

California Republican Party Convention

February 22, 2008
Hyatt Regency, San Francisco, CA

Healthcare Forum II

Presentation by Gil N. Mileikowsky, MD



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1. First do no harm

What happens when physicians strike ?

1. in California
2. in Belgium
3. in Israel

How does the strike impact the **mortality** rate of the population ?

1. increase
2. decrease
3. unchanged



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2. Patient Safety in US Hospitals, 2004 Health Grades Study:

200,000 patients die every year from preventable medical errors.

37 million Medicare (+65) medical records reviewed over 3 years



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3. First national Report Card on Quality of Health Care in America:

- **All adults** in the United States are **at risk** for receiving poor health care,
- no matter where they live
- why, where and from whom they seek care
- or what their race, gender or financial status is

Rand Corporation, 2006 report finding



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4. Many physicians keep quiet on reporting errors and incompetence:

“ **45%** weren't always reporting impaired or incompetent colleagues ”

“ **46%** of physicians who knew of a serious medical error were **not** reporting the error, at least once, to authorities ”

Institute on Medicine, 12/3/2007



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5.

WHY ?



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6. Whistleblower reports to federal authority

“ Chief of Surgery of Garden Gove Hospital in CA had just learned from hospital administrators that he’d spent months operating with instruments cleaned by what appeared to be broken sterilizers.

Aware that the operating room sterilizers were defective, the hospitals administrators were now telling the Chief of Surgery how to explain the situation when federal inspectors showed up for a big evaluation the following day, because the hospital had an unusually **high** rate of **post operative infections.**”

“ Instead, the Chief of Surgery resigned and went to federal authorities.”

Melissa Davis, TheStreet.com, 7/25/03



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7. Chilling CODE of SILENCE –

FEAR permeates through the health care system

“ Not even whistleblower laws, designed to give legal protection to those trying to report wrongdoing, safeguard the doctors in many cases.

Physicians who spoke up about poor care **faced reprisals**, including peer review hearings, demotions, temporary loss of credentials, involuntary transfers or outright dismissal. ”

Steve Twedt, 10/26/2003 Post-Gazette

The cost of Courage: How the tables turn on doctors



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8. What is a **DISRUPTIVE PHYSICIAN** ?

In September 1992, HCA's hospital alleged that Dr. Clark was engaging in:

“ activities or professional conduct which are **disruptive** to hospital operation ”.

Can you tell me what you believe this physician might have done ?



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9. What did Dr. Clark do to be labeled as a disruptive physician ?

Statement of Charges specified the conduct in question as:

1. A letter to CHAMPUS (a federal insurance provider) expressing concerns of substandard child psychiatric care.
2. Letters to JCAHO addressing concerns with the hospital's care.
3. Report to the Nevada State Board of Medical Examiners about another psychiatrist regarding the care of Dr. Clark's patient.
4. Dr. Clark alleged that the hospital improperly used his superior credentials to qualify an affiliate hospital for accreditation although he did not work there.

K.M. Clark, MD vs. Columbia/HCA, Supreme Court of Nevada, 6/21/01



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10. Who is disruptive here ?

- Both the Medical Executive Committee and the Board of Trustees agreed and affirmed the revocation of Dr. Clark's privileges.
- The Supreme Court of Nevada concluded that the revocation of Dr. Clark's hospital staff privileges was NOT with the reasonable belief that it was in furtherance of quality health care.
- Accordingly, the Supreme Court of Nevada reversed the district court.

K.M. Clark, MD vs. Columbia/HCA, Supreme Court of Nevada, 6/21/01



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11 . Independent “Blind folded study” concludes:

“ **83%** of cardio-vascular **surgeries** were ... **unwarranted** at
Redding medial Center ”

“ **59%** of the bypass **surgeries** at Doctors Medical Center in
Modesto were ... **unnecessary** ”

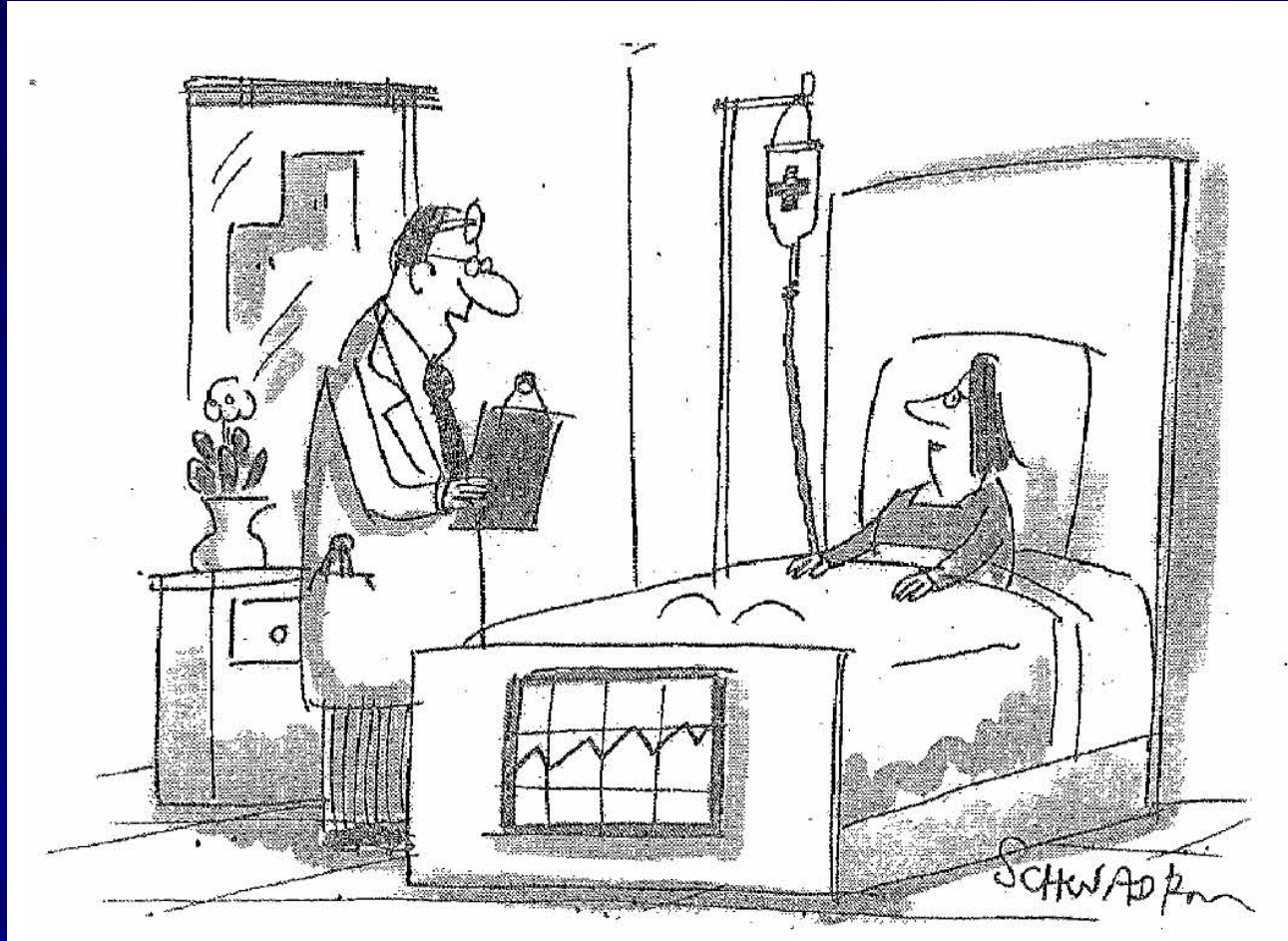
Melissa Davis 11/4/03, TheStreet.com



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12. “ We’ve upgraded your condition from critical to costly ”

H.L. Schwardon at Barron's



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**13. HCQIA relies on corporate hospital executives to,
report errors and complications they profit from.**

“ In most industries, defects cost money and generate warrantee claims. ”

“ In health care, perversely... Physicians and hospitals can bill for the additional services that are needed when patients are injured by their mistakes. ”

LL Leape, MD – JAMA 5/18/05



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14. If you were a **farmer** with a chicken farm...

Which animal would you choose to protect your **chickens** ?

1. Wolf
2. Fox
3. German Sheppard



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15. Unfortunately, the “ **protection** ” of our patients depends on:

- **Wolves,**

hospital corporate executives and their attorneys,
who profit financially from unnecessary procedures,
errors and complications,

and

- **Foxes,**

physicians, on staff at the same hospital,
members of the “old boys network”



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16.

How come wolves and foxes **control** the quality of delivery of care ?



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17. Rules of Fair Play don't always apply ...

Because the **wolves**,

Corporate hospital attorneys, Horty & Springer,
co-authored The **Immunity** Provision in the HCQIA.

Steve Twedt, Post-Gazette, 10/27/03

“ A professional review body's failure to meet the conditions described in this subsection shall NOT, in itself, constitute failure to meet the standards of subsection (a)(3) of this section ”

The Health Care Quality Improvement Act, 42 U.S.C. Section 11112(b)(3)



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18. Chief of Surgery reports to JCAHO

“ The Chief of Surgery was in for a major shock. JCAHO, the industry watchdog known to growl about the smallest misplaced exit sign ignored the chief of surgery and accepted the hospital’s explanation instead. “

“ Here I am telling them about a major threat to patients – and the blatant destruction of documents – and they just basically blow me off, ” the chief of staff marveled:

“ They gave the hospital a rating of 93. ”

“ JCAHO confirmed that it received the chief of surgery’s complaint, requested and accepted an explanation from the hospital and then closed the case ”

Melissa Davis, TheStreet.com, 7/25/03



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19. Follow the money !

- Hospitals pay JCAHO to perform their survey / 3 years for their accreditation.
- This survey will determine the hospital's Medicare rate of reimbursement.
- In order to assure higher grades, prior to the survey, hospitals can hire consultants affiliated with the JCAHO to prepare the hospital for their upcoming survey.

Do you see any conflict of interest here ?



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20. Would you cheat on your exams ?

What would the scores of SAT exams be IF, students graded themselves ?

What if, we allowed ... **examiners** ... to substitute for the students who wish to be accepted into Ivy League schools and needed a scholarship ?

What are the chances that such ' students ' would fail to be admitted to Ivy League schools with a scholarship ?



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21. Do we get what we pay for ?

“ The **US** ranks **37** in the world.

Between **Costa Rica, 36** and **Slovenia, 38** .”

WHO, The World Health Organization, ranking quality of care – 1997.

Yet, the **US spends twice as much money per capita**
than any other industrialized country.



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22. Leading causes of PREVENTABLE DEATH in hospitals.

- 1) FALLS, occur when patients need to use the bathroom and do not get response when using the call button, an attempt to climb out of bed without waiting for assistance, is the main cause of BROKEN HIPS, and leading cause of accidental deaths.
- 2) +/- 1.5 million MEDICATION ERRORS cause 40 – 80,000 deaths / year.
- 3) 4 – 6% of hospital patients develop HOSPITAL acquired INFECTIONS.

Hospital errors cause more deaths than car accidents, breast cancer or AIDS.

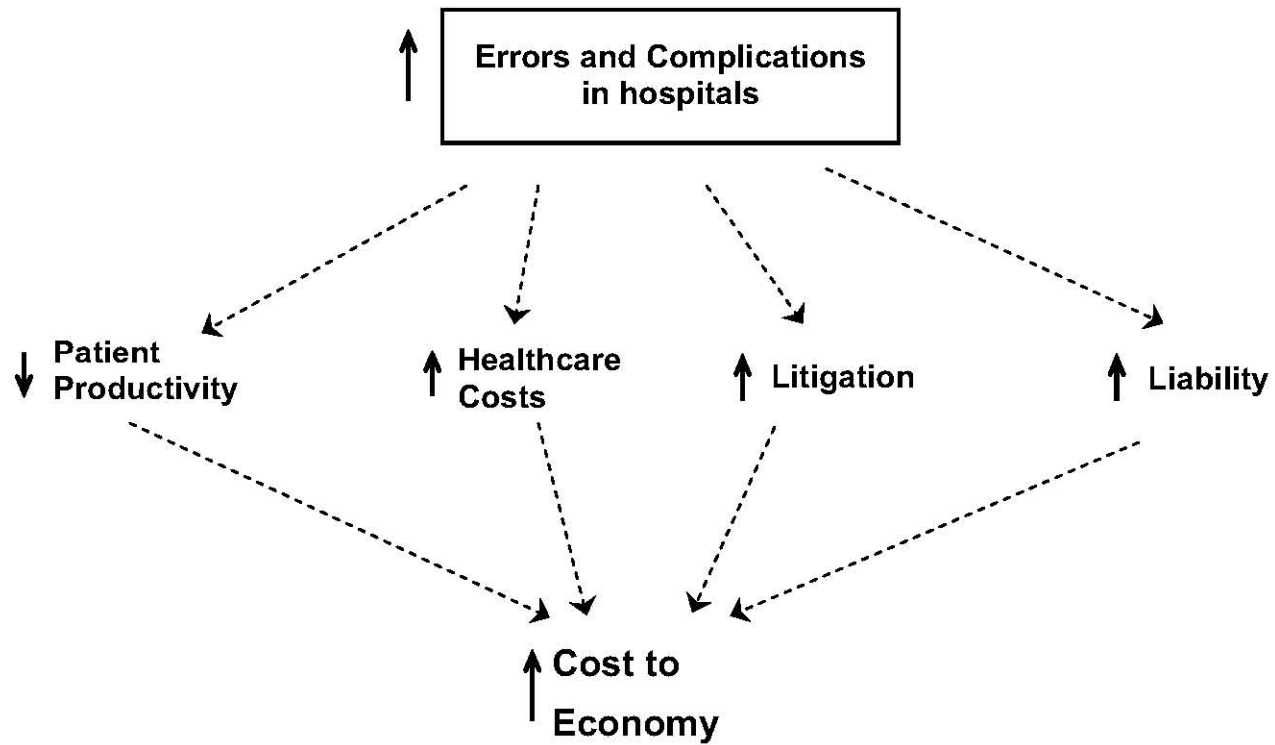
National Academy of Sciences



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23.

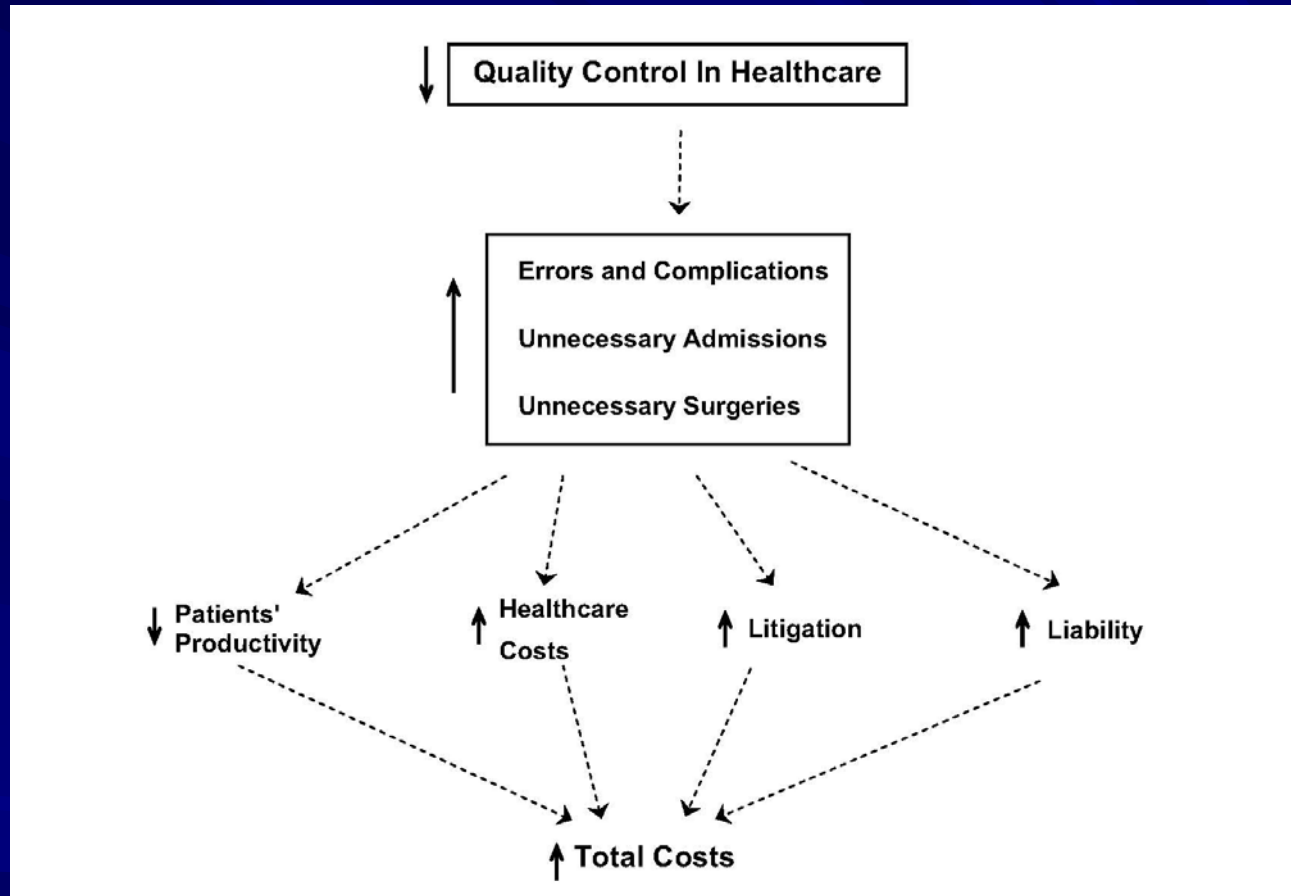
The Economic of the Lack of Patient Safety



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24. What happens when control of quality of delivery care is in the WRONG HANDS ?

NO Peer Review or Sham Peer Review

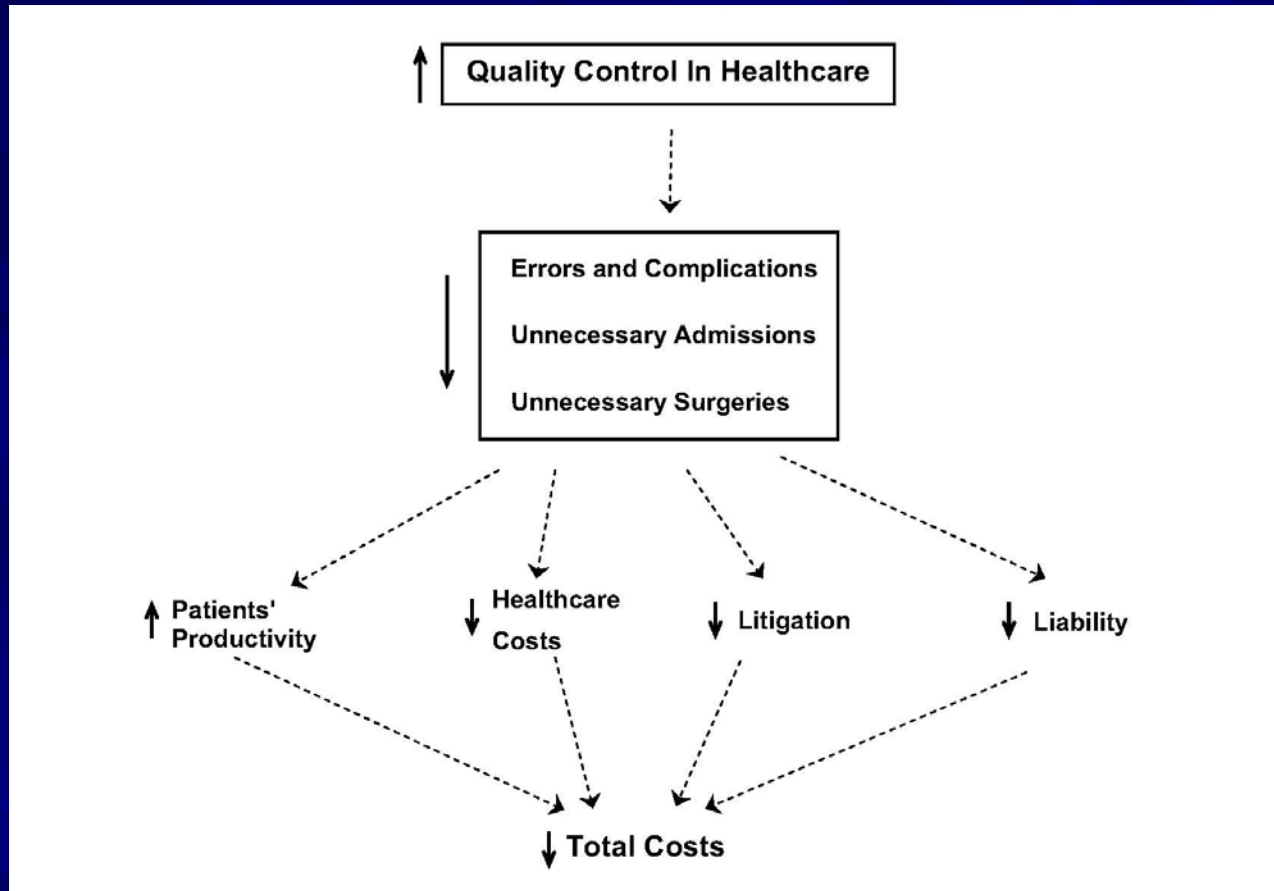


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25. What happens when control of quality of delivery care is in the RIGHT HANDS ?

Legitimate Peer Review



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