

# Healthcare's Betrayal

by Bill Smith 10-22-2024

## Introduction

The chilling image of patients on a conveyor belt to their graves underscores the grim reality that is hidden from the public, not unlike the Holocaust of WWII: preventable medical errors kill at rates that surpass all causes of death in America, only behind cancer and heart disease. Our blind trust in a healthcare system that has quietly devolved into one that obscures a staggering patient death toll—akin to a Holocaust every decade or two is a profound human tragedy. Had I known the extent of this betrayal, my beloved son would still be alive today. I will share more about my son's untimely death due to medical malpractice later, but first, I must establish the credibility of these assertions.



*Illustration 1: : According to Johns Hopkins Study, 250,000 to 400,000 patients per year are sent to early graves instead of being cured, then home to their families. Preventable **medical errors and negligent doctors** are to blame. This image was AI generated by feeding it this tragic healthcare story in text.*

## Research and Studies

A quarter-century ago, the Institute of Medicine estimated that between 44,000 and 98,000 deaths annually in hospitals were due to preventable medical errors. By 2016, the BMJ reported that this figure had surged to 251,000, making medical errors the third leading cause of death in the U.S. A 2019 Health Affairs study revealed that preventable errors contribute to over 400,000 fatalities each year, corroborating earlier findings from a Johns Hopkins study. While these figures are debated—downplayed by healthcare interests and deemed much higher by others on the “front lines” of healthcare—there is broad consensus that they reflect a stark reality for all Americans, whether in hospitals or during routine visits. The mistakes made in healthcare settings are often fatal.

## The Unacceptable Risk of Medical Errors

Although math and statistics may not be what most people want to read about, here is a sobering snapshot of the likelihood of becoming the next victim of unnecessary healthcare death: depending on various scenarios, an individual's lifetime risk of dying from a medical error ranges from 6.24% to a staggering 84.8% (Appendix A). This statistic represents an unacceptable risk for everyone—whether as potential victims or as loved ones of those harmed by medical negligence. —whether in the hospital or during a routine visit to the doctor. Their mistakes are often and often fatal.

We forge deep connections throughout our lives, making it likely that we will witness someone suffer due to a medical error. Unless we advocate for urgent reforms in healthcare safety, the odds of escaping this silent killer are grim. Appendix A offers a detailed statistical analysis of available data on deaths

due to preventable medical errors, which does not even account for non-fatal patient harm—an even more staggering issue.

### The Healthcare Divide

Our healthcare system's divide places profit over patient outcomes. On one side is a massive, well-funded healthcare industry—encompassing doctors, hospitals, and pharmaceutical companies. On the other side is a vulnerable population at the mercy of this powerful system. The legal apparatus, including courts and lobbyists, complicates patients' ability to seek justice for medical errors. It boils down to blocking a harmed patient for using the legal system that is anything but fair. It seeks to protect the healthcare industry and lighten the load for the courts.



### The Shield of Tort Reform

The legal avenue for medical malpractice lawsuits has been severely limited by "tort reform,"



legislation often backed by the healthcare industry that creates barriers to accountability. This has fostered a culture of impunity, shielding healthcare providers from the consequences of their negligence and perpetuating more errors—many of which remain unreported.

### A Culture of Impunity

This paper aims to expose the systemic flaws that cultivate a culture of impunity for medical errors. The profit-driven industry often prioritizes financial incentives over personalized care, leading to rushed appointments and inadequate patient-provider interactions. This environment contributes to misdiagnoses, medication errors,



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and other preventable mistakes. Patients grappling with the fallout of these errors find it nearly impossible to navigate the legal system to seek justice.

## A Personal Tragedy

The American healthcare system, once a beacon of hope, has tragically devolved into a profit-driven machine prioritizing financial gain over patient well-being. As a grieving father, I know this betrayal all too well. My son, Zander Smith, was a courageous young man with special needs who faced numerous challenges with dignity. Tragically, despite his resilience, he became a victim of a system that failed him, losing his life at the tender age of 20.

Zander's story is not unique; it reflects the healthcare industry crisis. Each year, over a quarter of a million lives in the U.S. are claimed by preventable medical errors, leaving countless families devastated. My experience, having spent four cumulative months in ICUs across multiple hospitals due to Zander's medical needs, exposed me to both the admirable dedication of many healthcare professionals and the negligence that pervades our system.

While many doctors are dedicated and ethical, they too are victims of a toxic environment that undermines their efforts. Their reputations are tarnished by the negligence of their peers, perpetuating a cycle of harm.

## Medical Negligence Takes Its Toll

The consequences of medical errors are profound. On September 17, 2024, flags were placed on the White House lawn to honor those lost to healthcare negligence—each flag, including one for Zander, represented a beloved family member whose life was cut short. This



*Illustration 2: Zander Smith, born with challenges that few ever face, concurred all with dignity and courage until medical malpractice became too much and took his life at only 20.*



poignant display underscores the urgent need for reform. The stakes are too high, and the time for change is now.

### Call to Action

As a victim of this betrayal, I am now an advocate fighting against the corrupt system that took my son’s life. Zander faced numerous challenges and triumphs, but ultimately, it was this flawed system that claimed him. It is my love for him that motivates me to expose the systemic flaws perpetuating medical errors.

Preventable errors devastate over a quarter of a million families each year. Close to 15,000 of them occur in my home state of New York. That’s more than one death—one family devastated every hour. If you struggle to envision yourself or a loved one on this conveyor belt to death, consider your odds. Unless we fix this broken system now, your loved ones could also fall victim to preventable medical errors.

Addressing Lack of Accountability: The perilous reality for survivors is compounded by malpractice lawyers and insurance companies working to cover errors. A negligent doctor experiences only a short-lived concern about being held accountable for a mistake that costs a patient their life. Meanwhile, grieving survivors can’t find an expert witness, convince a law firm to take their case, or navigate a sluggish legal system before time runs out. This leaves negligent doctors free from the consequences, while families are left to cope with enduring grief and suffering.

Overcoming Barriers from Tort Reform: Current “tort reform” legislation makes it nearly impossible for a victim of medical malpractice to successfully file a lawsuit against negligent healthcare providers. This culture of impunity has arisen from an environment where almost no consequences exist for healthcare mistakes. After facing a short statute of limitations—often only one or two years, unreasonable for grieving families—**I urge legislation for an increase in the statute of limitations to at least 10 years to allow adequate time for justice and accountability.**



*Illustration 3: Asking for reform is simply asking for more balance between the obstacles faced by patients and the survivors of lost loved ones and the advantages that the rich and powerful have in controlling the lives of others.*

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This is the death of a fellow human being—two years is an inappropriate and unjust to the deceased and their surviving family.

Improving Visibility and Patient Feedback: I participated in the Patient Safety Day event on September 17, which included "Hill Visits" with numerous Congress members and Senators, organized by Patients For Patient Safety (PFPS-US), affiliated with the World Health Organization (WHO). This initiative seeks legislative reforms for improved reporting of all healthcare functions and patient treatment matters which includes patients along with all other stakeholders. **Strong, widespread support has been demonstrated by the White House and support from all government entities is essential to accelerate this life saving matter.**

Advocating for Reform: While all states except New York have initiated healthcare reform, constant improvement is necessary to prevent further medical errors. A critical step is **urging New York's Governor Hochul to sign the Grieving Families Act.** If enacted, New York could position itself as a leader in meaningful healthcare reform.

## Conclusion

The American healthcare system is in dire need of reform. To restore public trust and ensure quality care for all, we must confront the systemic issues fueling the rise of medical errors. We must prioritize patient safety, transparency, and accountability. The time for decisive action is now.

*What will you do to end healthcare deaths due to preventable medical errors?*



*Illustration 4: The image is a depiction of what is hidden by hospitals around the world, everyday! Unnecessary death due to a negligent doctor's Patients die and families devastate for life.*



*Illustration 5: It happens 1000 times per day and is quietly swept under the carpet. These gruesome images were AI generated just by entering a text version of what takes place every day in our healthcare system.*

## Appendix A:

# You or someone you love will be harmed or killed by preventable medical errors – with supporting data and calculations, where do you fit in?

Medical errors represent a profound and alarming risk within our healthcare system, affecting everyone directly or indirectly. Estimates suggest that between 250,000 to 400,000 deaths occur annually in the U.S. due to these preventable errors. Depending on various calculations, an individual's lifetime risk of dying from a medical error can range from 6.24% to an astonishing 84.8%. This statistic isn't just a number; it signifies that we are all at an unacceptable risk of becoming a victim or knowing someone who is harmed by medical negligence.

The emotional toll of this reality is staggering. Each of us forms deep connections with at least 100 people in our lives. It is likely that we will witness at least one of them suffer due to a medical error unless we advocate for urgent reforms in healthcare safety. The potential grief and loss we face due to these avoidable tragedies are deeply personal and should galvanize us into action.

What compounds this issue is the troubling culture within healthcare systems that often underreports or conceals the extent of medical errors. Many healthcare professionals admit to making mistakes but face little accountability, leading to a pervasive environment where errors go unacknowledged. This lack of transparency suggests that the actual risk of medical harm is even greater than reported figures indicate. In fact, some studies show that nearly 90% of healthcare providers have witnessed mistakes that went unreported, underscoring the systemic failures that contribute to this crisis.

Without immediate reforms to enhance safety standards, demand accountability, and promote transparency, the cycle of preventable deaths will continue. We cannot afford to ignore the implications of inaction. This is not merely a statistical issue; it is a matter of life and death for us and our loved ones. To prevent further tragedy, we must advocate for significant changes in how our healthcare systems operate, ensuring that every patient is protected from the hidden dangers that exist within our current medical landscape. The stakes are far too high, and the time for change is now.

## Detailed Calculations and Tables

The following appendix summarizes key calculations, estimates, and statistical data used to quantify the risk of death due to medical errors in the United States. These figures represent a range of scenarios based on different data sources and methodologies, providing a compelling case for the urgent need for reform in healthcare safety.

### 1. Estimate of Deaths from Medical Errors

Based on credible sources, it is estimated that 250,000 to 400,000 deaths occur annually in the U.S. due to medical errors. This estimate forms the basis for calculating individual and lifetime risks.

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## Scenario Estimated Deaths per Year Due to Medical Errors

Low Estimate 250,000

High Estimate 400,000

### 2. Calculation of Risk per Hospital Stay

Using two different approaches, we calculate the risk per hospital stay of death due to a medical error:

Approach	Patients per Year	Deaths per Year	Risk per Stay (%)
Method 1 (CDC Data)	36 million	250,000	0.697%
Method 2 (Occupancy Rate)	11.8 million	250,000	2.12%

### 3. Cumulative Lifetime Risk (No Hospital Stay Assumed)

This table summarizes the cumulative risk of death due to medical errors over a person's lifetime, assuming an average lifespan of 78 years and no hospital stays.

Age (Years)	Low Estimate (0.366%)	Average Estimate (1.22%)	High Estimate (2.07%)
Birth (0)	0.00%	0.00%	0.00%
10	0.047%	0.157%	0.265%
20	0.094%	0.314%	0.530%
30	0.141%	0.471%	0.795%
40	0.188%	0.628%	1.060%
50	0.235%	0.785%	1.325%
60	0.282%	0.942%	1.590%
70	0.328%	1.099%	1.855%
78 (Avg.)	0.366%	1.22%	2.07%
80	0.376%	1.255%	2.129%
90	0.423%	1.412%	2.394%
100	0.470%	1.569%	2.659%

### 4. Cumulative Lifetime Risk (With Hospital Stays)

This table includes hospital stay risks, assuming the average individual will experience 3 to 4 hospital stays over their lifetime.

#### For 3 Hospital Stays:

Age (Years)	Low Estimate (0.366%)	Average Estimate (1.22%)	High Estimate (2.07%)
Birth (0)	0.00%	0.00%	0.00%
10	0.047%	0.157%	0.265%
20	0.094%	0.314%	0.530%
30	0.141%	0.471%	0.795%
40	0.188%	0.628%	1.060%
50	0.235%	0.785%	1.325%
60	0.282%	0.942%	1.590%

<b>Age (Years)</b>	<b>Low Estimate (0.366%)</b>	<b>Average Estimate (1.22%)</b>	<b>High Estimate (2.07%)</b>
70	0.328%	1.099%	1.855%
78 (Avg.)	0.366%	1.22%	2.07%
80	0.376%	1.255%	2.129%
90	0.423%	1.412%	2.394%
100	0.470%	1.569%	2.659%

**For 4 Hospital Stays:**

<b>Age (Years)</b>	<b>Low Estimate (0.487%)</b>	<b>Average Estimate (1.62%)</b>	<b>High Estimate (2.76%)</b>
Birth (0)	0.00%	0.00%	0.00%
10	0.062%	0.208%	0.354%
20	0.125%	0.417%	0.709%
30	0.187%	0.625%	1.063%
40	0.250%	0.833%	1.418%
50	0.312%	1.042%	1.772%
60	0.375%	1.250%	2.127%
70	0.437%	1.458%	2.481%
78 (Avg.)	0.487%	1.62%	2.76%
80	0.500%	1.663%	2.836%
90	0.562%	1.871%	3.191%
100	0.625%	2.079%	3.545%

**5. Conclusion: Risk Summary**

- **Annual Medical Error Deaths:** 250,000 to 400,000 per year.
- **Risk per Stay:** Varies from 0.697% to 2.12%, depending on assumptions.
- **Cumulative Lifetime Risk:** Between 6.24% and 84.8%, depending on the number of hospital stays and calculation approach.

These tables demonstrate the profound risk posed by medical errors in healthcare and emphasize the urgent need for system-wide reform. The risk is not just statistical—it is personal. Each of us will likely experience loss due to medical error unless we act to change the culture of impunity and underreporting that perpetuates this crisis.

**Closing Remark**

This analysis is based on the best available information, carefully tabulated to highlight that the risk of medical error affects everyone. Feel free to challenge these findings, as no matter whose study you rely on, the conclusion remains the same: we are all at high risk. The 2000 report "To Err is Human" highlighted this crisis, and the fact that little has been done in the past 25 years is simply intolerable. The time for change is now; we cannot afford to wait any longer.