THE *NEW YORK TIMES* BESTSELLER

UNACCOUNTABLE

What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care

"A gripping story about what's wrong with the American healthcare system and what we might do to make it better." —PETER PRONOVOST, MD

MARTY MAKARY, MD

Advancing the Science of Medical Transparency

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Department of Health Policy & Management

Johns Hopkins University


STERIS

How Many Die From Medical Mistakes In U.S. Hospitals?

by MARSHALL ALLEN, PROPUBLICA

September 20, 2013 4:52 PM

210,000 deaths

Sometimes the care that's supposed to help winds up hurting instead.

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By combining the findings and extrapolating across 34 million hospitalizations in 2007, James concluded that preventable errors contribute to the deaths of 210,000 hospital patients annually.

Causes of Death in the U.S.

1. Heart disease: 597,689
2. Cancer: 574,743

3. Chronic lower respiratory diseases: 138,080

Source: CDC

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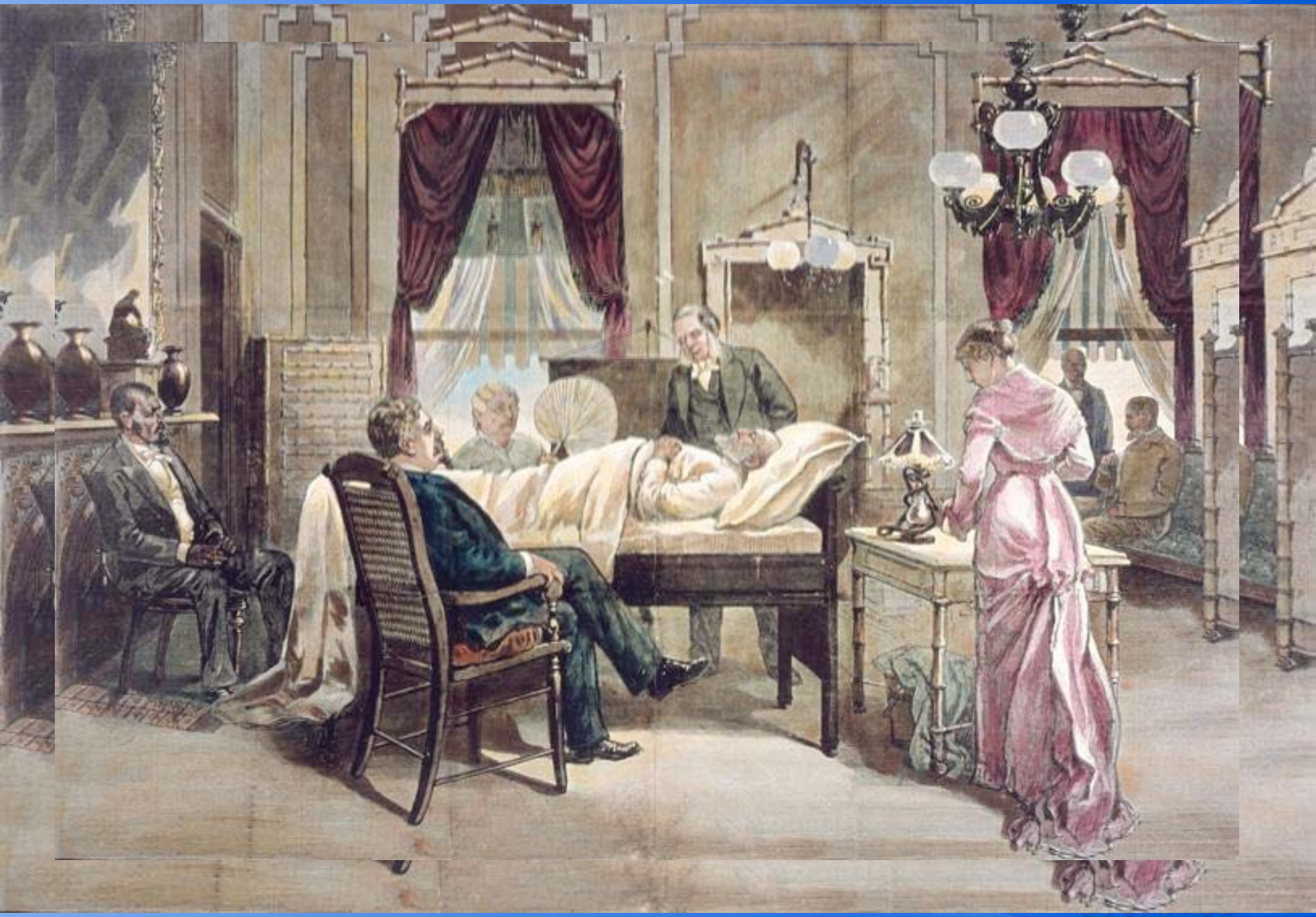

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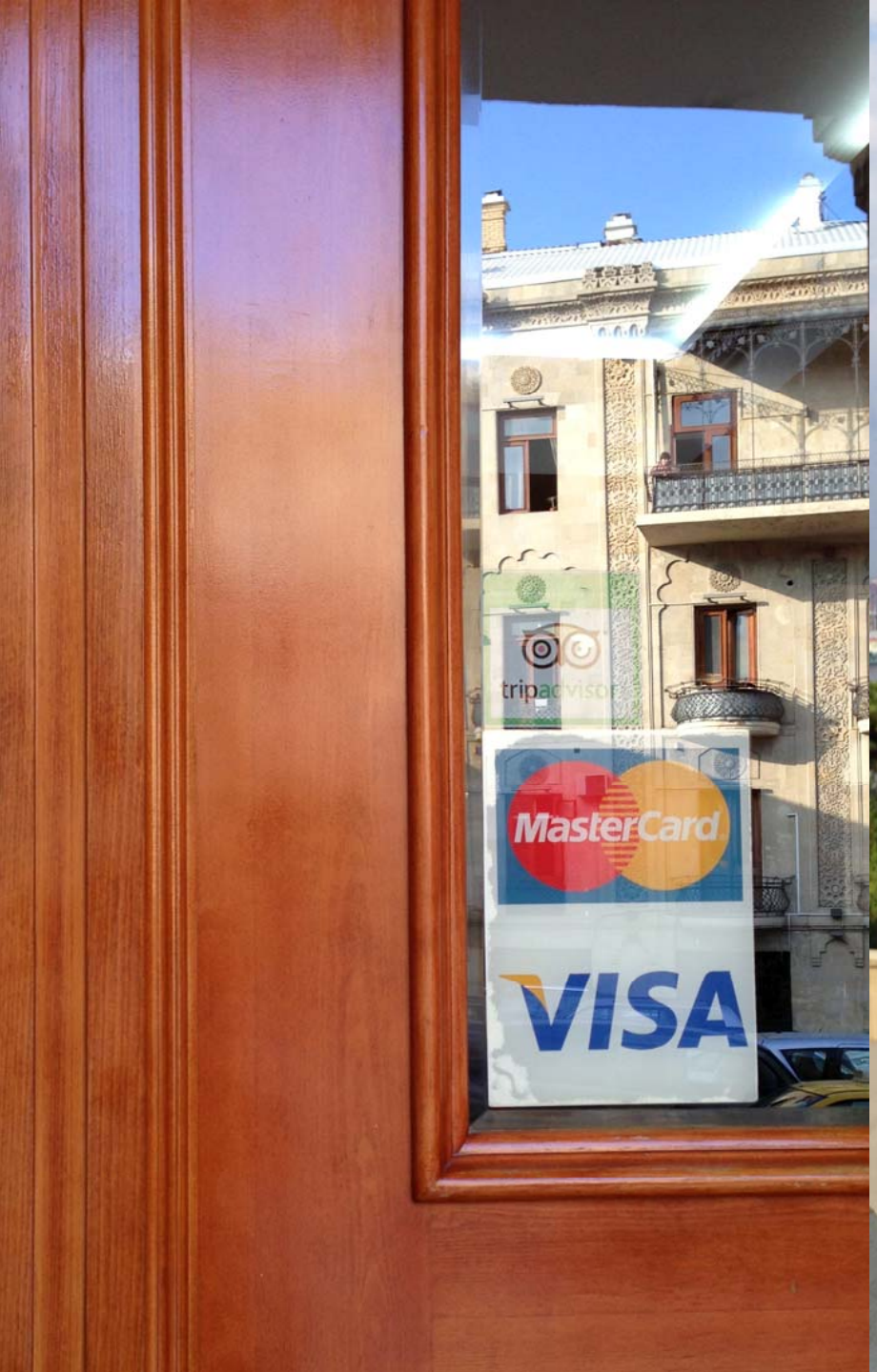
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City, hotel na

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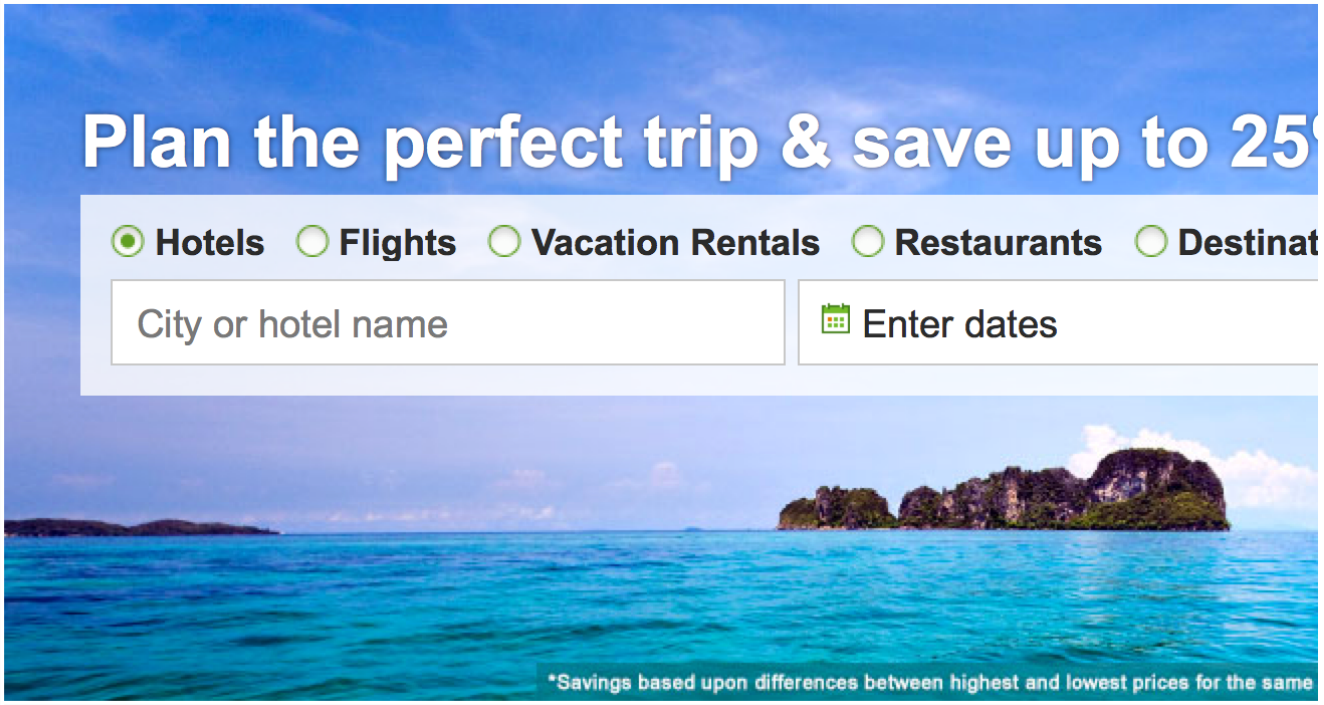

What travelers are saying about Baltimore

Hotel Reviews | Photos (4,470) | Forums (2,870)

timbolester
54 reviews
41 helpful votes

Wyndham Baltimore Peabody Court
"Changed over the years"
yesterday

Steph003
7 reviews

Royal Sonesta Harbor Court Baltimore
"Excellent Location Right in the Heart of Baltimore


7-9:30AM
4-7:00PM
MONDAY-FRIDAY
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EST. 1971
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SPEED
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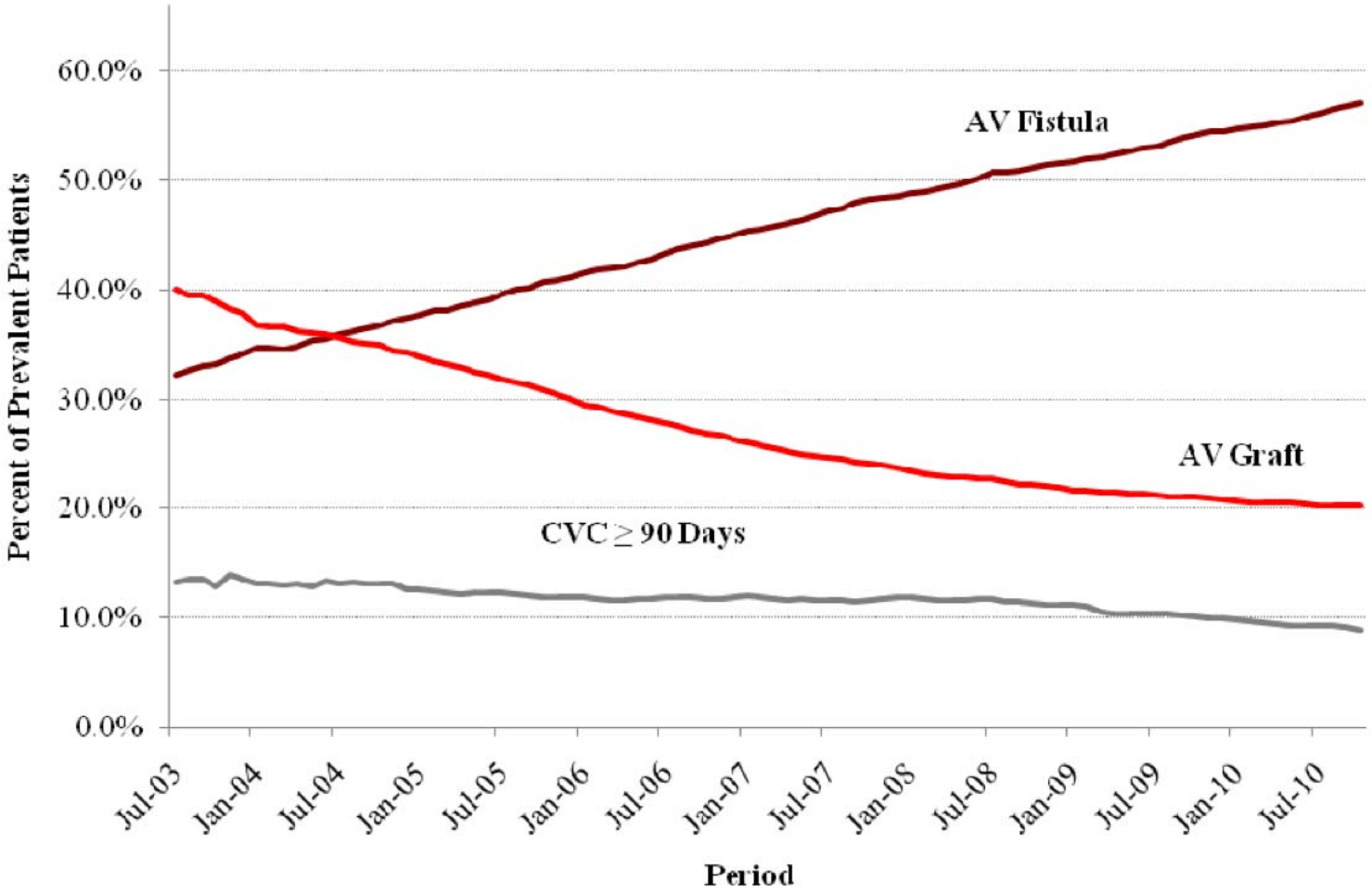
60.0%
50.0%
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Percent of Prevalent Patients
AV Fistula
AV Graft
CVC ≥ 90 Days
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Jan-04
Jul-04
Jan-05
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ONLINE FIRST

The Power of Video Recording

Taking Quality to the Next Level

Martin A. Makary, MD, MPH

IN MEDICINE, THE PROBLEMS OF WIDE VARIATIONS IN quality and poor compliance with evidence-based care are well known. More education is not the solution for these problems. Knowledge is abundant, but implementation of knowledge often lags. This Viewpoint explores whether use of an existing technology, video recording of medical procedures, can improve quality of care.

Although the World Health Organization's hand washing declaration and aggressive global awareness campaign has been long established, behavior change among health care workers remains a persistent struggle. For instance, at Long Island's North Shore University Hospital, hand washing compliance rates were consistently low despite educational efforts. In response to these low rates, the hospital took an assertive approach to solving the problem by installing cameras to monitor hand washing rates. The outcopy increased by 49% and quality of mucosal inspection improved by 31%,[2] suggesting a substantial improvement in quality because of the Hawthorne effect.

Peer review of videos can also enhance existing quality improvement efforts.[3] For example, procedure videos can better inform morbidity and mortality conferences and sentinel event root-cause analyses that have traditionally relied on the notes of clinicians, which can be limited and even biased. Moreover, the exportability of video files can facilitate external review, allowing a peer reviewer removed from a local department's politics to advise on what could have improved.

In addition to reviews triggered by patient harm, video recording also offers a valuable opportunity for coaching. In the same way that athletes learn from coaches when jointly watching videos of past games, physicians can also learn from their performance by viewing with a coach. At the Brigham and Women's Hospital,[4] a coaching program was developed in which surgeons spent 1 hour reviewing their procedure videos with an expert. The video-based peer review


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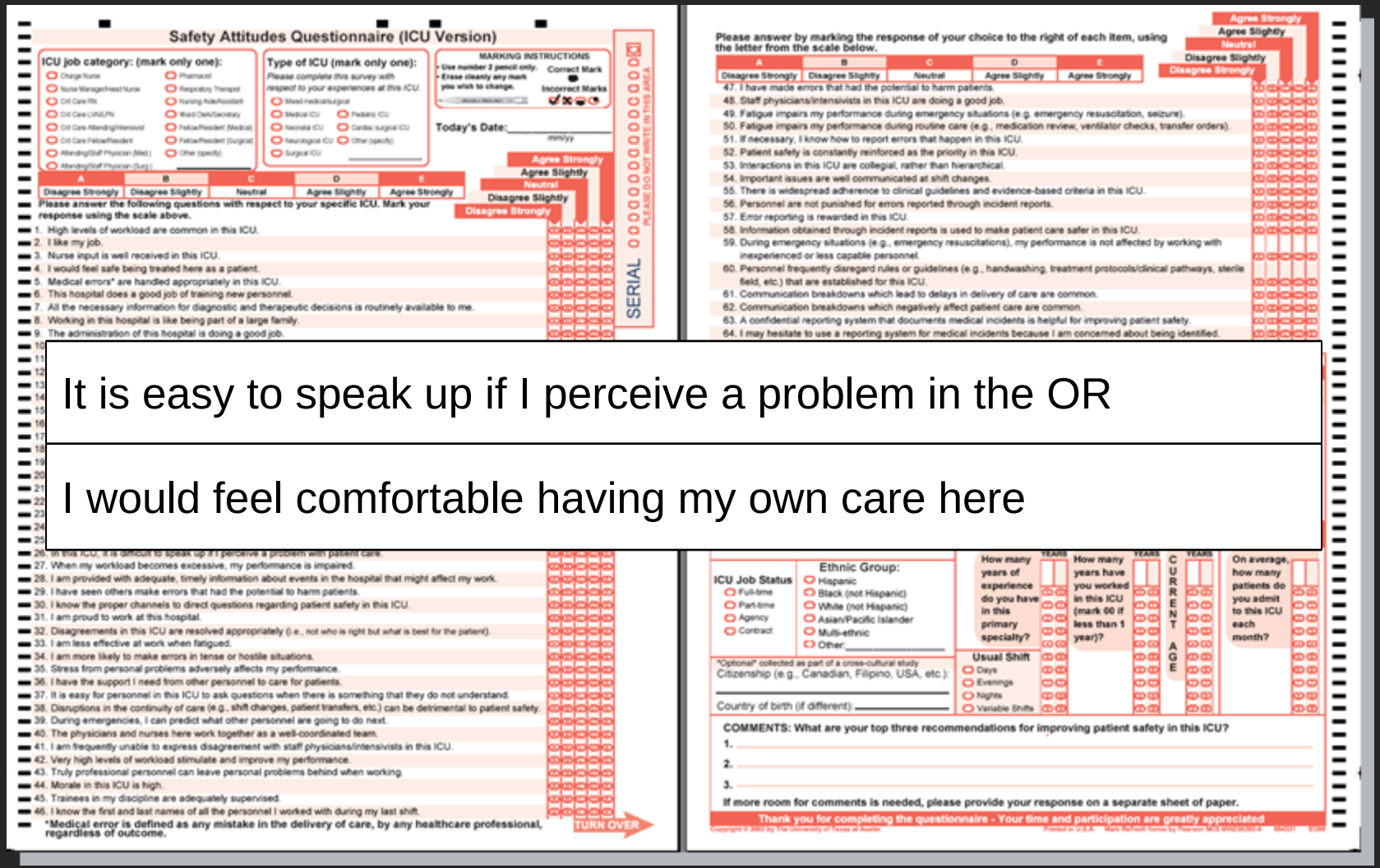
Safety Attitudes Questionnaire (SAQ)



It is easy to speak up if I perceive a problem in the OR

I would feel comfortable having my own care here

Makary M, Sexton JB, *Freischlag J et al.* Patient Safety in Surgery. *Ann Surg, 2006;243:628-32.*

Operating Room Teamwork among Physicians and Nurses: Teamwork in the Eye of the Beholder

Martin A Makary, MD, MPH, J Bryan Sexton, PhD, Julie A Freischlag, MD, FACS,
Christine G Holzmueller

BACKGROUND: Team
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STUDY DESIGN: Oper
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rated

RESULTS: Over
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The
"high
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CONCLUSIONS: Cons
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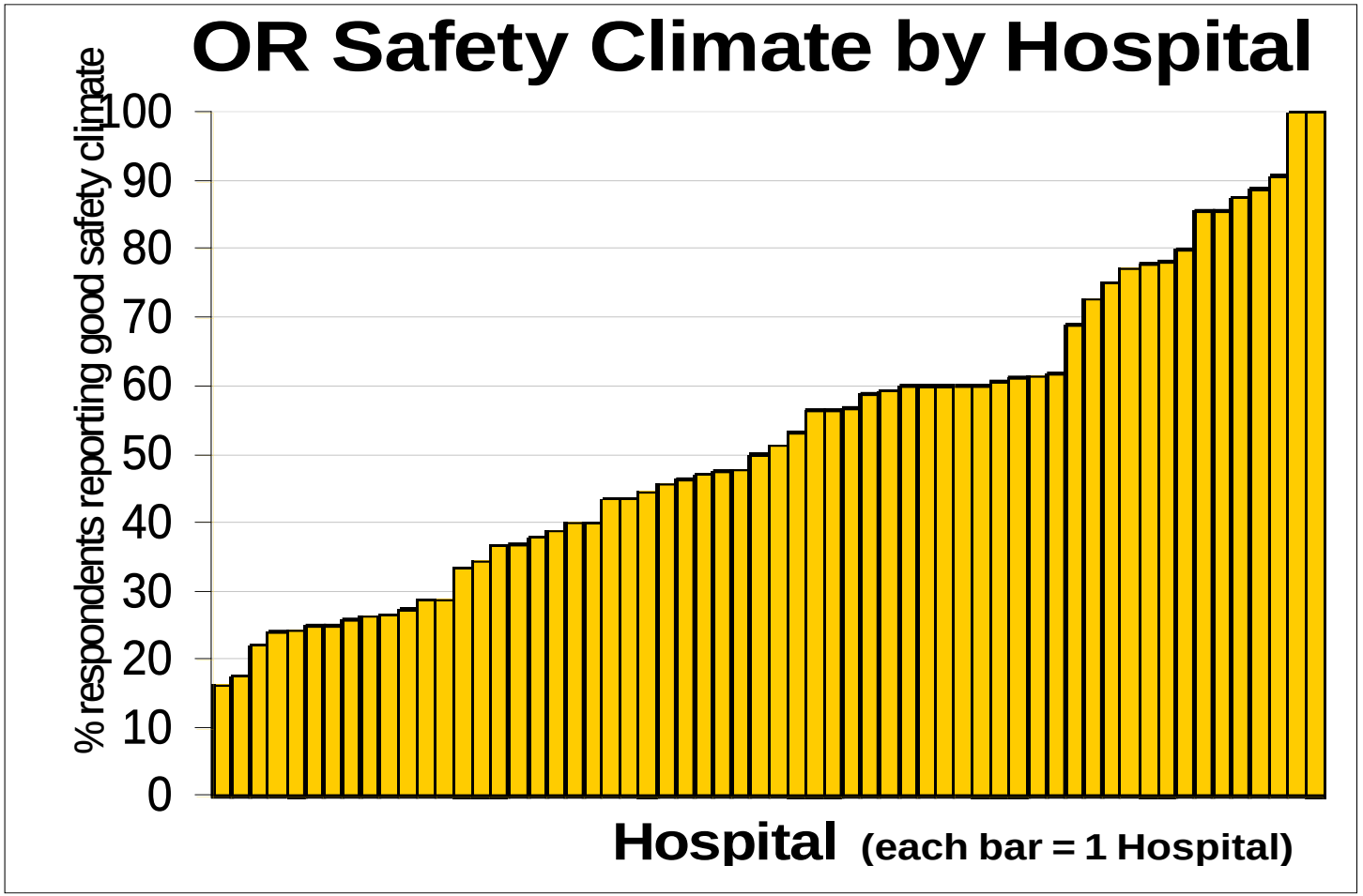
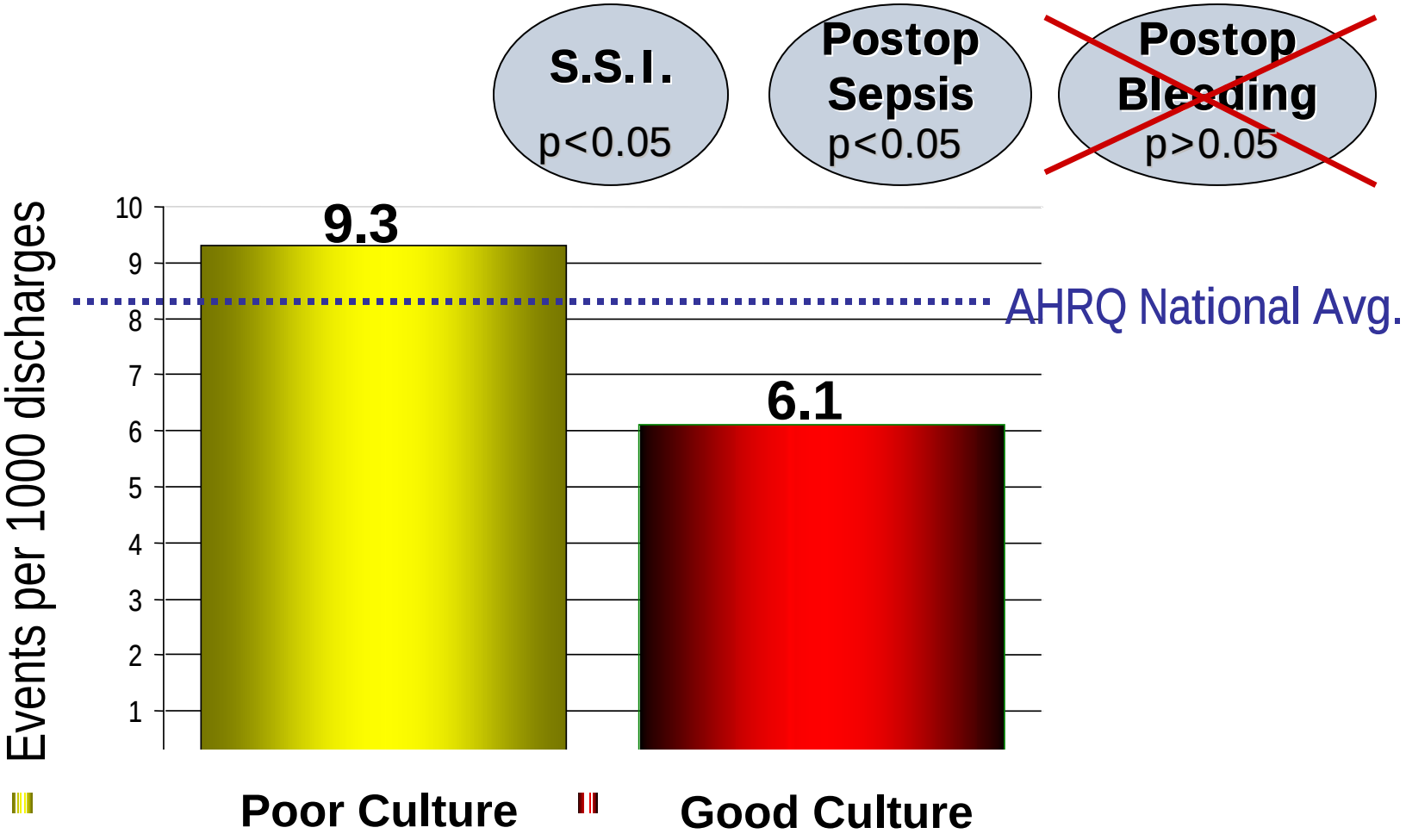
Caregiver Position Performing Rating \ Caregiver Position Being Rated	Surgeon	Anesthesiologist	Nurse	CRNA
Surgeon	85	84	88	87
Anesthesiologist	70	**96**	89	92
Nurse	**48**	63	81	68
CRNA	58	75	76	93



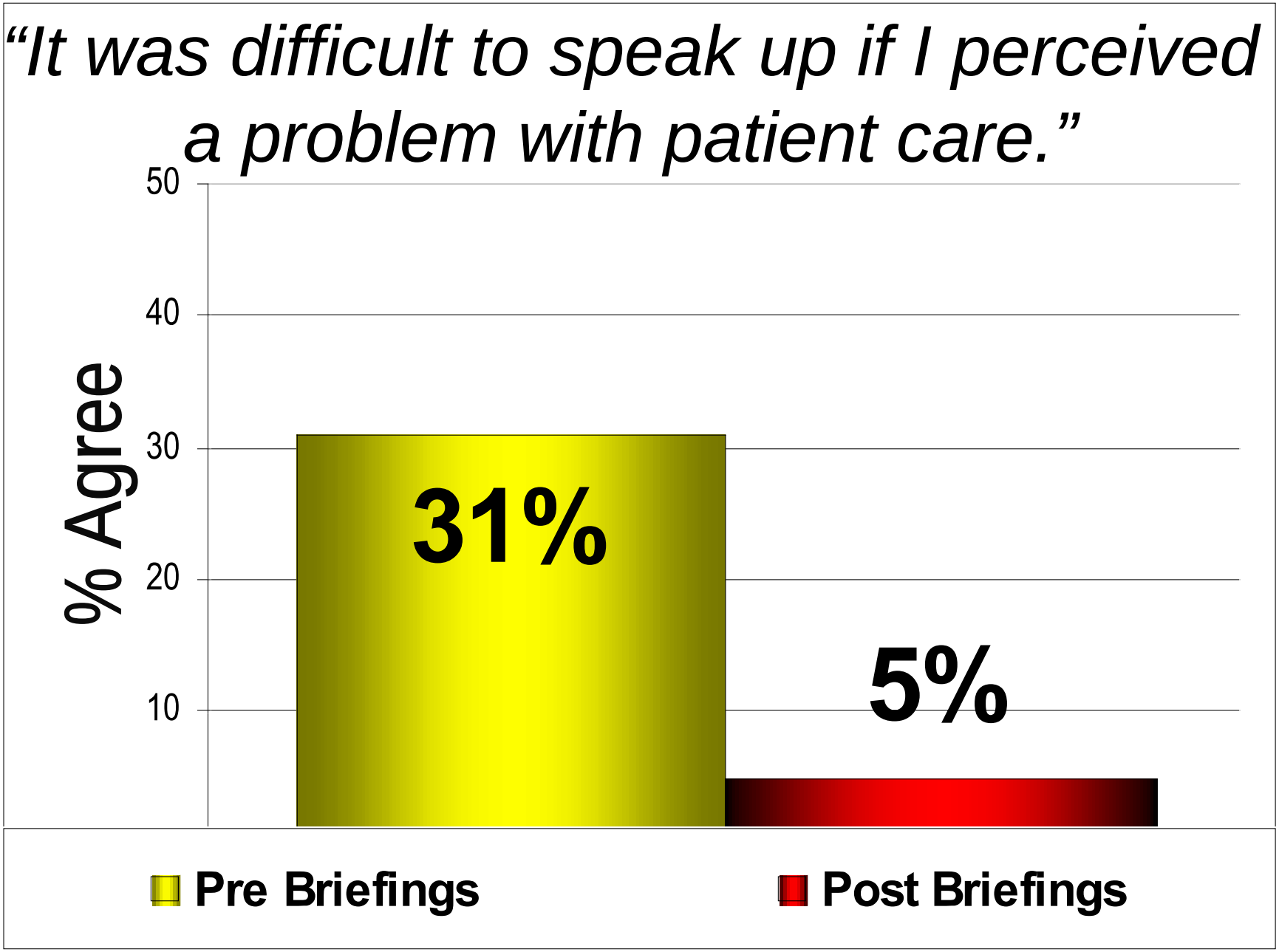
Makary M, et al., *Patient Safety in Surgery*, Annals of Surgery, 2006

Rates of PE/DVT



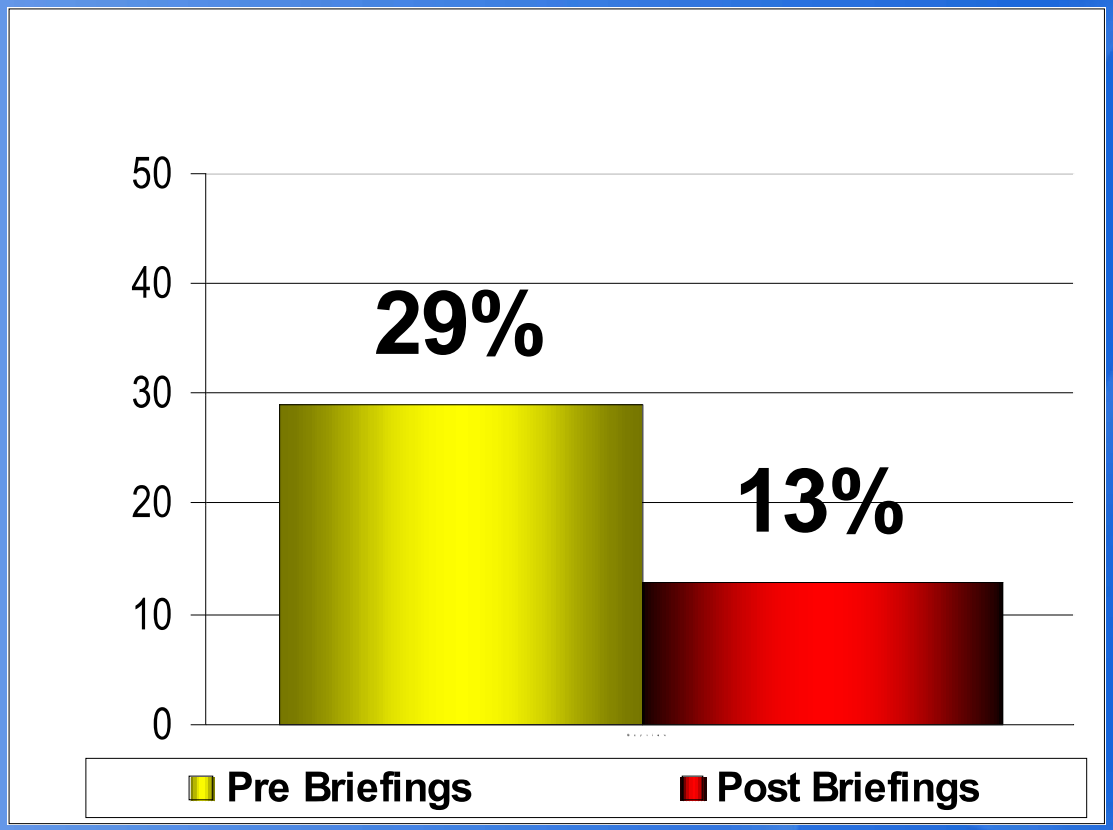
Unpublished data

"It was difficult to speak up if I perceived a problem with patient care."



Makary et al. Operating room briefings and wrong-site surgery. J Am Coll Surg 2007;204:236-43.

“There was an unexpected delay related to the case.”



Nundy S, et al. Impact of Preoperative Briefings on Operating Room Delays *Archives of Surgery, 2008*143:1068-72.

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