made, it has not produced overall improvement.

If I walk into a hospital today, would I be safer than 15 years ago? Dr. Ashisa Jha, M.D., MPH, a professor of Health Policy and Management at the Harvard School of Medicine, says the answer is "no!" See JAMA article, supra**.**

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So what is the answer? Why has there been no dramatic improvement in all areas of danger where patients suffer harm even death? This question will be answered in our next Antidote newsletter.