Society to Improve Diagnosis in Medicine (SIDM) Theoretical Efforts Avoid Reality

Diagnostic Error in Medicine 7th International Conference was held in Atlanta September 14-17. The theme of that meeting was Merging Policy, Practice and Technology: Paths to Improve Diagnosis. I attended a portion of that meeting as a SIDM member.

"Diagnostic error is the leading cause of medical malpractice claims in the U.S. and is estimated to cause 40,000-80,000 deaths annually. One in every ten diagnoses is wrong, and one in every thousand ambulatory diagnostic encounters result in harm."

Misdiagnosis in medicine has plagued that profession throughout its long history, and might cause one to think of, "What came first the chicken or the egg?" What makes the very existence of SIDM remarkable is the acknowledged magnitude of diagnostic errors in the midst of today's era of modern medicine. And the reasons for the existence of that sad combination are clearly evident, but consistently ignored, thus the purpose of this well-intended critique.

SIDM is a relatively small band of medical idealists who have chosen to confront one of medicine's most deadly flaws, while openly wondering why it has taken so long for such a concerted effort to take place. Clearly the need has always existed. But 80% of the Monday morning audience, including me, signified that this was their first SIDM conference indicating some difficulty in their effort to grow and become relevant.

Every new estimate of needless hospital deaths has been significantly greater than all previous estimates for the past quarter century – and diagnostic errors have always contributed to those tragedies.

Therefore it is my belief that SIDM cannot separate itself from that documented track record of patient safety failure that continues to go in the wrong direction, and with no evidence of being positively redirected. Yet that quarter century track record of failure regarding needless hospital deaths, and its possible reasons for such failure were ignored.

While the need for improved medical diagnosis throughout the profession is great, and the SIDM goal is praiseworthy, there was no evidence during the meeting of how diagnostic improvement measures could become effective throughout the healthcare delivery system. Speakers talked of changing the culture, increasing transparency, and measuring diagnostic errors during the four days of presentations, while neglecting to provide modalities for how to incorporate those measures in any specific segment of the current healthcare delivery system. The difficulty of making theoretical improvement measures become effective in any existing entity is an age-old dilemma that was all too apparent, but unspoken during the proceedings.

I anticipated that their meeting would not address the underlying causes of the extreme medical shortcoming they were seeking to improve after reviewing the conference program. That led me to write, and hand-deliver the following letter addressed to SIDM President Mark Graber, and the SIDM Board Members.

September 15, 2014

To: Dr. Mark Graber, President, and SIDM Board Members

Subject: Fundamental Facts Regarding All Patient Safety Efforts

6. How often does diagnostic error lead to adverse events and death? How often is death due to diagnostic error? Harvard Study showed diagnostic error accounting for 17% of adverse events (Leape, Brennan 1991)

Every new estimate of needless hospital deaths has been significantly greater than all previous estimates since Leape, Brennan, and the latest estimate of NHDs is quadruple their 1991 estimate. I believe there are clearly evident reasons why the IOM To Err Is Human promise to reduce NHDs by 50% in five years has been a broken promise.

The public continues to be promised greater patient safety through *culture change, transparency, patient centeredness,* etc., by experts who can't describe in detail their state's healthcare delivery system. Dr. Makary's one-word book title Unaccountable speaks volumes regarding what has always been missing in medical care.

Two fundamental facts: all medical care is local and states license doctors appear to indicate that each state is responsible to create and maintain an effective healthcare delivery system. Factor in all 50 state medical examining boards are each over 100 years old, and each have a mission statement containing "to regulate the practice of medicine".

Accountability is a by-product of authority, and/or delegated authority, but those necessary elements can only be found functional within a system with an organizational structure, and our current system has long been recognized as a non-system.

I assume each board member has seen and read **When Hyperbole Masquerades As Patient Safety Advancement**, my response to Dr. Singh" WSJ Op-Ed. Dr. Graber, in our email exchange, felt I was "beating up" on Dr. Singh when in fact, I was seeking to challenge he and every other patient safety expert. I feel Dr. Singh's article was exceeding misleading to the public by indicating that one vague new patient safety measure added to the volumes of such attempts in New York State, and numerous other states with similar patient safety bills might spark a change in medical practice.

Semmelweis did not create the facts that doctors, by washing their hands, and sterilizing their instruments, could save lives. He recognized those facts, tested them, and proved their life-saving value. But he died in an asylum because the medical leaders, first in Vienna, and later in Budapest rejected his offerings. Untold millions owe their lives to Semmelweis, and to Lister, for making their profession accept contrarian thinking. Medical history is filled with such stories of harmful resistance to change.

I did not create the facts that all medical care is local, and states license doctors, therefore each state must play an important part in every attempt to improve the quality of healthcare and patient safety.

Find The Black Box, my third book on healthcare, offers a three phase process that would include a plan for a 21st century healthcare delivery system that would go far beyond anything previously imagined. That plan is based upon recognition that each state is responsible for their aspect of that new healthcare delivery system, and I believe all patient safety improvement efforts will continue to be far less effective than promised or hoped for until each state's responsibility to contribute to those efforts is fully recognized. Since the consensus is that the current system is broken, I am disappointed, but not surprised at the complete lack of interest in what I may have to offer.

As a SIDM member, I am asking that the board give consideration to my efforts to join them in improving patient safety. I suggest that people must focus on the facts, and attempt to prove me wrong. No one should be shut out of the efforts to improve the quality of healthcare and patient safety. The lives of too many patients depend upon medical leaders who will mirror Lister, and his colleagues, and not those who failed not only Semmelweis, but also all of their future patients.

A simple exercise: Each board member, on their return home, should seek to identify each component of their state's current healthcare delivery system, describe in some degree how each functions, and attempt to demonstrate any systematic collaboration between some of those components. Non-systems' inherent deficiencies prevent systematic improvements to become effective, and the current healthcare system has long been recognized to be a non-system. SIDM and every other quality of healthcare and patient safety organization's failure to properly diagnose what has always been missing in the current healthcare non-system is why every new estimate of NHDs is significantly greater than all previous estimates for the past quarter century. SIDM needs to help cure the system before it can help cure the misdiagnosis problem within that system.

Respectfully,

Signed Ira Williams

Their response – I was shunned by every member of the Board.

How childish. Readers must reach their own conclusion regarding the above scenario. Personally I have found it exceedingly difficult to find quality of healthcare and patient safety experts with open minds in spite of the obvious great need for such.

My conclusion is that the Public (patients) must hope that the SIDM experts will be able to create theoretical diagnostic measures that will benefit future patients, but apparently it will be left to others who will hopefully find a way to make their theoretical measures become reality in a hospital near you because SIDM currently appears to have no real interest in current healthcare delivery system organizational shortcomings.

This Open Letter is designated 16a because there is a companion Open Letter 16b. Dr. Hardeep Singh, a SIDM Board Member, and active presenter at the meeting wrote a WSJ Op-Ed (Aug. 8), and I responded with a five-page critique that I only distributed to the

SIDM Board with they permission for further distribution if desired. Dr. Mark Graber, SIDM President, in an email exchange requested that I "Please just do me the favor of not beating up on our authors who have been pointing out the need to address diagnostic errors in the country." I thought I was just trying to initiate a deeper discussion regarding an urgent need. Unfortunately no such deeper discussion has taken place. Therefore Open Letter 16b will allow others to judge.

My hope is that Open Letters 16a and 16b will contribute to a far more intense discussion (debate) than I witnessed in Atlanta. I welcome all courteous, and well-intended responses. The subject needs clarity.

Reference:

http://is.gd/2NTcly SIDM 7th International Conference