The Healthcare Solution No One Else Is Talking About

"I have a clear vision of a 21st Century healthcare delivery system that should replace the current unorganized, dysfunctional, and all too often needlessly deadly non-system. That system will provide mechanisms for meaningful accountability at the point of patient care, and go far beyond anyone's imagination. Presently however I have no reason to be optimistic that I will ever be afforded an opportunity to present my vision of such a system in the manner in which I feel necessary. What I can't understand is why no one appears to take my offer seriously."

Find The Black Box, Prevent Needless Hospital Deaths, and The Solution No One Else Is Talking About is my third book on healthcare, and it was released to the public in early September 2013. I have written three books on healthcare in the past ten years, and to my knowledge no one has questioned, or disputed any aspects of those books. True scientific endeavors seek to be challenged, and are, or should be, open to new, and different considerations, especially in attempting to confront serious problems. Yet I have found it exceedingly difficult to find healthcare experts with open minds.

The most insightful response to my second book, **Misdiagnosed, Why Current Healthcare Change is Malpractice** 2010 was, "Ira, your problem is you are trying to tell everyone else they are wrong!" Actually that response was only half right. I am the messenger, and the facts are clearly telling every quality of healthcare, and patient safety expert that they are wrong, and their efforts during the past quarter century have been misdirected for several decades.

Every expert seeking to improve healthcare has either ignored, or failed to recognize several fundamental facts regarding healthcare, and how it is provided to the public. I do not seek hostile confrontation, but due to the needless hospital deaths crisis I do seek a courteous and respectful consideration for my contrarian views on what is really wrong with the current healthcare delivery system, and how to redirect future efforts in a far more beneficial direction

First two fundamental facts: all medical care is local, and states license doctors. Therefore each state is responsible to create, and maintain a functional healthcare delivery system, and no governor, or state legislature, past or present, has ever recognized, and attempted to fulfill that responsibility.

Additional state healthcare failure: Every state medical examining board is over 100 years old, and contained in each medical board's mission statement is the responsibility to "regulate the practice of medicine in their state." Each state medical examining board should be required to publicly demonstrate how their regulatory mechanism functions in their efforts to fulfill that responsibility to their citizens.

System: It is almost impossible to discuss the delivery of healthcare without the rapid need to use the word *system*. Yet that *system* is, and has always been devoid of any systematic characteristics. Furthermore, quality of healthcare experts recognized that

system to actually be a non-system first in IOM To Err Is Human 2000, and later in Dr. Elizabeth McGlynn's Rand Corp. 2004 "The Quality of Health Care Delivered to Adults in the United States." Yet there is no evidence in the quality of healthcare literature that there has been any recognition that the complete absence of an organizational structure so vital for systematic function was, is, and will continue to be, the root cause for why the quality of healthcare, and patient safety efforts have been so monumentally ineffective during the past quarter of a century.

Quality of Healthcare and Patient Safety Scorecard: the latest, highly supported estimate of needless hospital deaths annually is reported to be quadruple the 1990 estimate of 98,000 each year, and every estimate since 1990 has been significantly higher than the previous estimate. Additionally, the same study estimates that 10-20x that number of patients are medically harmed, but not fatally, each year.

Dr. Marty Makary, Johns Hopkins surgeon, in the one word title of his 2012 book **Unaccountable**, accurately describes the dire status of the quality of healthcare, and patient safety in the current healthcare delivery system. That non-system has lacked meaningful accountability since its inception, and the public continues to be expected to passively accept Sue or Forget It if they or a loved one appears to have been harmed by questionable care. His book provides detailed descriptions of his profession's consistent professional failures to the public.

While currently the White House, Congress, all forms of the major media, and most healthcare pundits have become so obsessed with determining how to pay for healthcare after-the-fact in order to try to save money the needless hospital death disaster continues to spiral downward unabated, and with little notice. Apparently dollars are more important than lives in the quest to improve the quality of healthcare, and the Association of Health Care Journalists has apparently been unable to grasp the full picture of how every increasing estimates of needless hospital deaths well into the third decade clearly indicates the wrong kind of progress.

It is naturally difficult for "experts" to accept the understanding that they have collectively, and individually, failed to recognize, or have ignored fundamental facts, and the results of either form of failure has resulted in over two decades of ineffective efforts. But the needless hospital death scorecard leaves no other conclusion. Drs. Berwick, Leape, Pronovost, and Chassin (Joint Commission), to name a few of the most prominent proponents for attempting to take safety measures from established industries, and insert them into the healthcare delivery system in order to improve patient safety continue to try to put a square peg into a round hole.

And the Quality of Healthcare and Patient Safety Experts Can Provide the Proof: Ask any quality of healthcare and patient safety expert to describe, in detail, the organizational structure of the healthcare delivery system in the state where they live by naming every component of that "system", describing how each component functions, and identifying any systematic collaboration between various components. Experts have been proclaiming their expertise, while promising to improve the quality of healthcare,

and patient safety by incrementally changing a non-system none of them can describe. Einstein's definition of insanity has become the reality of all of the efforts to improve the quality of healthcare, and patient safety for the past quarter century.

Second Question for Quality of Healthcare and Patient Safety Experts:
Can they provide a detail description of how they envision a 21st Century healthcare delivery system that is capable of functioning in a systematic manner? I have identified 16 different components that contribute in some manner to the South Carolina healthcare delivery system, and I have found no evidence of systematic collaboration between even some of those components. South Carolina has 68 acute care hospitals, and 65 surgery centers, and I seem to be the only patient safety expert that recognizes the need to include surgery centers in every reorganization consideration.

Dr. Eric Topol, in his book "The Destructive Creation of Medicine" provides a detail picture of the enormous infusion of technological advances pouring into what? An unorganized, dysfunctional non-system that none of the experts can describe in detail, and that is needlessly killing far too many patients that system is suppose to be trying to make better, and that is incapable of incorporating those new technologies to their full patient care benefit. Dr. Topol's future highly technical medical world needs, and deserves an equally advances healthcare delivery system.

What is My Vision of a 21st Century Healthcare Delivery System, and Why Can I Not Provide a Brief Summary of that System?
Any attempt to briefly describe a completely reorganized (finally organized) state healthcare delivery system would be a disservice due to the enormous size of that subject. Also due to the lack of detail in a brief summary, such an offer would be too open to uninformed, negative criticism.

I need one full day to present my vision of a 21st Century Healthcare Delivery System.

Yes, I am well aware that many, if not most people will find the above statement to be incredulous as to my claimed inability to offer a brief summary, but I feel I have no other choice, and for reasons well established in my mind. If people want to know what I have to contribute to the efforts to improve the quality of healthcare, and patient safety they will have to provide me with sufficient support, and opportunity to present my vision in the manner that I consider most appropriate, and most effective. I can promise this; those who will remain for the entire presentation will be given a detail picture of a healthcare delivery system that they will want to pursue.

The Alternative: Keep what you've got, and let the current quality of healthcare, and patient safety experts continue to try to incrementally change an enormous "system" none of them can describe in detail, and that is, and has always been, a long-recognized non-system, and with a quarter of a century track record of dismal failure as demonstrated by the consistently escalating estimates of needless hospital deaths, plus the much larger number of those medically harmed, but not fatally.

The Subject: Your healthcare system, your children's healthcare system, and for those with, or hope to have, your grandchildren's healthcare system. Healthcare becomes very personal when each person becomes a patient, and unfortunately, the greatest healthcare system in the world is unorganized, dysfunctional, too often chaotic, and far too often needlessly deadly, or non-fatally harmful. I know how to begin a process to completely reorganize (finally organize) the healthcare delivery system.

http://is.gd/UK4Uk0	Find The Black Box (Index available on web site)
http://is.gd/LTnBli	Brennan, Leape, et al, 1990
http://is.gd/2MSBhR	To Err Is Human IOM, 2000
http://is.gd/eqpqXm	Dr. Elizabeth McGlynn, Rand Corp. 2004
http://is.gd/GzKOg3	John T. James, PhD, 2013
http://is.gd/Gag91b	ProPublica article Sep. 19, 2013