The Most Important Lesson that Should be Learned from the VA Crisis

Department of Veterans Affairs Health Care System has been a tragic disgrace, long recognized, and passively ignored for decades. Doctors' War Stories From VA Hospitals, a WSJ Op Ed by Dr. Hal Scherz is a suitable synopsis of gross patient care misconduct within the walls of most, if not all VA hospitals in the nation. Dr. Scherz says, "There are 153 VA hospitals. Most of them are affiliated with the country's 155 medical schools, and they play an integral role in the education of young physicians." I too am a product of the VA training programs where my surgical residency was affiliated with Marquette University, and the Milwaukee County Hospital, and University of Wisconsin School of Medicine.

My contention is that the current, but long standing VA System crisis is both a snapshot of the entire health care delivery system, and an opportunity for some to step back from the current, polarized effort to dramatically change how health care is paid for after-the-fact long enough to recognize that even with a perfect solution for that aspect of health care that system's delivery system would continue to remain unorganized, dysfunctional, and far too often needlessly deadly.

Curiosity Lands on Mars while Health Care Crashes in America.

Health care directly impacts every person, plus those yet unborn, and no one can deny that our health care system is highly flawed and far less than it could or should be. While at the same time over 2 billion dollars was spent to see if there is any trace of life on Mars.

Question: Why hasn't there been an equal amount of concentrated effort to improve the quality of health care as has been used in successfully landing a highly sophisticated engineering marvel on a planet 154 million miles from earth?

Our health care system, while not a mystery of the universe, is composed of two equally important aspects: How to pay for health care after-the-fact and the health care delivery system. People (you & I) with medical problems first enter that system through the health care delivery system and that aspect of our health care system is universally recognized to be "broken". But while the process of how to pay for health care is continuously and contentiously being debated, the health care delivery system portion of that problem receives as much attention as a fourth place finisher in an Olympic event.

Congress and the federal government control and dictate how to pay for health care after-the-fact, while at the same time every state is individually responsible for the creation and administration of their portion of the health care delivery system. What people seem to miss in that dual responsibility of health care is that change *may* enable the saving of money in how to pay for health care, BUT change in the health care delivery system can save both lives and money. Perhaps our health care priorities have gotten lost in the rhetorical tsunami of ObamaCare.

Absolutes regarding our nation's health care system:

It will reach out and grab you and your loved ones.
It is far less than it could or should be.
State responsibility for their part of the delivery system must be recognized.
Both aspects of that system demand equal consideration.
No facet of our society has received less detailed consideration of all its aspects.

Curiosity demonstrates, as have so many other great national achievements, what this nation is capable of doing – When & If – a similar, concentrated effort is orchestrated with a clear goal. It is long past time to put as much, if not more, effort into making our nation's health care system (both aspects), far better as has been made in successfully landing Curiosity safely on Mars. Think of the benefits to all if only our health care delivery system received as much effort as Curiosity required, and ObamaCare has received. (A thought paper submitted to, but not printed by WSJ)

VA crisis, and the fact that every new estimate of needless hospital deaths annually is significantly greater than all previous estimates of such tragedies during the pass quarter century are prima facie evidence of systemic failings within the entire health care delivery system, regardless where one might look. Problem is no one is looking at, or for those systemic failings. To make matters worst, if possible, no one is recognizing clear evidence of how those systemic failings are identified, and overcome within the health care delivery system at a major health care institution. And to make matters even more frustrating, a perfect example of both the systemic failings, and a process to overcome those failings took place over 30 years ago, and the entire medical profession, and health care industry took scant notice.

What follows is, in my opinion, one of the most important articles in the entire medical, and patient safety literature:

Standards for Patient Monitoring During Anesthesia at Harvard Medical School, Eichhorn, J.H., Cooper, J.B., et al., JAMA, Aug 22/29, 1986, Vol. 256, No 8.

Harvard is self-insured and has its own risk management organization. Even so, Harvard Medical School was not spared as the second wave of the medical malpractice crisis cycled through our nation in the early 1980s. Particularly noteworthy to the Harvard Risk Management Department was the costly impact of the Medical School's Anesthesia Department. That department's leadership was told, "You must do something to greatly improve your present rate of medical liability." And to that department's credit they did do something quick and dramatic. The Harvard Medical School Department of Anesthesia controlled nine separate departments at nine separate hospitals within their system. A committee was formed, and the past patient care incidents were studied to gain an understanding of where the greatest cause(s) of those incidents occurred. Their findings showed that basic patient monitoring practices were thought to be so important in accident prevention that they must become mandatory. The creation of mandatory basic monitoring guidelines in the practice of medicine had never been done before.

The Harvard Medical School Department of Anesthesia devised seven specific, detailed,

mandatory standards for minimal patient monitoring during anesthesia at its nine component teaching hospitals. I see those minimal standards like seven lines drawn in the sand that said to every department anesthesiologist, "Doctor, if you cross one of those lines, we can not help you." By going where no other medical organization had ever gone before, they became professional heretics.

A brief description of those seven minimal standards of patient monitoring during anesthesia were:
1. Anesthesiologist/nurse anesthetist present in OR.*
2. Blood pressure and heart rate @ **5** minutes.*
3. Electrocardiogram.
4. Continuous monitoring (ventilation and circulation).*
5. Breathing system disconnection monitoring.
6. Oxygen analyzer.
7. Measure temperature (malignant hyperthermia).

Individually and collectively, none of those minimal standards appear to be asking too much of a dedicated anesthesiologist. Harvard risk management got the quick and dramatic result they were seeking. Within one year, the medical liability rate for that anesthesia department showed a wonderful improvement. But improved quality patient care is not the perspective taken by Organized Medicine.

Harvard's view of their new, minimum standards: "As part of a major patient safety/risk management effort, the Department of Anesthesia of Harvard Medical School, Boston has devised specific, detailed, mandatory standards for minimal patient monitoring during anesthesia at its nine component teaching hospitals. They are fundamental, minimal standards that would be achievable in the smallest rural community hospital. Such standards had not previously existed and resistance to the concept was anticipated, but not seen. Physicians have traditionally resisted standards of practice that dictate their day-to-day conduct of medical care."

Organized Medicine's view of those standards: JAMA August 1986 (response to the original article and immediately following): "The opportunity for self-determination, for being one's own boss, has been for many of us one of the pluses of being a physician. As such, it is presented not so much to enlighten JAMA readership concerning monitoring as one aspect of anesthesia care, but as an example of a process for extracting a collective minimum standard from individuals long accustomed to defining their own destiny and unaccustomed to others telling them what they should do. The essence of our role as problem-solving givers of care is independent thought and action. Anything that appears to constrain that freedom will be viewed as threatening one's ability to provide care in the way each of us believe to be the best. We are being provoked to be accountable for both the costs and the benefits of our care.

My view of those standards: I was taught the three minimal standards that are noted in the list above by the asterisks (*) in 1963, and the other four minimal standards represent technological advancements. Malignant hyperthermia became a recognized anesthesia

hazard in the mid to late 1970s.

Harvard risk management view of those standards: Joyful shock at the positive and rapid results of such simple, "mandatory minimums" in patient care and safety.

Wisconsin State Journal, December 1986: "A majority of anesthesia deaths are malpractice. As many as 75% of the 2,000 or more anesthesia deaths are the result of malpractice. Fourteen percent of 624 cases studied involved failure to maintain the patient's airway open."

What did the Harvard Anesthesia Minimum Standards Really Demonstrate? Organized Structure, Authority, and **Delegated Authority:**

Authority, Accountability, Meaningless Words in Health Care

Wall Street Journal ended an editorial on RomneyCare 2.0 (WSJ, Aug. 6, 2012) with this ubiquitous health care lament, "Everyone agrees that the health system needs to deliver medicine more efficiently and be more accountable, *but to whom*?" (Emphasis added).

The obvious need for greater accountability in health care receives more recognition and less deep consideration as to "how" and "by whom" than almost any other aspect of patient care in the quality of health care literature. However, WSJ editors might have made a more cogent point of need if they had said "by whom" rather than "to whom". Perhaps a more elementary discussion of accountability in health care will be beneficial.

Authority: the power to control, command or determine.
Accountability: responsible, answerable, explicable.
Explicable: capable of being explained.

State governments create state health care agencies and empower those agencies with *authority* to *regulate* their expressed portions of that state's health care delivery system. All 50 state medical examining boards are over 100 years old. Yet accidental deaths that occur in state authorized hospitals and surgery centers receive NO immediate review by a source of *authority*. Why?

Accountability (meaningful accountability) can only occur in the presence of *sufficient authority*. Problem is, no state can explain (explicable) its current mechanism of health care accountability that must be established through its system of health care *authority*.

Contributing to this morass of incompetence is the following inconsistency; the most vocal elements actively seeking to improve the quality of health care, both on a national and state level, are agencies and organizations with NO (zero) *authority* within any state's health care system, while those same states' agencies which were created and given regulatory health care authority remain relatively silent. Examples of this dichotomy at both national and state levels are:
American Medical Association (AMA) and American Hospital Association (AHA)

These are both regularly sought out as sources of health care expertise despite the fact that, as membership organizations, neither one has the ability to exert true authority over any of their members, doctors and/or hospitals. Any association member only needs to resign their membership *if* threatened with review of questionable behavior by the parent organization. Therefore membership organizations are toothless regulatory entities.

At the same time, has anyone noticed the silence and lack of active participation in the efforts to improve the quality of health care being offered by any state medical examining board, or for that matter, the Federation of Medical Examining Boards (FMEB)? Those who voice concern for the obvious need for greater accountability in health care should first determine who is responsible for establishing health care accountability and how might greater health care accountability thusly be established.

When people get tired of having their state governor and legislature allow accidental deaths in hospitals and surgery centers receive NO accountability and instead be ignored by their state's health care regulatory apparatus then perhaps a new day in health care accountability will emerge. A first step toward this end might be to have any state first demonstrate even the existence of their state's health care *regulatory mechanism*. (Another thought paper offered to WSJ, but not printed)

Note: Brennan and Leape began their four-year study leading to the original 1990 estimate of needless hospital deaths in 1986, the same year Harvard Anesthesia Dept. published their game-changing article in the JAMA. Yet the positive results achieved by Harvard Anesthesia have been basically ignored by all those seeking to improve patient safety for the past 30 years.

Gov. Nikki Haley has signed an order suspending the Simpsonville mayor from his elected position until the charges against him are resolved. Greenville News, May 29, 2014. (A perfect example of *authority*, and *accountability* in action. Try to find similar examples in any state's health care delivery system at a hospital near you.)

Harvard Medical School Department of Anesthesia demonstrated what has always been missing in every form of health care delivery (including VA), and how an organizational structure, with clearly defined points of authority, and delegated authority are necessary for meaningful accountability to take place.

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