that rate rise will dampen the brisk U.S. economic growth and thus dampen corporate profits in the coming year, hurting stock earnings performance.

"The real reason for this heavy selloff," insists London's Lewis, "is the attempt of the various central banks to drain the huge liquidity from the markets as soon as possible." An old Wall Street adage states that the "job of a central banker is to take away the punch bowl just when the party gets really going." The Fed, having soused the banks late last month, seems to have decided to do just that to the banks. Over just two days, as of Jan. 5, the Fed had drained out of the banking system some $50 billion of the $100 billion-plus emergency liquidity it had pumped in late last year. A similarly large liquidity drain by the European Central Bank is blamed for the sharp market plunges there as well.

"The severe collapse in the U.S. stock market on Jan. 4 was the direct consequence," Lewis says, "of the Fed draining some $35 billion that day." Banks caught short had to demand margin calls from their clients who had borrowed to buy stocks on margin. The result was the hair-raising selloff in Nasdaq and other U.S. markets. "By evening on Jan. 4, the Fed began to chicken out," Lewis explains. They began to add funds back in, even if slightly. That led to the widely hailed "recovery" on the Dow the following day.

"The problem is, the worst is still to come," he adds. "This pause is only temporary. The Fed, I estimate, has to drain another $90 billion, and that will cause at least another 1,000 point drop in the Dow. They are trying to do it in stages, to limit the collateral damage, such as brokers going under."

Here is the deadly dilemma faced by Greenspan and the other central bankers. If they hesitate too long in removing the liquidity, Lewis adds, bond markets will panic and force the market rates on bonds far higher than the already alarming levels of today, on the bet that Fed laxness will guarantee that all the excess money will create huge inflation problems in the next few months.

Sharply higher interest rates would endanger the record levels of corporate bonded debt created over the past five "boom years" in the United States, likely triggering a chain-reaction of bankruptcy defaults by many fledgling high-tech and other companies, in turn spreading a deep economic recession or worse.

At that point, a bond market crisis could easily spill over into a full-blown U.S. dollar crisis, as the record number of foreign holders of U.S. stocks and bonds head for the exit.

On Dec. 28, a week before the market bubble began to deflate, Lyndon LaRouche issued a statement in which he declared, "Some in print, and many more bankers, economists, and statesmen privately, are warning that the world is faced with something far more serious than a stock market crash. The world's financial system, is doomed to a systemic collapse, from which only a radical return to earlier pro-nation-state policies could rescue humanity."

'Experts' ignore role thousands die from

by Linda Everett

One of the leading causes of death and injury in America is medical error, according to a report entitled "To Err Is Human: Building a Safer Health System" (National Academy Press), released on Dec. 1 by the Institute of Medicine (IOM). The report, by the IOM's Committee on Quality Health Care in America, based on a year-long review of hundreds of studies, determined that between 44,000 and 98,000 people die in hospitals every year due to preventable medical errors by doctors, pharmacists, and other health professionals—far more than the number of Americans dying from breast cancer, highway accidents, or AIDS.

As stunning as these figures are, the committee says that these known fatalities are a modest estimate of the magnitude of the problem, which costs the nation as much as $29 billion a year. Practices resulting in preventable deaths, permanent injuries, and unnecessary suffering are also rampant in nursing homes, day-surgery and out-patient clinics, and retail pharmacies.

The report lays out a comprehensive strategy to reverse the crisis, and calls upon Congress to create a new patient safety center to address the basic flaws in the system. Within days of the report's release, President Clinton launched three initiatives to address the problem on several Federal fronts; a Senate Committee held hearings on the crisis, with more planned for the coming year; and Sen. Edward Kennedy (D-Mass.) proposed legislation to require mandatory reporting of medical errors, as the committee also proposed.

There are legitimate medical safety issues raised by the committee that warrant immediate action on state and Federal levels. According to "Incidence of Adverse Drug Reactions in Hospitalized Patients," in the April 15, 1998 issue of the *Journal of the American Medical Association,* fatal medication errors *alone* ranked among the fourth- to sixth-leading cause of death in the United States in 1994. Adverse drug effects are not always preventable, such as when a specific antibiotic is administered to a patient whose allergy has not been previously identified. But, basic flaws in how the health system is organized, and how these flaws lead to preventable deadly mistakes, are well known.

In testimony presented on Dec. 13 to a Senate subcommit-

# of managed care as medical errors

tee, the American Nurses Association (ANA) said that one such flaw is the practice of stocking patient-care units in hospitals with full-strength drugs, even though they are toxic unless diluted. Illegible medical records is another, that can result in a wrong drug being administered. The IOM committee calls for adopting a system-oriented approach to reduce errors, such as implementing standarized medication doses for specific hospital units, and having a hospital's central pharmacy prepare high-risk intravenous drug solutions.

A flaw in the report

However, there is a fatal flaw within the perspective and *non*-findings of the 223-page report itself, which will doom all "patient safety" initiatives and centers—of which there are already many. The tip-off to the problems with the report came at the IOM's press conference, where *EIR*'s Carl Osgood asked whether managed care's cost-cutting regime was a major factor in medical errors—to which committee members said that there isn't enough information to draw such a conclusion.

In fact, the report never mentions the murderous pressures by managed care firms on hospitals to slash patient care costs, and it ignores the decades-long take-down of the U.S. hospital and health care delivery systems by both managed care and market-driven policies—all of which *EIR* has thoroughly documented. The report is comparable to an analysis of the faults in the composition of a building's bricks, while the foundation of the building and the mortar holding the bricks together are crumbling to dust due to major earth tremors. The committee ignored those catastrophic tremors in the health care delivery system, and instead focussed on making the case that "human error" is the cause for these preventable and fatal medical errors. But, as Dr. Judith Shindul-Rothschild, R.N., C.S., Ph.D., professor at Boston College School of Nursing, and a member of the ANA Congress on Nursing Economics, told *EIR,* while a study such as this one is long overdue, "the IOM committee never deals with the system flaws that set up physicians and nurses to make those mistakes."

One need only consider the composition of the committee to see why that is the case, i.e., many have a vested interest in the managed care system. The Institute of Medicine, an arm of the National Academy of Sciences, is a Federally chartered independent organization of scientists. Among the committee's members are the president and CEO of the Kaiser Foundation Health Plan, the nation's oldest health maintenance organization (HMO) conglomerate of for-profit and not-for-profit entities, and the Executive Managed Care Director of the Blue Cross and Blue Shield insurance company. The chair is William Richardson, president and CEO of the W.K. Kellogg Foundation, which funded the shift to neo-Malthusian medical ethics and now promotes welfare-to-work projects. That is, the aim is to balance the government's budget, partly through systemic reform of health care policy—all part of the wrong-headed "post-industrial" policies engineered by Wall Street financial interests which have contributed to our national and international economic collapse.

The committee calls for system-wide changes that strike a "balance between regulatory and market-based initiatives" to reduce errors. But, it is exactly those "market-based" policies, such as managed care, that are murdering thousands, and even entire classes of patients (see L. Everett, "General Welfare Is Being Trampled by HMO Human Rights Violations," *EIR,* Aug. 13, 1999). Such polices, as Democratic Presidential pre-candidate Lyndon LaRouche has declared, are crimes against humanity.

Case studies for disaster

Let us examine some specific crises now unfolding. Shady Grove Adventist Hospital in Rockville, Maryland, for example, is losing its Medicare accreditation after major deficiencies in patient care were found. Maryland health officials investigating more than 100 patient complaints, found cases where hip surgery had been performed on the wrong hip, critically ill patients had been left unattended and died, and other horror stories. In October, the hospital's medical board publicly labelled conditions at the 263-bed hospital "unsafe." Physicians and nurses charge that administrators severely cut back the hospital's nursing and ancillary staff because of payment reductions by managed care plans, HMOs, and Medicare. The result was that a single nurse was often assigned to care for as many patients as are generally cared for by three or four nurses, in addition to transporting patients and moving equipment. The increased workloads by exhausted nurses, physicians said, caused "rampant" mistakes in patient care, with patients consistently given the wrong medications, and physicians' orders for patients ignored.

At Howard University Hospital, beloved by the African-American community in the nation's capital, health professionals held a day-long strike in October, because patient care was suffering from forced overtime and a permanently pared-down nursing staff. *EIR* was told, "Nurses are being forced to care for too many patients. Pharmacists are unable

to effectively dispense medications on a timely basis," while neither dieticians nor social workers can adequately address patients' needs. The problem? Stringent managed care contracts paid the hospital less and less for patient care.

Such policies have become commonplace throughout the United States since the advent of managed care—and more intensely so, whenever financial consultants like the Hunter Group, or Ernst and Young, are brought in to "salvage" hospitals savaged by HMO policies. These consultants and hospital "turnaround specialists," are experts in cost-cutting, which is *known* to cause patient fatalities.

For example, over a decade ago, hired hachet-men at St. John's Episcopal Hospital in Long Island imposed a sweeping restructuring plan that enforced 16-hour days for nurses, shifted nurses experienced in the medical-surgical unit to orthopedic or other units, with no clinical training to prepare them. (They were given aroma therapy, team-building and conflict-resolution sessions, which included watching the film, "Dog Day Afternoon.") Nurses were told: "Get off the train or lie on the track." The "re-engineering," as much as managed care, caused "total devastation," according to hospital staff, from which the hospital never recovered. Nurses are now on strike at another Long Island hospital, North Shore University at Plainview, because they are assigned 16 medical-surgical patients each, and are expected to provide medications, check vital signs and IV bags, and care for patients just out of surgery.

The IOM report never hints at the utter mayhem caused by free-market policies. In one recent survey, 70% of Minnesota nurses report that they are "unable to perform the fundamental duties of nursing"—like feeding patients! Medication or IVs were not dispensed or were given late 22% of the time.

In 1998, the U.S. Agency for Health Care Policy and Research, the same agency which the IOM wants appointed to implement its recommendations, published a study clearly demonstrating a strong inverse relationship between registered nurse staffing and adverse patient events—the fewer the nurses, the greater the number of crises and complications patients suffered (see L. Everett, " 'Managed Care' and Nursing: Back to the 19th Century," *EIR,* June 18, 1999). But, the IOM did not have one practicing registered nurse on its committee. As Chris deVries, ANA Deputy Director of Programs, told *EIR,* "Clearly, if you had a dozen nurses in a room studying this problem, you would come up with a very different report!"

Professor Shindul-Rothschild told *EIR,* "The number-one reason that mistakes are made in every service sector industry, whether it's piloting an airplane or working in a hospital, is because of fatigue, overwork, and stress." Right now, she said, "we have the fewest number of nurses per population of most industrialized countries. We have ratios of nurse to patients that are at their lowest point [i.e., highest number of patients per nurse] in the past two decades"—due to managed care pressures on hospitals to cut their payment rates by drastically cutting nursing and staff. What good are the IOM's remedies, such as using a computer to double-check the appropriateness of medication, if it's going to collect dust because there are not enough nurses and physicians on staff with the time to look at the computer screen? Rothchild asks. "That's the real crux of the matter: Who is going to be at the bedside in adequate numbers so that the ones who are there are not so exhausted that they can't think critically about what's appropriate for the patients."

We solved the nursing shortage of the 1980s by improving working conditions for nurses, she said, but this was reversed overnight in the 1990s, with "selective contracting, the main mechanism that managed care used to rachet down health care costs. [They] pit hospitals against each other and use capitation and other risk-sharing arrangements to force hospitals to cut their deals. Labor was the major component of hospital budget. To rachet down their costs quickly, they cut their numbers of nursing staff."

Shindul-Rothschild said that "in our 1996 *American Journal of Nursing* study, half of the nurses in oncology medical-surgical settings reported . . . an increase in medication errors in the past year. . . . Half of nurses in speciality areas reported *unequivocally* that these preventable injuries were occurring at a rate that had been unprecedented. When you have half the nurses in speciality areas reporting an increase in *any* event in the last year, you have to pay attention to that and look at what other factors are causing that increase. *You can't have in one year half of your labor force suddenly becoming incompetent and making mistakes*—something has happened to the system in which these men and women are working. . . . You would be hard pressed to ignore the fact that this precipitous rise in injuries to patients coincided with a rapid change in the financing of health care from an indemnity [fee-for-service] model to managed care."

"The fact that we have seen a precipitous rise in lawsuits and malpractice cases involving errors made by doctors and nurses also is something that you cannot ignore, given the impact that financing has had on the quality of care," she said. "We've had more laws passed to protect patients since the rapid proliferation of mananged care than we have ever had in the history of this country."

The IOM report can is a useful starting point for the Federal government, as the main authority charged with responsibility to uphold the general welfare of the population, to repudiate the managed-care concept and restore the basis of health care delivery and policy to that outlined by the 1946 Hill-Burton Act. That Act mandated, by Federal law, that the country must provide the critical infrastructure and staff necessary to provide for the medical needs of every member of every community, regardless of race, creed, or ability to pay. If that objective is reached, one major cause of medical errors—market-based "health care"—will be eliminated.