A Brief Conversation with Dr. Catherine Cassel, NQF CEO & President

Everyone agrees, our current health care system is chockfull of problems, and beset by multiple groups of experts who have been diligently seeking for the past quarter century to make that non-system better, while every new estimate of needless hospital deaths is significantly greater than all previous estimates. Yet what might be considered the bookends of the problems in the current healthcare delivery system struggle to gain broad attention, while those who have been attempting to confront those problems continue to pursue promised improvements while using the same, or similar methods.

Bookend 1: A quarter century after Brennan and Leape, et al., provided the first strongly supported estimate of needless hospital deaths annually in 1990 *every new estimate of such tragedies* has been significantly larger than all previous estimates, thus establishing what should be accepted as a reliable track record of failure. The latest estimate of needless hospital deaths (NHD) annually calculates that more than one thousand patients die under highly questionable circumstances each, and every day each year, and have been doing so for an undetermined period of years with no discernable evidence of beneficial methods to reverse that deadly trend. Yet the phrase *needless hospital deaths* rarely captures the attention of all forms of the major media, and more importantly, all forms of elected officials at every level of decision making. How can thousands of people needlessly die seemingly in a vacuum?

Bookend 2: I can provide a plan for the complete reorganization (finally organization) of any state's health care delivery system! Is any one interested? Furthermore, I first made that offer to South Carolina Governor Haley shortly after she obtained that office, and I have been attempting to widely circulate that offer as my brief conversation with Dr. Cassel illustrates, but with little positive response, also as that conversation illustrates. But the importance of that brief conversation should not be ignored.

Dr. Cassel and my brief conversation: http://is.gd/wdU2CM Open Letters

Conversations, Discussions, and Debates: The nation is being drenched in polemic conversations, discussions, and debates regarding how to pay for health care after-the-fact, and with no true consensus evident. But even with a miraculous method for how to pay for health care after-the-fact each state's health care delivery system would remain unorganized, dysfunctional, and far too often needlessly deadly. Thus the need for even more conversations, discussions, and debates focused on the past quarter century of no discernable progress in reducing the estimated annual scourge of needless hospital deaths.

The Dichotomy of Patient Safety: An army of experts has been diligently laboring to improve the quality of health care, and patient safety for over four decades as evident by the colossal amount of literature thus far accumulated, and the volumes added each, and every day. Yet all of this activity appears to take place in the same vacuum as where those NHD occur. In that very large circle of activity there are numerous organizations, agencies, and foundations, plus a multitude of highly recognizable leaders who command the respect of every one who has chosen to participate in patient safety endeavors. Yet

this very real world of activity appears to exist with little or no formal recognition from elected officials, major media, and the vast majority of the public. Like stealth combat aircraft, the quality of health care, and patient safety efforts appear to take part under the public awareness radar.

Perhaps that is why the consistently increasing estimates of NHD over a quarter of a century period appear to have taken place in a vacuum isolated from the masses. How else can one explain how so many people can be estimated to be needlessly dying in our hospitals daily, weekly, yearly, and the enormity of this scourge takes place like a tree falling in an empty forest? Stories of individual tragedies make the mainstream news, but the enormity of thousands of needless hospital deaths annually fails to strike a cord.

Example: Agency for Healthcare Research and Quality (AHRQ) is one of the twelve divisions of Department of Health and Human Services (DHHS). NQF list AHRQ in their Glossary as the lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans. How many people know of that agency, and that Dr. Carolyn Clancy was Director for several years up until last year? Both AHRQ, and Dr. Clancy are cited in Find The Black Box.

Until, and unless the quarter century track record of needless hospital deaths receives the recognition and consideration such a scourge deserves to receive people will continue to enter our nation's hospitals seeking acceptable medical care, and instead contribute to the ongoing statistical nightmare of NHD. Statistics are something that happens to someone else. Reality is when you contribute to other people's statistics.

Never Events: The term "Never Event" was first introduced in 2001 by Ken Kizer, MD, former CEO of the National Quality Forum (NQF), in reference to particularly shocking medical errors (such as wrong-site surgery) that should never occur. Over time, the list has been expanded to signify adverse events that are unambiguous (clearly identifiable and measurable), serious (resulting in death or significant disability), and usually preventable. (Taken from AHRQ web site)

Interestingly never events and needless hospital deaths are terms not included in the NQF Glossary. Serious Reportable Events (SRE) are listed, and classified, but there is no mention of to whom such events should be reported, and what meaningful response might be anticipated. Needless hospital deaths do not take place in a vacuum, although their lack of recognition leads one to assume so.

The Need for Conversations, Discussions, and Debates Regarding Patient Safety: Hopefully my far too brief conversation with Dr. Cassel can become the catalyst that will ignite a firestorm of open conversations, discussions, and debates focused on current efforts to improve the quality of health care, and patient safety. Then perhaps my offer will receive consideration for why each state's responsibility to create, and maintain a functional health care delivery system deserves recognition, and thorough evaluation. Surely it is time for those like Dr. Cassel to seek to consider new, and different points of view regarding such a well-recognized, and long standing national tragedy.

Debates: Dr. Donald Palmisano, AMA President claimed there was a great need for a debate on patient safety in 2003. I still have copies of our exchange of correspondence where I accepted his offer, but he claimed to be too busy to accept. To my knowledge Dr. Palmisano has never fulfilled that need for such a debate during the past decade.

Dr. Charles Denham, Sully Sullenberger, Dennis Quaid, and John Nance collaborated on a Journal of Patient Safety article, An NTSB for Healthcare, where the authors claimed the desire for an open debate in 2012. My message to Dr. Denham accepting their offer has never received a response.

Public claims for the need for debates far out number the times reasonable debates ever take place, and that is a great loss to the public. However, I believe too many would miss the most significant factor that should be the result of such much needed exchanges; winner and loser of the debate should not be as important as will the mere fact that a hopefully meaningful debate has taken place initiate a torrent of conversations and discussions?

Conversations, discussions, and meaningful debates should be taking place all over this nation regarding the quality of health care, patient safety, and why the past quarter century of effort to improve same have proven so ineffective. **Find The Black Box** was written expressly as a well-intended challenge to all of the quality of health care, and patient safety experts seeking to initiate such meaningful exchanges.

National Quality Forum (NQF)
NQF Glossary: Accountability: An *obligation or willingness to accept responsibility for performance.*

Find The Black Box: Accountability is a byproduct of Authority, and Authority can only exist in an Organizational Structure.

Unaccountable, Dr. Marty Makary, Author: Those seeking to better understand the presence, or lack thereof, of accountability in our current health care delivery system should read Dr. Makary's book. Next read:

Balancing "No Blame" with Accountability in Patient Safety, Wachter, R. M., Pronovost, P. J., NEJM, October 2009.

Problem: Health Care Delivery System is devoid of an Organizational Structure, and therefore has always lacked meaningful accountability.

Subjects for Conversations, Discussions, and Debate:
Since all medical care is local, and states license doctors, is each state responsible to create, and maintain an effective health care delivery system?

Can anyone describe in detail their state's current health care delivery system, name each component, describe how each component functions, and describe any identifiable systematic characteristics, i.e., multiple components interacting?

Can centrally created standards, i.e. AHRQ, NQF, etc., ever provide the necessary patient safety improvements while lacking any degree of authority at the point of patient care?

And the list can go on, and on, because there is so much about why so little real progress has been made in improving the quality of health care, and patient safety, and so little discussion about the true source(s) of those existing problems. Those who seek Transparency in health care need to open the conversations, discussions, and provide the debates so long missing.

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