First, Do No Harm?

It is a widely held misconception that the familiar dictum "First, do no harm" comes from the Hippocratic Oath, an oath many physicians take when they enter medical practice. However, the Hippocratic oath expresses a similar idea, but never uses the words, "First, do no harm". In the opinion of many scholars Hippocrates did originate the phrase, but did so in his *"Epidemics"*, Bk. 1, Sect. XI. One translation reads: "Declare the past, diagnose the present, foretell the future; practice these acts. As to disease, make a habit of two things – to help, or at least to do no harm."

I bring this up because at 14% of the gross national product, healthcare spending reached $1.6 trillion in 2003. We should be reversing disease, preventing disease, and doing minimal harm. However, after careful and objective review of the medical documents it shows the opposite.

A definitive review and close reading of medical peer-review journals, and government health statistics show that American medicine frequently causes more harm than good. According to the Journal of American Medicine (JAMB) the number of people having in-hospital adverse drug reactions (ADR) to prescribed medicine is 2.2 million. The number of unnecessary medical and surgical procedures performed annually is 7.5 million. The number of people exposed to unnecessary hospitalization annually is 8.9 million. The total number of iatrogenic deaths (caused by a doctor), shown in the following table is 783,936.

Condition	Annual Deaths	Cost
Hospital ADR	106,000	$ 12 Billion
Medical Error	98,000	$ 2 Billion
Bedsores	115,000	$ 55 Billion
Infection	88,000	$ 5 Billion
Malnutrition	108,800	----------
Outpatient ADR	199,000	$ 77 Billion
Unnecessary Procedures	37,136	$122 Billion
Surgery Related	32,000	$ 9 Billion
Total	**783,936**	**$282 Billion**

Hospitals are supposed to be a safe place to go when someone is sick. However, a recent investigative report by the Chicago Tribune revealed in 2000, an estimated 103,000 deaths were linked to infections acquired in U.S. hospitals. This makes our hospitals one of the more hostile environments and most dangerous infectious places on earth. So wide spread is the problem that hospital acquired infections are ranked as the fourth leading cause of death in the United States. What's more the article noted that nearly three-quarters of the deadly infections were preventable. This was the result of unsanitary facilities, germ-laden instruments, unwashed hands and other lapses.

The Tribune conducted extensive research for the report, analyzing records gathered among 75 federal and state agencies, as well as internal hospital files, patient databases and court cases from around the country. The result is the first comprehensive analysis of preventable patient deaths linked to infections within 5,810 hospitals nationally, it noted: "Since 1995, more than 75% of all hospitals have been cited for significant cleanliness and sanitation violations."

It is evident that the American medical system is the leading cause of death and injury in the United States. The 2001 heart disease annual death rate was 699,697; and the annual cancer death rate was 553,251. All the statistics above represent just a one year time span. Imagine the numbers over a ten-year period.

Condition	10-Year Deaths
Hospital ADR	1.06 million
Medical Error	0.98 million
Bedsores	1.15 million
Infection	088 million
Malnutrition	1.09 million
Outpatient ADR	1.99 million
Unnecessary Procedures	371,360
Surgery Related	320,000
Total	**7,841,360 (7.8 million)**

This projected 10 year death rate from issues created by doctors or prescribed medicines is more than all of the casualties from all of the wars America has fought in its entire history.

Medical science amasses tens of thousands of papers annually, each one a tiny fragment of the whole picture. But the numbers and statistics were always hiding in plain sight. You just have to connect the dots. No one likes to admit they are wrong and especially to put that in writing, so the experts say that only 5% to 20% of iatrogenic events, those symptoms or illnesses brought on unintentionally by something that a doctor does or says.

The medical system is broken and in need of complete and total reform, from the curriculum in medical school to protecting patients from excessive medical intervention. It is quite obvious with anything that we do, that we can't change anything if we are not honest about what needs to be changed. After we are honest about what needs to be changed, we have to deal with the people or organizations that have a vested interest. What stands in the way of change in the medical system are powerful pharmaceutical companies, medical technology companies, and special interest groups with enormous vested interests in the business of medicine. A 2003 study found that nearly half of medical school staff, which serves on institutional review boards (IRB) to advise on clinical trial research, also serves as consultants to the pharmaceutical industry.

Former editor of the New England Journal of Medicine (NEJM), Dr. Marcia Angell, struggled to bring attention to the world the problem of commercializing scientific research in her outgoing editorial titled "Is Academic Medicine For Sale". Angell left the NEJM in June 2000; by June 2002 the NEJM announced that it will now accept biased journalists (those who accept money from drug companies) because it is too difficult to find ones that have no ties. An ABC News Report said that one measurable tie between pharmaceutical companies and doctors amounts to over $2billion a year spent for over 314,000 events that doctors attend. Data also shows that in 1981 the drug industry "Gave" $292 Million to colleges and universities for research, in 1991 it "Gave" $2.1 Billion.

Dr. Lucian L. Leape opened medicine's Pandora's Box in his 1994 Journal of the American Medical Association (JAMA) paper "Error in Medicine." He found that a researcher reported in 1964 that 20% of hospital patients suffered iatrogenic injury, with a 20% fatality rate. Another researcher reported in 1981 that 36% of hospital patients experienced iatrogenesis with a 25% fatality rate and adverse drug reactions were involved in 50% of the injuries. Again in 1991 a researcher reported that 64% of acute heart attacks in one hospital were preventable and were mostly due to adverse drug reactions. Dr. Leape, however, focused on a "Harvard Medical Practice Study" published in 1991. He was looking to tie some real numbers to these reports instead of just talking about percentages. He found that in 1984, in New York State, there was a 4% iatrogenic injury rate for patients with a 14% fatality rate. From the 98,609 patients injured and the 14% fatality rate, he estimated that in the whole of the U.S. 180,000 people die each year, partly as a result of iatrogenic injury. To put it in real perspective you can imagine three jumbo jet crashes every two days.

Dr. Leape acknowledged that literature on medical error is sparse and we are only seeing the tip of the ice berg. He calculated the rate of error in an intensive care unit. First, he found that each patient had an average of 178 "activities" (staff/procedure/medical interactions) a day, of which 1.7 were errors, which means a failure rate of 1%. This may not seem like much, but putting it perspective, industry standards where in aviation a 0.1% failure rate would mean 2 unsafe plane landings per day at O'Hare airport; in the U.S. Mail 16,000 pieces of mail lost every hour; or in banking, 32,000 bank checks deducted from the wrong bank account every hour.

Why is there no public outcry? Hospital errors are spread out over the entire country in thousands of different locations. They are also perceived as isolated or unusual events. However, the most important reason that medical error is unrecognized and growing is that doctors and nurses are unequipped to deal with human error, due to the culture of medical training and practice. Doctors are taught that mistakes are unacceptable. Medical mistakes are therefore viewed as a failure of character and any error equals negligence.

In 1995 a report in JAMA said that, “Over a million patients are injured in U.S. hospitals each year, and approximately 280,000 die annually as a result of these injuries. Therefore, the iatrogenic death rate dwarfs the annual automobile accident mortality rate of 45,000 and accounts for more deaths than all other accidents put together.

An article in Psychiatric Times outlines the stakes involved in reporting medical errors. They found that the public is fearful of suffering a fatal medical error, and doctors are afraid they will be sued if they report an error. This brings up the obvious question: who is reporting medical errors? Usually it is the patient or the patient’s surviving family. If no one notices the error it never gets reported. Janet Heinrich, Associate Director at the U.S. General Accounting Office, said she acknowledged the fear of being blamed, and the potential for legal liability playing key roles in the under reporting of errors.

Drugs comprise the major treatment modality of scientific medicine. The drugs themselves, even when properly prescribed, have side effects that can be fatal. A survey of a 1992 national pharmacy database found a total of 429,827 medication errors from 1,081 hospitals. Medication errors occurred in 5.22% of patients admitted to these hospitals each year and if we projected this number out around the country we have a minimum of 90,895 patients annually being harmed by medication errors. A 2002 study shows that 20% of hospital medications for patients had dosage mistakes. Nearly 40% of these errors were considered potentially harmful to the patient. Problems involving patients’ medications were even higher the next year. The error rate intercepted by pharmacists in this study was 24%, making the potential minimum number of patients harmed by prescription drugs 417,908.

We have reached the point of saturation with prescription drugs. We have arrived at the point where every body of water tested contains measurable drug residues. We are inundated with drugs. We just have to listen to the news broadcasts to hear of the tons of antibiotics used in animal farming, which runs off into the water table and surrounding bodies of water that are contaminating our drinking water. This runoff also confers antibiotic resistance to germs in sewage, and these germs are also found in our water supply. Flushed down our toilets are tons of drugs and drug metabolites that also find their way into our water supply. We have no idea what the long term consequences of ingesting a mixture of drugs and drug breakdown products will do to our health. It's another level of iatrogenic disease that we are unable to completely measure.

It's not just America that is plagued with iatrogenesis. A survey of 1072 French general practitioners tested their basic pharmacological knowledge and practice in prescribing Non-steroidal anti-inflammatory drugs (NSAIDs). NSAIDs rank first among commonly prescribed drugs for serious adverse reactions. The results of the study suggested that General Practitioners don't have adequate knowledge of these drugs and are unable to effectively manage adverse reactions. A cross-sectional survey of 125 patients attending specialty clinics in South London found that possible iatrogenic factors such as "over-investigation, inappropriate information, and advice given to patients as well as misdiagnosis, over-treatment, and inappropriate prescription of medication were common."

A 1998 JAMA article ran a statistical analysis of 33 million U.S. Hospital admissions. Hospital records for prescribed medications were analyzed. The number of serious injuries due to prescribed drugs was 2.2 million, 2.1% of in-patients experienced a serious adverse drug reaction; 4.7% of all hospital admissions were due to a serious adverse drug reaction; and fatal adverse drug reactions occurred n 0.19% of in-patients and 0.13% of admissions. While the percentages may not be very high when you look at the actual numbers, there were 106,000 deaths that occurred from adverse drug reactions annually, with an associated cost of $5,483 per patient on average being treated for adverse drug reactions. Therefore, the cost of the 2.2 million patients that receive treatment for adverse drug reactions is costing the country about $12 Billion annually.

Perhaps the word “healthcare” gives us the illusion that medicine is about health. Allopathic medicine is not a purveyor of healthcare but of disease-care. Studying the mortality figures in the Healthcare Cost and Utilization Project (HCUP) within the U.S. Government’s Agency for Healthcare Research and Quality, I found many points of interest.

The HCUP computer program calculates the annual mortality statistics for all U.S. hospital discharges. The mortality rates that were indicated in the tables and charts for each procedure were not necessarily due to the procedure but only indicated that someone who received that procedure died either from their original disease or from the procedure. There are also no codes for adverse drug side effects, none for surgical mishap, and none for medical error. Until there are specific codes for medical errors, statistics for those people who are dying from various types of medical error will be buried in the general statistics.

In the United States of America we are faced with a shocking health care crisis. One in three Americans does not have health care insurance! A recent finding by the Institute of Medicine is that the 41 million Americans without health insurance have consistently worse clinical outcomes than those with insurance, and are at increased risk for dying prematurely. The United States is the only developed country that does not provide universal health care. We seem to be a country that cares more about dollars than people. The cost of the Iraq War is $350 million PER DAY! Why isn’t this money used to care for Americans in need? Why does the insurance industry operate on a for-profit basis, which necessitates neglect and denial of health care?

The short story goes something like this. Prior to the 1930s, health care was provided by doctors and hospitals, and paid for by patients. During the Great Depression, patients started to be unable to pay their hospital bills. Two things resulted: the Social Security Act was passed, which did not include health care; and, a system was created by Baylor Hospital in Dallas that evolved into the Blue Cross Insurance organization. In the very beginning, Blue Cross, and later Blue Shield were nonprofit health insurers that served local community organizations like the Elks. In exchange for government tax breaks, the Blues kept premiums reasonably low, so that folks

could afford to pay for their insurance. The Blues, in their early days, charged everyone the same premium, regardless of age, sex, or pre-existing conditions.

In the 1940s, President Harry Truman tried to introduce universal health care, and his plan was denounced as communist! Since the Blues' system was working, companies began offering health insurance to their employees in lieu of higher wages. Labor unions started negotiating for health benefits, and tax laws were changed to make provision of them attractive to employers. By the 1950s, private health insurance was well-entrenched.

In the 1960s, Medicare and Medicaid legislation was passed as an amendment to Social Security, which provided for citizens aged 65 and over, or disabled under Social Security guidelines. In the 1970s, President Richard Nixon tried to introduce sweeping health care reform, which was opposed by the medical-industrial complex: hospitals, doctors, medical device and pharmaceutical companies, and the insurance industry. Both Congress and the courts took actions to increase competition within the medical marketplace, based on the theory that it would reduce costs. In the end, Nixon endorsed legislation to create Health Maintenance Organizations, HMOs, which fully assimilated the concepts of managed care.

Corporatization of health care grew in the 1980s under President Ronald Reagan. By the 1990s, healthcare costs had doubled. The Clinton Administration attempted legislation to reform the industry, but it was vehemently undermined, and failed. Meanwhile, the AIDs epidemic ensued. Sixteen percent of the population was uninsured. Now, in the 2000s, we realize that the Medicare system is unsustainable, the employer-paid system is failing, and onethird of the population is uninsured. The medical-industrial complex survives by denying benefits and excluding highrisk people; prescription drug advertising has been condoned, and the pharmaceutical companies are thriving.

Today, including tax subsidies for health insurance, 51% of American health care spending is by the government, paid for by its taxpayers. Yet, one-third of the taxpayers are uncovered, and much of this spending has accumulated in the form of the national debt.

HMOs exist to make money. The primary customers of HMOs are its shareholders. This new paradigm is uniquely American. Every other Western nation has bent the market to accommodate the needs of health care. The U.S. bends health care to accommodate the needs of the market.

Despite aggressive cost-cutting measures taken by HMOs (which now enroll over 80% of insured Americans), the premiums paid by employers haven't fallen. The savings are not returned to the payer in the form of reduced premiums, nor turned back into the healthcare system in the form of improved or widened services; rather, they are returned to the HMOs in the form of administrative costs, huge bonuses for top executives, and profits for shareholders. Estimates suggest that an average of 25% of all health insurance premiums paid to HMOs goes for administrative overhead and profit. Only 20% goes to doctors.

The widespread sale of not-for-profit community hospitals to for-profit corporations such as HMOs is a relatively recent phenomenon, fueled by the notion that the latter are inherently more efficient. These transfers are overseen by either a state insurance commissioner, or a state attorney general, who seem unable to establish an accurate value for nonprofit hospitals. They do the negotiations behind closed doors, with no public disclosure. The hospitals are undervalued, the HMO stock value goes up, the efficiencies of scale are instituted, and the venture begins.

The biggest risk the HMO faces is sick patients. The sickest 10% of the population account for over 70% of all health care spending, and one very sick subscriber can wipe out the potential profit from twenty, thirty, or even fifty healthy subscribers. Sick patients are to be avoided like the plague.

Most HMO coverage is only available through employers, so only employed people can sign up for it. Employed people are, on average, healthier than unemployed people. HMOs increase profits by shutting down expensive facilities such as heart disease and cancer centers. They hire powerful lobbyists to counter congressional

attempts to make insurance available to everyone. To get rid of sick subscribers, they just let the system bog down in red tape.

HMOs are notorious for trying to control the behavior of their physicians. They terminate doctors whose only concern is the patient. When financial goals are exceeded, there are bonuses. It is all based on capitation, which is a fixed dollar amount allocated to a physician for the care of each patient. It is an enforced budget. Further, there is a gag clause in physicians' contracts that "the physician agrees not to take any action or make any communication with patients or patients' families, potential patients or potential patients' families, employers, unions, the media or the public that would tend to undermine, disparage, or otherwise criticize [the HMO] or [the HMO's] health care coverage. The physician further agrees to keep all proprietary information such as payment rates, reimbursement procedures, utilization-review procedures, etc., strictly confidential."

You can take action to make a difference in our convoluted healthcare saga. Contact your elected officials, join an organization that supports health care reform, support candidates that stand for health care reform, and, most importantly, take responsibility for your own health as much as possible.

The healthcare system can and will not take care of you. Preventive care is the best precaution. Use your time, energy and resources to sustain the health you have, and to heal what you can on your own or through non-invasive, alternative methods. Make necessary diet and lifestyle changes; embrace your emotional and spiritual awareness for the purpose of healing yourself and others. Trust that you have the power to change, and start making those changes right now. Your quality of life is 'insured' by your health and well-being!