

# American Healthcare Solutions, LLC

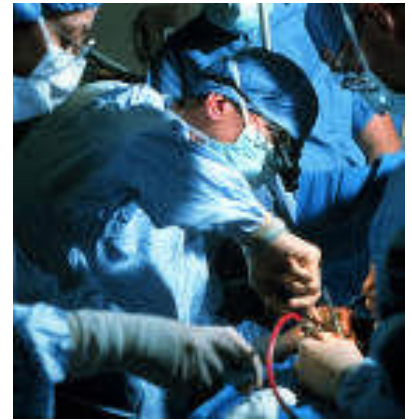


Since 1999

## Up to 98,000 Unnecessary Hospital Deaths

Occur Every Year . . . And the Band Plays On

by Jan Jennings



In 1987 Randy Shilts wrote [And the Band Played On: Politics, People, and The Aids Epidemic](#). Shilts documented the utter failure of the American healthcare delivery system to manage the epidemic. In 1994, at the age of 42, Randy Shilts died of AIDS. He was a respected journalist with the San Francisco Chronicle, and his writings and public speaking went far to energize to action many leaders in the healthcare delivery system, the medical research community and public service.

If he were alive today, Shilts might be writing about another scandal in the American healthcare delivery system. Once again, and largely unrecognized by the American public, an epidemic of preventable hospital errors and death has been met with extraordinary indifference and apparent resignation. In 1999, the prestigious Institute of Medicine published [To Err is Human: Building A Safer Health System](#). According to two well-constructed studies contained in this report, between 44,000 and 98,000 deaths occur annually as a consequence of medical errors in American hospitals. The Institute found that “. . . each year more people die as a consequence of medical errors than die of motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).” In economic terms, the report concluded: “Total national costs (lost income, lost household production, disability and healthcare costs) of preventable adverse events (medical errors resulting in injury) are estimated to be between \$17 billion and \$29 billion, of which healthcare costs represent over one-half.”

Curiously, while this epidemic of unnecessary hospital deaths continues, it is largely unknown to the public and has not been aggressively addressed by the medical, hospital and nursing home industries. Why? The indifference to this problem is rooted in both denial and the obvious fact that a lot more good than bad occurs in the American healthcare delivery system. We are content in our belief that our hospitals do more good than harm. This is not good enough. The first principle of medical care is to do *no* harm.

There is an old adage: “those that fail to learn from history, live to repeat it.” Almost one hundred years ago, there was a scandal in American medical education. There was an understanding that the quality of American medical education was uneven. The Carnegie Council commissioned a study of all U.S. medical schools. The study was conducted by an obscure Vanderbilt University Professor of Biology, Abraham Flexner, Ph.D. A medical doctor could not be found willing to undertake the study. Dr. Flexner visited every medical school in the United States and in 1910 published what came to be known as the Flexner Report. He concluded that

approximately one-half of all U.S. medical schools served no useful purpose, and they closed. As a result, we have fewer medical schools in 2004 than we had in 1904.

What can we learn from the medical education scandal that can help us address the epidemic of unnecessary hospital deaths?

Leadership:

While Dr. Flexner provided personal and professional leadership, he would have been helpless without the funding and support of the Carnegie Council. As to the current crisis of preventable hospital errors, it is unclear from where the necessary leadership will emerge.

More Focus on Standardization than Standards:

We live in a more complex world than that of Dr. Flexner, and lofty standards for hospital treatment alone are simply inadequate. Standards are often too general and subject to local interpretation and implementation. For instance, there is a "standard" that every patient admitted to a U.S. hospital undergoes a nursing assessment. How helpful is that when the nursing assessment processes are not uniform, or "standardized", from one hospital to the next? It only takes one serious error or omission to lead to the untimely death of a patient.

Here is another example of the failure of American hospitals to "standardize". Less than 250 of 5,500 U.S. hospitals have initiated implementation of an electronic medical record. It is important to note that in 2004, life and death decisions in the American hospital are largely based on handwritten notes and records. Abbreviations are barely standardized within one hospital, and most physicians work at more than one hospital. Information is the lifeblood of diagnosis and treatment. Pursuit of high patient quality standards is futile in the absence of uniformity or "standardization" of the basic means of communication within U.S. hospitals.

There is a tragic irony within the American hospital. Great resources are devoted to training highly competent physicians and nurses, and developing breathtaking technology for diagnosis and treatment. However, these assets are cobbled together with anachronistic communication methods, unreliable technology integration and antiquated medical and hospital information systems. The hospital patient is unwittingly caught in the middle.

Healthcare quality reform is coming. It will require national leadership and standardization in the delivery of medical and hospital care. The American public finances the most expensive and best healthcare delivery system in the world. It will become better as a consequence of change. It is time for leaders to emerge to respond to the quality crisis of the American hospital.

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