How Many Patients Have to Die Needlessly in Our Hospitals before Someone Notices?

Lives are precious, to themselves, and to others, therefore those lives needlessly lost greatly increases the pain those left behind must endure. Deaths of Ambassadors, regardless of cause, require public recognition, and the death of such national representatives due to acts of terrorism are particularly tragic, but the sense of loss for those who have loved ones die needlessly in our hospitals must be considered to be equally painful. People go to hospitals seeking to be healed, and not to become another statistic in the continuing saga of needless hospital deaths.

We are well into the third decade of recognition of the enormous number of needless hospital deaths anticipated annually, and every estimate of such predicable losses is significantly greater than all previous estimates. Yet the specific issue Needless Hospital Deaths remains primarily the periodic subject of an article in one of the many patient safety journals that are read by a discrete segment of the healthcare system. Where is the national outrage?

Furthermore, needless hospital deaths are rarely, if ever, the principle subject of the numerous organizations of patient safety meetings that have been held in the past several years, and most articles about the subject during the first two decades (1990-2010) focused on new measures promising dramatic improvement in how to improve the management of such tragedies, while decreasing their occurrence. Sadly, there is no evidence that those promises have even come close to fulfilling the promises made to begin to reverse that deadly trend.

NY Times first reported on the Benghazi attack, and death of the US Ambassador, and three other Americans on Sep. 11, 2012. One year later the Journal of Patient Safety published the latest estimate of needless hospital deaths by John James, PhD that estimates perhaps more than 400,000 needless hospital deaths annually.

The death of an American Ambassador, regardless of cause of that death, is of urgent media attention, but it should be asked how many patients must needlessly die in hospitals year after year, with no evidence of positive measures to reverse that carnage before both the federal and state governments, and major media sources will not only take notice, but demand action?

In this Open Letter regarding what is really wrong with healthcare I will challenge every governmental, and major media source to explain to the public how literally millions of patients could have needlessly died in hospitals during the past several years, and have been doing so for decades, while decision makers, and media watchdogs remain passively silent?

A close review of the efforts to improve the quality of healthcare and patient safety during the past two decades reveals a litany of great promises, and a paucity of positive results. Sporadic media attention, as when Sully Sullenberger, Hero on the Hudson gained national attention as a newly qualified patient safety expert, should be considered insufficient coverage for such a long standing, monumental loss of life, particularly when

every succeeding estimate is significantly greater than the previous estimate. Both political parties quibble over how to save money in healthcare while ignoring the enormous loss in patient's lives. Granted, healthcare cost are a critical issue that demands consideration, but lives are far more valuable.

So, the point of this Open Letter is; how is it possible to create as much attention to the needless hospital death issue as has been given to how to pay for healthcare after-the-fact for the past several years? According to John James' estimate over two million patients have needlessly died in hospitals since ObamaCare was being incubated, yet the public has little, if any recognition of the term *needless hospital deaths*. And I believe there are clearly evident reasons why each estimate of needless hospital deaths is greater than the previous estimate, and those reasons have been either unrecognized or ignored by the vast army of quality of healthcare and patient safety experts.

The Needless Hospital Deaths (NHD) Track Record

Well over twenty years should be sufficient time to establish a proven track record, and the strongly supported statistical evidence of the results achieved (unachieved) thus far to reduce such carnage spells disaster. Even the best Spin Doctors can't spin a rosy picture out of the fact that every new estimate of needles hospital deaths annually is significantly higher than the previous estimate.

Brennan and Leape set the initial NHD bar at 98,000 annually in 1990 after four years of research in upstate New York hospitals. IOM To Err Is Human 2000 used that estimate as the base line to announce the ability to reduce that number of NHD by 50% in five years, and Dr. Leape contributed to the efforts of one of the two major committees creating that much herald patient safety publication.

Reality began to set in beginning with Dead By Mistake, Hearst Newspapers, Aug. 2009, and Sully Sullenberger's quote of the equivalent of Boeing 747s crashing into our nation's hospitals weekly the next year, both with significantly higher estimates. But the worst was yet to come.

A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care, John T. James, PhD, Journal of Patient Safety, Sept. 2013.

Article Abstract: Using a weighted average of the 4 studies, a lower limit of 210,000 deaths per year was associated with preventable harm in hospitals. Given limitations in the search capability of the Global Trigger Tool and the incompleteness of medical records on which the Tool depends, the true number of premature deaths associated with preventable harm to patients was estimated at more than 400,000 per year. Serious harm seems to be 10- to 20-fold more common than lethal har

Conclusions: The epidemic of patient harm in hospitals must be taken more seriously if it is to be curtailed. Fully engaging patients and their advocates during hospital care, systematically seeking the patients' voice in identifying harms, transparent accountability for harm, and intentional correction of root causes of harm will be necessary to accomplish this goal.

But there is more:

How Many Die From Medical Mistakes in U.S. Hospitals? Marshall Allen, ProPublica, Sep. 19, 2013.

Excerpts: Dr. Lucian Leape, a Harvard pediatrician who is referred to as the "father of patient safety" was on the committee that wrote the "To Err Is Human" report. He told ProPublica that he has confidence in the four studies and the estimate by James.

Members of the Institute of Medicine committee knew at the time that their estimate of medical errors was low, he said. "It was based on a rather crude method compared to what we do now," Leape said. Plus, medicine has become much more complex in recent decades, which leads to more mistakes, he said.

Dr. David Classen, one of the leading developers of the Global Trigger Tool, said the James study is a sound use of the tool and a "great contribution." He said it's important to update the numbers from the "To Err Is Human" report because in addition to the obvious suffering, preventable harm leads to enormous financial costs.

Dr. Marty Makary, a surgeon at The Johns Hopkins Hospital whose book "Unaccountable" calls for greater transparency in health care, said the James estimate shows that eliminating medical errors must become a national priority. He said it's also important to increase the awareness of the potential of unintended consequences when doctors perform procedure and tests. The risk of harm needs to be factored into conversations with patients, he said.

Leape, Classen and Makary all said it's time to stop citing the 98,000 number.

My response to James' new estimate, and the three doctors' support:

Dr. Leape was Co-Leader of the original 1990 research that created the 98,000 estimate, and member of the IOM To Err Is Human 2000 committee that used that estimate as their base line, He now says "the committee knew at the time that their estimate (98,000) of medical errors was low", and now "it's time to stop citing the 98,000 number. Dr. Classen, a leading developer of the Global Trigger Tool used by Dr. James, and Dr. Makary, author of "Unaccountable" join Dr. Leape in strongly supporting Dr. James' new estimate of NHDs.

Additional insight can be found in a recent blog by Dr. Ashish Jha, a Harvard policy researcher.

I suggest that people truly interested in needless hospital deaths study a combination of the James, ProPublica, and Jha blog seeking to understand what they collectively say, and don't say about that critical subject while keeping in mind that we are well into the third decade of enormous effort to reverse that deadly trend, and with NO evidence of reversing the reality of NHDs in our nation's hospitals.

So where is the major media? Where are the federal and state governmental leaders, and decision makers? Where is the outrage? What will it take?

All forms of the major media responded vigorously when young Jahi McMath sadly bled to death following throat surgery, and the resultant impasse on determining end of life, and similar cases of individuals dying in hospitals, if controversial enough, make headlines. Still the larger picture of how each new estimate of needless hospital deaths is significantly greater than the previous estimate continues to fail the test for what makes national news demanding answers.

Perhaps the Association of Health Care Journalists can provide the answer for what makes a subject as seemingly important as needless hospital deaths worthy of major media attention on a grand scale. Their Association web site has a Select Topic drop down box with over 60 items to choose from, but needless hospital deaths, or even "never events" did not make their list. "Controversy sells", and the needless hospital deaths crisis is loaded with controversy, or so it would seem. But apparently not sufficiently for healthcare journalists.

We are well into the third decade of constantly increasing estimates of needless hospital deaths. Isn't it time for a national focus on this critical issue? One can only assume that there are vital elements regarding that subject that haven't been recognized to date, and that would perhaps become recognized during such a meaningful process.

Find The Black Box identifies several of the elements that have always been missing in the efforts to improve the quality of healthcare and patient safety, and offers The Solution No One Else Is Talking About. It should be time to talk more about the Solution.

References:

(http://is.gd/z0Lte3) NY Times Benghazi attack, Sep. 11, 2012

http://is.gd/LTnBli Brennan, Leape, et al, 1990

http://is.gd/2MSBhR To Err Is Human IOM, 2000

http://is.gd/60TFKy Dead By Mistake, Hearst Newspapers, Aug. 2009

http://is.gd/26uxXj Sully Sullenberger, 200,000 quote Politico, Aug. 1, 2013

http://is.gd/GzKOg3 John T. James, PhD, 400,000, Sep. 2013

http://is.gd/Gag91b ProPublica article Sep. 19, 2013

http://is.gd/TsiYce Dr. Ashish Jha, Harvard policy researcher blog, Mar. 5, 14

http://is.gd/mAMbXk Jahi McMath: Bay Area News Jan. 25, 2014

http://is.gd/Tn8gJo Association of Health Care Journalists