That Mothers Might Live, Hollywood's Praise of Dr. Ignaz Semmelweis the True Father of Patient Safety (Watch the movie)

Dr. Semmelweis' story is one every person passionate about the quality of health care, and patient safety should know, and know well. Hollywood's short, 1938 movie shows, with some literary deviations, the achievements, trials, and posthumous immortalization of the true Father of Patient Safety. But just knowing his story, regardless of how inspiring it is, is not enough. Semmelweis' story is being replicated in our nation's hospitals today by the fact that every new estimate of needless hospital deaths is significantly greater than every previous estimate.

Semmelweis did not create the facts that adequate hand hygiene, and instrument sterilization would save lives. He recognized, tested, and proved their life-saving value. And his reward from the medical leadership, first in Vienna, followed by those leaders in Budapest, was rejection, and shunning by everyone in his profession. His inglorious death, thought to be self-inflicted, in an asylum for the insane lays at the feet of the medical leadership of those two nations.

The true Father of Patient Safety can only be Dr. Ignaz Semmelweis. Dr. Joseph Lister gained well deserved credit for making Semmelweis' published work accepted in the medical profession throughout the world, and for always giving the original credit to its rightful source. But Lister's task of making Semmelweis' safety measures become recognized, and adopted as sacrosanct professional behavior did not take place as rapidly as it should.

Medical history is replete with stories of how geniuses of their day were met with derision, and rejection during their laborious efforts to improve the science of medicine, and the lives of those they sought to serve. Medical leadership, throughout the history of their profession, has not always served their profession, or society in a very professional manner. Semmelweis' story is far too typical of what lay in store for those who sought to advance scientific understanding. And Semmelweis' story is being replicated today in more ways than just the fact that too many patients are needlessly dying due to substandard patient care similar to that of the mid-19th century.

There is a person currently anointed as the "father of patient safety", and each candidate for that title has a decades-old track record that should form the basis for such recognition.

Dr. Lucian Leape is currently well established as today's "father of patient safety" within the quality of health care, and patient safety diverse community. The equally established track records of those two individuals, however stands in stark contrast.

Semmelweis' track record of patient safety:
Semmelweis began to immediately document positive results due to his dual patient safety measures of hand hygiene, and instrument sterilization, and those positive results were measured in *lives saved*. But the medical leadership, first in Vienna, and later in

Budapest chose to ignore his findings, and to continue needlessly killing patients. Suffice it to say an untold millions of lives were saved during three different centuries thanks to Lister's ability to make Semmelweis' contributions to mankind become accepted.

Leape's track record of patient safety:
Leape began his collaboration with others in the mid-80s during the conception of an organized movement to improve the quality of health care, and patient safety, and he has been a seminal participant in many of the most recognizable pivotal points in the past several decades.

1990 Brennan, Leape, et al. After four years of research in upstate New York hospitals they provided the original estimate of needless hospital deaths annually based on a study of that size. Their findings were presented in a three-part article in the New England Journal of Medicine in 1991. That estimate (98,000) was used as the base line for**;**

2000 Institute of Medicine (IOM) To Err Is Human That much-heralded report promised to reduce that original estimate by 50% in five years. That report also recognized that the health care system was in fact a non-system, but failed to recognize the significance of that important understanding. (Dr. Leape was an active participant in the creation of that report)

2009 Dead By Mistake, Hearst Newspapers That study estimated 180,000 needless hospital deaths nine years after To Err Is Human's failure to fulfill.

2013 Sully Sullenberger – "There are 200,000 preventable deaths each year in the U.S. healthcare system. It would be like having 20 Boeing 747 airliners going down each week."

2013 John James, PhD His report estimates up to 400,000 needless hospital deaths annually, and 10-20x that number medically harmed, but not fatally.

2013 James' report is strongly supported by Dr. Leape, and two other highly acclaimed patient safety experts the same month in another publication.
A Point of Clarification: (for those reading James' article) IOM To Err Is Human did NOT create the estimate of 98,000 needless hospital deaths annually used in that report. Brennan, Leape, et al. originated that estimate in their four year study first reported in 1989, and published in NEJM in a three-part series in 1991. Dr. Leape, as mentioned previously, was an active participant in the collaboration to create To Err Is Human, first reported in 1999.

Contrasting Track Records

Semmelweis: Documented lives saved beginning immediately, and continuing for centuries.

Leape: Every new estimate is significantly greater than all previous estimates of needless hospital deaths, and there is no evidence that tragic tide is being reversed.

There is Concern

Balancing "No Blame" with Accountability in Patient Safety, Drs. Robert Wachter and Peter Pronovost, New England Journal of Medicine, Oct. 2009.
This article is about trying to force caregivers to adequately wash their hands.

Is the Patient Safety Movement in Danger of Flickering Out? Wachter's World, Feb. 18, 2013.
"Yet I've never been more worried about the safety movement than I am today. My fear is that we will look back on the years between 2000 and 2012 as the Golden Era of Patient Safety, which would be okay if we'd fixed all the problems. But we have not."

Will Medicine Ever Become Safer? Dr. George Lundberg, Medscape, Nov. 26, 2013
Dr. Lundberg was unable to answer his own question, and is uncertain that anyone else can.

But How Much Concern

James' article in September 2013 was rapidly supported that same month in another publication quoting **Leape**, and others. Then followed by **Silence** within the quality of health care, and patient safety well established community of agencies, organizations, and foundations, and within all levels of government, and major media sources.

I have attended two major patient safety conferences (spoke at one) since late last year, participated silently in webinars, and searched numerous patient safety internet contributions.

The Result: It is as though James' article, and Leape's, and others rapid support took place in a vacuum. It seems the FACT that every new estimate of needless hospital deaths is significantly greater than every previous estimate for the past quarter century has been passively accepted, and the promise stated in To Err Is Human never happened.

Not only is Semmelweis' recognition of what was causing needless deaths in his day being replicated, but the Medical Leadership's response of denial is also being replicated. The Needless Hospital Deaths Crisis is a national tragedy that is taking place in an atmosphere of intellectual abandonment.

My Challenge to All Patient Safety Experts

I believe there are clearly evident reasons why every new estimate of needless hospital deaths is significantly greater than all previous estimates, and also why the public has had to passively accept highly speculative *estimates*. No element of the current health care delivery system can provide even semi-precise numbers for those needlessly dying in their area's hospitals because that "system" is devoid of any systematic characteristics, and always has been.

I CAN PROVIDE A PLAN FOR A 21ST CENTURY HEALTH CARE DELIVERY SYSTEM!

That system would have systematic characteristics, and would go far beyond any thing ever previously imagined.

Semmelweis did not create the FACTS that adequate hand hygiene, and instrument sterilization would save lives. He recognized, tested, and proved their life-saving value, and his thanks was to die in a Hungarian insane asylum, shunned by almost every member of his profession.

I did not create the FACTS that all medical care is local, and states license doctors, therefore states MUST BE RESPONSIBLE to create, and maintain a functional health care delivery system.

No one can deny that patients are currently needlessly dying in our hospitals due to the very same unsanitary shortcomings that were needlessly killing patients over 150 years ago. Likewise, no one can deny that no discernable evidence of meaningful progress can be found in the efforts of the past quarter of a century to improve the quality of health care, and patient safety. Therefore, it should be troubling to see that Dr. Wachter, or anyone else could possible ever consider that the period 2000 to 2012 *might be* considered the *Golden Era of Patient Safety*.

Medicine has a long, and well-documented history of rejecting those who sought to contribute to the efforts to improve patient care while simultaneously questioning the current thinking. Hopefully it is time for those with open minds to consider that there might be a better way.

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