Alliance for Patient Safety

All that is necessary for the triumph of evil…
… is for good men to do nothing.
Edmund Burke

Opposition to AB 655, as it Compromises our Patients' Safety by Promoting the "Code of Silence"

Sent by Fax to: 916-319.33.06 and E-mail, on August 11, 2011.

ATTENTION: California Assemblymember Mary HAYASHI, 18th Assembly District,
----
Chair, Assembly Committee on Business, Professions and Consumer Protections

Honorable Assemblymember Hayashi,

Kindly, include my letter into the legislative history of AB 655.

I, hereby, incorporate herein all the letters you received to date in opposition to AB 655 posted on our website, under:

Letters to Elected Officials in Opposition to A.B. 655
(Hayashi), http://allianceforpatientsafety.org/opposition-hb-655-hayashi.php

I urge you to be selfish, think about yourself and your loved ones, NOW, because once you will be admitted to a hospital it will be too late.

Don't be fooled for a second, the fact that you are an Assemblymember does not shelter you from the risks all patients are exposed to,

when admitted to a hospital. You are a "Consumer " like any other present and future patient in any hospital.

Hence, despite your busy schedule, may I suggest that you take 5 minutes to read the following two articles regarding the mother of a

prominent physician, Dr John Maa, assistant professor of surgery at the University of California, San Francisco, and a national leader

in improving emergency care. Her death could have been prevented, see:

2934 1/2, North Beverly Glen Circle, # 373
Los Angeles, California 90077
310-858-1888
310-382-2412 (f)
http://allianceforpatientsafety.org
gil@allianceforpatientsafety.org

The Waits That Matter, NEJM | June 15, 2011 | Topics: Health Care Delivery, Quality of Care
by John Maa, M.D.

http://healthpolicyandreform.nejm.org/?p=14705

Honorable Assemblymember Hayashi,

If, you do not listen to the physicians who are on the Frontline of patient care, then how will you know what to fix in the "House of Medicine" ?

If, hospitals are allowed to continue to enforce a pernicious "Code of Silence ", then our patients will continue to die.

AB 655, as it is written presently, only encourages hospitals to retaliate against any physician who expresses a critical opinion.

In today's NY Times you will find the observations of a most dedicated physician with an inquisitive mind, Dr Pauline W. Chen, bio attached.

Following, please find, excerpts from Dr Chen's article:

"And those challenges have the potential to affect every single one of us personally, patient and doctor."

“Emergency room overcrowding and boarding are formidable challenges that even I, as a surgeon dedicated to emergency care,

couldn’t address for my mother,”

Dr. Maa said recently. “What about other patients who don’t have a physician as a family member?”

The major challenge for any patient in the emergency room is a reimbursement system that offers little incentive to decrease crowding or minimize boarding.

Hospitals prefer patients who come in electively for scheduled procedures, at least from a financial perspective.

For one thing, they are far more likely to be well insured than those admitted through the emergency room."

"Truly effective changes won't occur until we have addressed the lopsided repercussions of a system that allocates care based on insurance

coverage rather than clinical status."

"In emergency care, in order to be efficient, you have to be equitable," Dr. Hsia said. "But as long as elective admissions take priority over emergency ones,

then we will see the kinds of consequences that Dr. Maa's mother suffered."

Those consequences, as Dr. Maa showed us, can be deadly. And they can happen to anyone."

Honorable Assemblymember Hayashi,
I trust that your sense of self preservation and good judgement will prevail.

Hence, for your own sake and your loved ones, YOU MUST OPPOSE AB 655 !

Respectfully submitted,

Respectfully submitted,

Gil Mileikowsky MD
- President and Founder,
- Alliance For Patient Safety, AFPS, http://allianceforpatientsafety.org/
- http://allianceforpatientsafety.org/socalphysgm.pdf
- http://allianceforpatientsafety.org/blackbox.pdf

ENCLOSURES:

Pauline W. Chen

FINAL EXAM

Pauline W. Chen attended Harvard University and the Feinberg School of Medicine at Northwestern University and completed her surgical training at Yale University, the National Cancer Institute (National Institutes of Health), and UCLA, where she was most recently a member of the faculty. In 1999, she was named the UCLA Outstanding Physician of the Year. Dr. Chen's first nationally published piece, "Dead Enough? The Paradox of Brain Death," appeared in *The Virginia Quarterly Review* and was a finalist for a 2006 National Magazine Award. She is also the 2005 cowinner of the Staige D. Blackford Prize for Nonfiction and was a finalist for the 2002 James Kirkwood Prize in Creative Writing. She lives near Boston with her husband and children.

Dr. Pauline Chen is available for lectures and readings. For information regarding her availability, please visit www.knopfspeakersbureau.com or call 212-572-2013.

http://www.amazon.com/Final-Exam-Surgeons-Reflections-Mortality/dp/030727537X/ref=pd_bbs_sr_1?ie=UTF8&s=books&qid=1199848386&sr=8-1#reader_030727537X

Imminent Danger - Close and Personal - A Reality Check by a Concerned Surgeon

---

A Canary in the Health Care Coal Mine

The New York Times

Thursday, August 11, 2011

When Hospital Overcrowding Becomes Personal

By PAULINE W. CHEN, M.D.

http://well.blogs.nytimes.com/2011/07/14/when-hospital-overcrowding-becomes-personal/

Dr. John Maa with his mother, top left and top right, and his mother through the years.

2934 1/2, North Beverly Glen Circle, # 373
Los Angeles, California 90077
310-858-1888
310-382-2412 (f)

http://allianceforpatientsafety.org
gil@allianceforpatientsafety.org

Early in my residency, I realized that like Pavlov's Russian dogs of yore, the other surgeons-in-training and I had developed a conditioned response to our electronic pagers. Our blood would rush and our breath disappear at the sight of one five-digit extension on our beeper's screen.

The emergency room was calling.

It wasn't that we disliked the E.R. Some of our most memorable training experiences occurred there. It was just the sheer crowding of that area of the hospital that made our stomachs drop.

Day and night, the hallways of the E.R. were lined with gurneys, sometimes parked two rows deep. Patients were forced to wait, or "board," on those flimsy narrow stretchers until a bed became free at the "Inn," as the E.R. staff referred to the rest of hospital.

Stuck for hours and sometimes entire days, these patients were surrounded by the groans, cries and hacking coughs of others who waited with them. Doctors and nurses did what they could, pinning curtains around two stretchers to create makeshift semiprivate rooms and dimming the lights to bring some sense of calm to the chaos. But there were always more new patients, and the "boarders" would be left to continue their wait, calling out to whoever approached to ask for water, a bedpan or an extra blanket to keep warm in the chilly corridors.

None of my colleagues were surprised when we heard one day that a patient had died in those halls waiting for a bed.

"I'm not sure there's much more we can do about this overcrowding," an E.R. nurse later confided to me.

"It's not like we can turn people away; that's against the law."

Since 1986, when Congress passed a bill that made emergency care a legal right, emergency rooms have served as the safety net of the American health care system. But providing such care has become increasingly difficult in recent years. More and more hospitals are being forced to close their emergency departments, a major source of lost revenue, even as the demand for them continues to rise.

Once seen primarily as a problem of urban medical centers that affected only the poor and medically underserved, emergency room closings and overcrowding are increasingly viewed in a different light. More and more experts now believe that the current crisis in emergency care is a canary in the health care coal mine, a warning of more vexing challenges ahead for medicine in general.

And those challenges have the potential to affect every single one of us personally, patient and doctor.

The far-reaching implications were made painfully clear last month in The New England Journal of Medicine. In an eloquent and moving essay, Dr. John Maa, an assistant professor of surgery at the University of California, San Francisco, and a national leader in improving emergency care, describes the all-too-familiar story of a 69-year-old woman who is admitted to the E.R. for a

procedure to correct an irregular heartbeat. Her operation is delayed because she has to board for a full day while waiting for a real bed. During the delay, she suffers a major stroke and dies.

The woman, we learn, was the author's mother.

"Emergency room overcrowding and boarding are formidable challenges that even I, as a surgeon dedicated to emergency care, couldn't address for my mother,"

Dr. Maa said recently. "What about other patients who don't have a physician as a family member?"

The major challenge for any patient in the emergency room is a reimbursement system that offers little incentive to decrease crowding or minimize boarding.

Hospitals prefer patients who come in electively for scheduled procedures, at least from a financial perspective.

For one thing, they are far more likely to be well insured than those admitted through the emergency room.

By boarding E.R. patients in crowded halls, hospitals can offer the required emergency care for all while minimizing the effect on their bottom lines.

"It becomes a question of who can keep our hospital afloat," said Dr. Renee Y. Hsia, an assistant professor of emergency medicine at the University of California, San Francisco, and an author of two recent major studies on the emergency care crisis. "Being an emergency doesn't necessarily move you up to the head of the line."

In the last few years, several initiatives have attempted to address the overcrowding and boarding issues. In England, a new law limits the length of emergency room visits to four hours. Some American hospitals are reserving beds for emergency admissions and "smoothing admissions," distributing elective admissions more evenly throughout the week rather than clustering them on Monday mornings. Dr. Maa has led a "surgical hospitalist" initiative in his hospital that has now spread to hundreds of other hospitals across the country; it ensures that emergency rooms have a dedicated surgeon who will see patients within 30 minutes of arrival to speed their admission, discharge or follow-up care.

As promising as these efforts are, they have also revealed one thing: **Truly effective changes won't occur until we have addressed the lopsided repercussions of a system that allocates care based on insurance coverage rather than clinical status.** "In emergency care, in order to be efficient, you have to be equitable," Dr. Hsia said. "But as long as elective admissions take priority over emergency ones, then we will see the kinds of consequences that Dr. Maa's mother suffered."

Those consequences, as Dr. Maa showed us, can be deadly. And they can happen to anyone.

Perspective

The Waits That Matter

NEJM | June 15, 2011 | Topics: Health Care Delivery, Quality of Care

John Maa, M.D.

http://healthpolicyandreform.nejm.org/?p=14705

She was 69 years old and, with the exception of mild heart disease, was in excellent health. One day, around mid-morning, she noticed that her heartbeat was irregular and she felt slightly short of breath. Using her home blood-pressure cuff, she found that her pulse was 130. Since her blood pressure was stable, she decided to forgo a call to 911 and instead asked her husband to drive her to the local hospital — one of the most highly regarded academic medical centers on the West Coast.

After waiting about an hour to be seen, she was diagnosed with rapid atrial fibrillation around 8 o'clock on a Thursday evening. Given her age, the emergency department (ED) staff and the consulting cardiologist decided to admit her to the hospital. The medical team started giving her intravenous heparin for anticoagulation and planned to perform electrical cardioversion the following day if a transesophageal echocardiogram (TEE) confirmed the absence of an atrial thrombus.

Because no inpatient bed was available, the patient was kept in the ED overnight. The narrowness of the stretcher and the noise and bright lights of the ED hallway made it hard for her to get much sleep. The following day, shortly before noon, she was wheeled upstairs to a bed.

Early in the afternoon, the cardiologist stopped by to let her know that because her admission had been delayed, it would not be possible to complete her procedures before the end of the workday. Therefore, she would remain in the hospital receiving intravenous heparin and oral warfarin throughout the weekend and would undergo TEE and cardioversion the following Monday.

The next day, without warning, the patient sustained a massive embolic stroke. The clot occluded her right common carotid artery and extended into the intracranial branches. Within moments, signs of middle cerebral artery syndrome developed. A neurosurgeon rushed the patient to the operating room and attempted to extract the embolus. Unfortunately, the procedure tore her internal carotid artery. Because of the anticoagulants in her system, rapid intracranial bleeding ensued and led quickly to brain-stem herniation. For the next 2 days, the patient lay intubated in the ICU without evidence of neurologic recovery. Her family asked that she continue to receive

mechanical ventilation until preparations for her funeral could be finalized. At that point, life support was withdrawn — 112 hours after she walked into the hospital.

Perhaps the various delays in this woman's care played no role in her death. After all, she was 69 years old and had chronic heart disease. But earlier initiation and closer monitoring of her anticoagulant treatment might have prevented the development of the thrombus that subsequently broke loose. Since it's difficult for professionals working in a crowded ED to precisely monitor intravenous infusions for long periods, undesirable compromises are often made in the quality of care delivered. Had cardioversion been performed shortly after the patient entered the ED, she might be alive and healthy today. We'll never know for sure. Only one thing is certain: an intelligent woman who loved her husband and son is dead. She was my mother.

Ironically, I am an academic surgeon and founder of a surgical training program dedicated to improving the availability and quality of emergency surgical care. But because I practice in a different city, I was unable to persuade the staff of my mother's hospital to expedite her care. Many Americans cling to the notion that the shortcomings that afflict our health care system affect only the poor. They are mistaken.

The cardiologist who postponed my mother's care never returned. One of the only doctors who acknowledged our loss was the ICU intern, who offered me his condolences in the hallway the following day. But when he learned that my father and I wanted to finalize my mother's funeral plans before withdrawing life support, he told us, in a frustrated tone, that her condition made further treatment futile and her ICU bed was needed for other patients. He added that it was very selfish of us not to immediately withdraw life support. His words stung, but they were true. I have since wondered how many additional patients spent unnecessary hours in the ED because my mother was occupying an ICU bed.

Such tragic deaths happen every day in U.S. hospitals. The factors that contribute to ED crowding and its consequences have been amply documented in reports by the Institute of Medicine, the Government Accountability Office (GAO), the Robert Wood Johnson Foundation, the Center for Studying Health System Change, and others.[1,2] "Boarding" admitted patients in ED exam rooms and corridors for extended periods has become so commonplace that it is accepted as the norm, particularly in large urban hospitals. But a crowded ED is more than a nuisance; it is a threat both to individual patients and to overall public health. Still, the financial imperatives of hospital operations trump patient safety. The GAO has noted that many hospital administrators tolerate ED crowding and even divert inbound ambulances rather than postpone or cancel elective admissions.[3]

Crowded EDs are only one part of the problem. Inefficient hospital operations are another. Death, disease, and injury occur around the clock, but many hospitals still operate the majority of their services only 5 days a week. A growing number of specialists are either refusing to take after-hours call or demanding payments for doing so.[4] After-hours and weekend gaps in coverage have real consequences; mortality rates associated with acute myocardial infarction and other time-critical conditions are significantly higher on weekends than on weekdays.[5]

Politicians decry long waiting lines for elective procedures in Britain, Canada, and other countries. A lengthy wait for elective surgery can be irritating, but it is rarely deadly. The waits that matter are those for emergency treatment such as defibrillation for out-of-hospital cardiac arrest, surgical management of traumatic injuries, initiation of antibiotic treatment for meningitis and other deadly infections, and percutaneous coronary intervention for acute myocardial infarction with ST-segment elevation. The passage of the Affordable Care Act may actually make stories like my mother's more common, as 32 million more Americans seek access to an emergency care system that is already overwhelmed.

Those of us who have dedicated our careers to health care must confront the fact that our inability (or, more likely, unwillingness) to reduce the waits and delays that bedevil emergency care is harming and even killing our patients. The Shakespearean warning "Defer no time, delays have dangerous ends" is an apt precept for the treatment of emergency and urgent conditions which has been underemphasized of late. We fill our hospitals with patients recovering from elective surgery and then run out of hospital beds for the patients in the ED. In other countries, hospitals first take care of all the patients who are in the ED or are waiting as inpatients and then allow the operating room to proceed with elective surgery if beds are still available. A solution to ED boarding may thus be to invert the current paradigm of incentives and reimbursement and reprioritize our scarce health care resources and hospital beds for patients with emergency or urgent conditions, whose immediate medical needs exceed those of patients undergoing elective procedures. But this is not a problem that ED physicians, surgeons, and nurses can solve alone. It is a responsibility we must share with others throughout the hospital and, ultimately, the entire health care system.

The solution will come too late to save my mother. But it would help me honor her memory.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

Source Information

From the Division of General Surgery, University of California, San Francisco, School of Medicine, San Francisco.

References

1. Institute of Medicine Committee on the Future of Emergency Care in the United States Health System. Hospital-based emergency care: at the breaking point. Washington, DC: National Academies Press, 2006.
2. Hospital emergency departments: crowding continues to occur, and some patients wait longer than recommended time frames. Washington, DC: Government Accountability Office, 2009. (GAO-09-347.)
3. Hospital emergency departments: crowded conditions vary among hospitals and communities. Washington, DC: General Accounting Office, 2003. (GAO-03-460.)

4. American College of Surgeons Division of Advocacy and Health Policy. A growing crisis in patient access to emergency surgical care. October 2006. (http://www.facs.org/ahp/emergcarecrisis.pdf.)
5. Bernstein SL, Aronsky D, Duseja R, et al. The effect of emergency department crowding on clinically oriented outcomes. Acad Emerg Med 2009;16:1-10CrossRef | Web of Science | Medline