No Excuses: The Reality That Demands Action

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Abstract: At least six excuses sabotage dramatic improvement in hospital safety. Sometimes they are voiced, but more often they are the elephants in the room, representing barriers to action that no one wants to recognize. They are ever present in hospitals across the country and the excuses they embody include: (1) the business case; the pure economic return on investment (ROI), often argued by CFOs; (2) the evidence for action excuse—that there is not enough compelling evidence to act immediately; (3) the capacity and resources excuse—that balancing act of operations and resource allocation; (4) the absence of leadership and values, when our leaders fail to live the values of the organization; (5) power and autonomy excuses, those hierarchical issues inside an organization and secondly, the power dynamic between those inside and doctors outside who do not work for the hospital; and lastly (6) disclosure fear—that the disclosure of errors to patients and families will increase malpractice claims and public shame.

Key Words: adoption barriers, autonomy, business case, capacity, disclosure, hospital safety, patient safety, power, values, leadership


INTRODUCTION

This proceedings article captures the essence of the opening session of the 7th Annual National Patient Safety Foundation (NPSF) Congress. The session was divided into short, rapid-fire sections in which thought leaders framed each excuse, defined the reality dispensing the excuse, and shared their argument to leaders for real action. Video interview segments from front-line leaders reinforced the undeniable message for action (see Appendix).

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The vision of the plenary session and the educational materials that would ultimately follow it was to reach a broader audience than just the 1500 people who attended it. It was to have nationwide impact on the growing crisis of healthcare systems failures.

The entire video production of this session and a set of ‘must-see’ resources are available, complimented by a full bibliography for this material. See end of article for the web address to access this information.

THE ELEPHANTS, THE PROPHETS, AND THE MIAs


Our session has three patient safety targets: the elephants, the prophets, and the MIAs. First, there are elephants in the room that sabotage patient safety initiatives in frontline hospitals everyday. They are the excuses that we rarely talk about, yet they cripple true entrepreneurship for quality.

Second are the patient safety champions—the “prophets who hath no honor in their own country.” They are the Quality and Safety Leaders who return from meetings like the NPSF World Congress, freshly energized by stories of real impact, shared by the innovators, only to hit a wall of inertia, armed with nothing more than citations and anecdotes.

Third are the MIAs—the missing in action. Those are hospitals that do not even send staff to patient safety meetings because they are so engrossed in the action of the front line. Desperately trying to cost-contain themselves into financial success, they miss the boat. These are the hospitals that are not here today.

The ongoing research from our 2100 hospital TMIT National Test Bed and the results of the Leapfrog surveys have given us a unique picture of care at the front line. It is very clear that the rate of system failures and harm to patients is growing faster than our adoption of patient safety practices.

We clearly have a crisis on our hands.

Today our speakers seek to face the elephants head-on, arm the prophets, and reach out to the missing. And the NPSF and TMIT organizations seek to equip you with the tools to make a sustained impact on patient safety.

For the months to come, these messages from our wonderfully distinguished panel are complimented by the clinical and multimedia work of scores of men and women who have dedicated their careers to making patient safety a reality.
who are not present at this session. We pray that these collective efforts will impact your hospital and the patients you serve.

**Opening Video**

**Dr. Denham:** At least six issues sabotage dramatic improvement in hospital safety. Sometimes they are voiced, but more often they are the elephants in the room that no one wants to recognize. They are ever present in hospitals across the country. They include (1) the business case; the pure economic return on investment (ROI), often argued by CFOs; (2) the evidence for action for which there is not enough compelling evidence to act now; (3) the capacity in resources excuse—that balancing act of operations and resource allocation; (4) the absence of leadership and values, when our leaders fail to live the values of the organization; (5) power and autonomy excuses, those hierarchical issues inside an organization and secondly, the power dynamic between those inside and doctors outside who do not work for the hospital; and lastly, (6) disclosure fear—that the disclosure of errors to patients and families will increase malpractice claims and public shame.

Thought leaders representing certifying and quality organizations, front-line hospital systems and even consumers will lead this program. They will accomplish three objectives:

1. They will frame each excuse.
2. They will define the reality for each excuse.
3. They will share their argument to leaders for action.

**Dr. Denham:** The message of each of the speakers is his or her own. A number of the speakers used a role-playing technique to illustrate how typical excuses play out at the front line. Additionally, messages from front-line leaders were captured in various environments, assembled by TMIT videographers from the TMIT library, and played for each excuse.

**EVIDENCE FOR ACTION**

**Dr. Denham:** We will start with the issue of “Evidence for Action.” Dr. Daley, please illustrate for us the issue of Evidence for Action—the ever-present excuse that we hear from clinicians and administrators—that there just is not enough evidence to act now.

**Jennifer Daley, MD.** Chief Medical Officer and Senior Vice President, Office of Clinical Quality, Tenant Health Care. Dallas, TX. Dr. Daley is a national champion for safety and quality.

So, join me in taking a walk around a typical American hospital early in the morning. The parking lot is slowly filling up with doctors, nurses, and pharmacists coming in for the beginning of the day. The night shift is gradually waking patients to take their vital signs and weights so they can give reports to the day shift. In the operating room locker room, several anesthesiologists are changing into scrubs. A transplant surgeon calls across the locker room: “I knew it. Those guys at Duke are turkeys. That can’t happen here. That surgeon at Duke must have been really stupid not to check the ABO compatibility himself. If it were me, I would’ve checked it myself. After all, doctors are the only people who are really responsible for our patients’ safety. The buck stops here.”

In the executive suite, the hospital Chief Executive Officer (CEO) is meeting with the Patient Safety Officer (PSO) and the Chief Nursing Officer (CNO) to discuss the implementation of the 100,000 Lives Campaign. The CNO and the PSO have been approached about joining the initiative and are briefing the CEO about the six interventions the hospital would have to implement. Reviewing the 100,000 Lives briefs, the CEO stops at some of the estimates of the number of patients who are harmed in hospitals each year and the estimates of deaths associated with medical errors. “I just don’t believe the data. Who did that study that showed over 100,000 patients die every year from errors?” The CNO tells him about the studies of medical negligence from New York, Utah, and Colorado. He responds with disdain. “I knew it. These numbers are from a bunch of lawyers from Harvard. That explains why I don’t believe these numbers. Why, if those numbers are true, we “kill” at least a patient a week here and I know that isn’t true!”

In the labor and delivery suite, the night shift team is cleaning up after an emergency C-section. The obstetrician has just left the room patting himself on the back for a case well done, basking in the praise and thanks of the new parents. Both baby and mother are doing well. The circulating nurse on the case is working with the operating room (OR) tech to clean up the room and the instruments. She thinks to herself as the obstetrician walks out the door: “Boy, he may think he’s the captain of this ship, but he doesn’t know how much we do to clean up after his mistakes. We would have had a retained sponge if I hadn’t triple checked the sponge count. I’ll bet my next paycheck he’ll never come to a team training seminar and learn that labor and delivery (L&D) is about teamwork.”

**Dr. Denham:** Dr. Wachter will now frame for us the reality regarding Evidence for Action. Is there evidence for immediate action for leaders and are there resources that can help us with preventable harm?

**Robert Wachter, MD.** Professor and Chief of Medical Service, University of California Medical Center, San Francisco, CA. Editor of AHRQ Patient Safety Network (PSNet), a national web-based resource featuring resources on patient safety. Co-author of the book “Internal Bleeding.”

It is a pleasure to be here. When the first Institute of Medicine (IOM) report was released in 1999, it actually was a legitimate excuse to say that the evidence base for safety practices was weak. It no longer is a legitimate excuse. I helped edit a report for the Agency for Healthcare Research and Quality (AHRQ) a couple of years ago that looked at evidence-based safety practices. Even back then, there were dozens of practices that had very strong supportive evidence, and that has only gotten better. We just launched the AHRQ Patient Safety Network (AHRQ PSNet). One of the things we do is scan the world’s literature in patient safety trying to find the newest tools, resources, and articles. We have enough space for 10 to 12 new entries each week, and I can tell you that I never
have any trouble finding enough important new literature to fill
that space.

In fact, it seems to me that the problem has shifted over
the past few years from an environment in which there was not
sufficient evidence on which to choose safety practices to one
in which there really is a treasure trove of evidence. And so our
most important job has become determining how to prioritize
among practices we know are good things to do. Just look at
the evidence: computerized patient order entry (CPOE), all of
the practices in the 100,000 Lives campaign, the Leapfrog and
NQF practices, practices supported and promoted by the Joint
Commission on Accreditation of Healthcare Organizations
(JCAHO), nursing ratio, resident duty hours and teamwork
training—these are all good things to do. But no organization
can do all of these things at the same time. However, the fact
that there are so many is not an excuse for inaction.

At UCSF, where I work, we try to divide our efforts in
patient safety into three relatively equivalent buckets. The first
are things that we have to do because of regulations, laws, and
JCAHO standards. The second involves reacting to problems,
incident reports, and adverse events. Finally and importantly,
we try to reserve about one third of our time for proactive
implementation of safety practices. Even for problems that
we’ve not yet seen (at least that we know of) and are not yet
JCAHO standards, we are proactive about corrective action
where the evidence is quite strong and we think it is the right
thing to do. I think it is important to reserve that kind of time
and energy. Increasingly, I believe that, when you hear the
push back ‘Where’s the evidence?’, what people are really
saying is ‘This is hard’ or ‘I don’t want to’. Passive aggressiv-
ness is being cloaked in the very nice garb of evidence-
-based medicine, and I think we just have to get over that.

One final comment; I’m a big believer in evidence-based
medicine. I work in the middle of a big academic medical
center and it’s not hard to find instances in clinical medicine of
things that should have worked, but proved not to; estrogen
replacement therapy being one of the more recent examples.
Yet, there has never been a randomized control trial of the use
of parachutes and we did not need a randomized controlled
study to convince us to barricade the cockpit doors after 9–11.
Sometimes, ‘let’s just get on with it’ is exactly the right mantra.

**Dr. Denham:** Thank you. Let’s hear excerpts from
the front-line caregivers and our experts.

### Evidence for Action Video Montage

**Julie Ann Morath, RN, MS.** COO, Children’s Hospi-
tals and Clinics of Minnesota. Ms. Morath was honored to be
the recipient of the first John M. Eisenberg Patient Safety
Award in the “Lifetime Achievement” category, bestowed by
NQF and AHRQ “for her tireless and successful work at
Children’s Hospitals to introduce a culture of patient safety
that promotes the sharing of information about errors to
improve safety in the care of patients.”

This is where I come down. If there were a disease or if
there were a new medical finding that carried the same lethality
that medical accidents in health care do, we would be all over
it. Why patient safety isn’t looked at in that same way is
beyond me. It’s a time to take off the blinders and recognize

**Dr. Denham:** The 100,000 Lives campaign was
launched by the Institute for Healthcare Improvement (IHI)
in December of 2004, led by Dr. Don Berwick and his world-
class faculty and staff. It challenges hospitals to adopt
evidence-based practices that will save 100,000 lives in less
than 18 months.

**Donald Berwick, MD, MPP.** President, CEO, Institute
for Health Care Improvement.

This is how we’re going to do it. We’re going to take
some things we know about lifesaving changes and care
systems and processes and we’re going to make them our
standard, our national standard. We’re going to harness what
we know everywhere. You be the judge. Check the data. Check
the reports. See what level of confidence you can build. You
can find fully referenced literature, journal papers, studies,
meta-analyses, and review papers. They will provide you the
evidence. We’re going to give you story boards and contact
names for the organizations that have tried these changes and
reported back the results. The tasks are specific; they’re
countable; they’re scheduled; they’re either done or not done.
Maybe doesn’t count. Later doesn’t count. Some is not
a number. Soon is not a time.

**Kenneth Kizer, MD, MPH.** President and CEO,
National Quality Forum.

There is plenty of evidence to support what we’re doing.
That doesn’t mean that we have all the answers or that the
evidence-base is good enough. It has to get better; however,
we’re starting at a level that, certainly the evidence we have is
sufficient to justify, is moving forward and starting to go in the
right direction. The evidence-base will build and get better
over time. The measures will get better over time. They’re not
perfect. There’s clearly room for improvement there and we
will improve them over time. But again, where we’re starting
from, we have a long way to go and I think that we’ve just
started what’s going to be a long journey.

**David Bates, MD, MSc.** Chief, General Medicine,
Brigham’s and Women’s Hospital. National expert in adverse
drug events.

I think the NQF Safe Practices represent the single best
compendium of practices for improving safety for hospitals in
health care. There are 30 of them. It’s just a great set of things
for hospitals to look at in terms of improving safety.

**Michael Leonard, MD.** Physician Leader for Safety,
Kaiser Permanente and a national thought leader in team-
based training.

The benefit of applying basic tools and behaviors to
increase collaboration, enhance communication and teamwork
is that people work together better. We see fewer mistakes. We
see lower nursing turnover and when we measure with safety
attitude instruments, we see substantial positive shifts in how
those people perceive their work environment. Frankly, it just
makes sense.

### LEADERSHIP AND VALUES

**Dr. Denham:** Sue Sheridan, please frame for us, your
perspective as a consumer. Are our healthcare leaders living
the values on the wall or are we really living unwritten values that are driving our values?

**Sue Sheridan, MIM, MBA.** Cofounder and VP, Consumers Advancing Patient Safety. Eagle, ID. Founder of Parents, Infants and Children with Kernicterus. (PICK)

I lost my husband to a medical error 3 years ago. As a matter of fact, he chose to die right here at Disney World. My little boy, Cal, suffered brain damage from untreated and untreated jaundice; so, he now has cerebral palsy and other neurologic disorders. After witnessing two very profound medical errors in my family, I asked myself ‘How could this happen and who are our leaders?’ In my own analysis of leadership, I believe that leaders need honor. They have honesty, profound commitment to values and doing what is right. They live their code of ethics and their institution’s mission, which in turn, breeds trust. They commit to humanity. They are courageous. They have the willingness to explore a new territory, to take chances, the willingness to fail and the willingness to try again, the willingness to change the status quo. They do not do what is easy. They have the willingness to accept risk and they are adventurous. They also are wise. They have knowledge, curiosity, creativity, and they’re veterans of adversity. They are passionate. They love what they do and they do what they love. They have commitment and tremendous energy. They create contagious enthusiasm in their organization. They have truth to self. They are inspiring and they are persistent and they have hope. They’re living the future that they envision. They embody optimism. They’re always in pursuit of bigger ideas.

I guess the excuse for poor leadership is a departure from these values in the face of fear, in the face of fear of litigation, in the face of not being accepted, in the face of challenging legal counsel and medical staffs, in the face of bottom-line management, evidence-based medicine, and pressure to protect the public image. I have heard from leaders that sometimes they are too busy or they simply pass problems on to someone else. I advise leaders to live, breathe, and eat your institution’s mission. Put it right on your desk and let it be your guide.

**Dr. Denham:** Lillee Gelines, as both a nurse and health care thought leader, would you please frame for us, the current reality of leadership at the front line. What are our good leaders doing and what is happening at the front line? What’s the reality?

**Lillee Gelines, RN, MSN.** VP and CNO, VHA Inc. Irving, TX. Nationally recognized thought leader in hospital performance improvement.

Sue really has framed the excuse extremely well. United States health care has great leaders, just too few of them. Why is it that with over 5000 hospitals in America, less than 15% have designations of excellence like Baldrige, Magnet, Top 100, Employer of Choice? Why? The behaviors of leaders in those top organizations have been studied. There is evidence. That’s the reality. Clinically and administratively there is no lack of evidence. There is a lack of execution. Why? I love the book “Good to Great” written by Jim Collins. You’ll see that in your bibliography. Jim Collins said, “the path to greatness, it turns out, requires simplicity and diligence. It requires clarity; not illumination. It demands each of us to focus on what is vital and to eliminate all the extraneous distractions.” For us, what must we stop doing? Why? Because we have to start doing a few right things.

The current reality of leadership in America’s hospitals has three basic tenants. First, hospitals that are succeeding with exceptional clinical quality outcomes have leaders that create the vision, live the vision, and communicate it well. Second, we find one single differentiator between outstanding hospitals and poor performing hospitals: uncompromising commitment to values and standards. Third, there is evidence-based leadership in management that has as much science-based as evidence-based clinical practice. That evidence-based leadership in the literature confirmed our opinions—things like creating and sustaining trust, actively managing change, and involving workers in decisions.

It is clear that the difference between compromising and uncompromising leadership behavior is evidence-based. So, know these key differentiators. Is performance excellence in a hospital the floor or the ceiling? Is it the valley or the top of the mount? That is the debate when in reality, performance excellence in outstanding hospitals that have leadership excellence should be our standing operating platform. Failure is not an option.

**Dr. Denham:** Few would disagree that we have a leadership vacuum in our industry. We certainly have a lot to learn from other industries and the front line.

**Leadership Video Montage**

**Dr. Denham:** Without vision, our people will perish. It is time for our leaders to step up and live the values of patient-centered care. Jet Blue and Southwest Airlines have overcome even greater challenges than we have in health care. Ann Rhoades, the guru of both of these companies cites one common denominator—leadership.

**Ann Rhoades.** President, PeopleInk. Jet Blue Founder. Southwest Airlines Leader.

You know, what is interesting is that we always have these words on a piece of paper, but if you look at the behaviors of the leaders, we can tell you what the values really are. There are always stated values and there are lived values. The lived values are the ones that depict and are emulated everyday in terms of behaviors of those leaders and it starts at the top.

Leaders drive the values. Values drive the behaviors and behaviors drive the quality of care received in a hospital. If you want to change and improve that quality of care, you have to go back and start with the leaders. There is just no other way to do it.

**Greg Meyer, MD.** Chief of Staff, Massachusetts General Hospital. Co-Chairman, NQF Safe Practices Program.

If I could speak to a board member today, here’s what I would tell them. What we need to do is have board members who pay an equal amount of attention to quality and safety issues. As a board member, you need to be as informed on how you can learn about what is going on in quality and safety in your institution as you are about looking at the profit and loss statement. Hold our feet to the fire. Help us move forward, because you are the ones that provide direction to us.
Denham et al  

Ginny Ueberroth. Trustee, Hoag Hospital. Newport Beach, CA.

When we found out how far quality has slipped in all of our hospitals today, we were shocked. As trustees, we have the responsibility to bring the resources to bear to bring quality back to the level it should be and that we all deserve. You know, this quality issue is never going to stop and as a trustee it’s very important that we follow it everyday and that we continue to raise the bar as we move forward.

Chris Queram, MPH. CEO, The Alliance. Director, JCAHO, NQF, and The Leapfrog Group.

In Wisconsin, there are a number of promising voluntary reporting initiatives that have, at the core, a willingness on the part of executive leaders of many of our leading hospital and medical group organizations to stand in front of audiences and say we have far too much variation in clinical practice. We commit far too many mistakes. We haven’t done enough to learn from other sectors of the economy that have shown that they can engineer and re-engineer their processes to continuously higher levels of performance at reduced cost. We have not done a good job of learning from those examples. To me, that is an excellent illustration of the type of leadership that we need to see more of to be successful in our efforts to improve and transform our industry.

David Classen, MD, MS. Associate Professor of Medicine, University of Utah.

As organizations move down this road in a process of self discovery and building awareness, they realize that there are lots of areas where we could markedly improve the safety of care we offer. I think it’s up to the physician community to really embrace a number of these areas and lead them to successfully improve this. After all, physicians certainly have led previous efforts when they’ve discovered serious problems in health care. It should be no different this time.


Without leadership from the top of the organization and without strong values constantly communicated and lived out, there would be no progress at all. Every hospital and health system in America is faced with priorities and challenges coming from every direction; but when you sort them all out, none is more important to your relationship with patients, the community, and your obligations to front-line caregivers than keeping safety and quality at the top of the agenda.

Dr. Denham: It starts with leadership. It ends with leadership. It is all about leadership. I think our panel all would agree that we could have a whole session on leadership.

BUSINESS CASE

Let’s move on to the business case for patient safety. Dr. O’Leary, would you please frame the business case excuse for us—the pure return on investment (ROI) excuse made by hospitals for not investing in patient safety?

Dennis O’Leary, MD. President, Joint Commission on Accreditation of Healthcare Organizations. Chicago, IL. Dr. O’Leary is a steadfast champion for patient safety.

Let us be clear at the outset that the business case, as used in this context, needs to be defined in strict financial terms: a return on investment that matches or exceeds the original investment. This is of particular practical importance because a significant proportion of hospital CEOs are former CFOs and/or come from hard-nosed MBA education and training platforms. If the business case is going to be argued, it will need to be framed in their language and on their terms.

There are clearly dramatic examples of safety-related wastage of dollars in health care and equally dramatic examples of interventions that produced major dollar savings, but the sobering reality is that those who make significant investments in patient safety interventions—that is, organization leaders—are often not the same parties who reap the financial benefits of these interventions. That’s good news for purchasers and payers, but bad news for CEOs. That basic misalignment of incentives raises poignant questions as to “Whose investment is this anyway?”

Further, the fee-for-service payment system introduces additional perverse incentives. Here the care of patients with iatrogenic injuries may lead to increased reimbursements by private sector payers and through up-shifting of patients to more lucrative DRG categories. Conversely, successful patient safety interventions, for example reductions in adverse drug events or postoperative wound infections, can place organizations in financial jeopardy simply by reversing these revenue shifts. No good deed shall go unpunished.

Finally, there is the fundamental problem that payers, beginning with the Medicare program, pay exactly the same dollar for safe care and for unsafe care, for high-quality care and for truly lousy care. Most CEOs are strong advocates for patient safety and high-quality care, but it is very naive to believe that the central message of the current payment system is lost on them.

Dr. Denham: Dr. Bagian, could you address and frame for us, the argument for investment in patient safety? What is the truth and the reality, at least at this point in time, about the ROI on patient safety?

James Bagian, MD, PE. Director, Veterans Health Administration, VA National Center for Patient Safety. Ann Arbor, MI. Dr. Bagian is a former astronaut and one of the leaders of the stunning performance of VA hospitals.

I think there are many excuses that Dr. O’Leary just went over. They are certainly out there. There certainly are problems with misalignment; except I would say there are many places where there are alignments and those alignments more than make up for the reasons or rationale you might use to not go forward. I think one of the things people often talk about is the cost of patient safety and the cost of various modalities they might use, but they don’t view it necessarily from the context of “What do we get for the cost of that investment?” There is cost to everything. What do you get for back for incurring that cost?

For example, if we look at direct cost benefits of patient safety activities in our facility, we see that root cause analysis (RCA) takes, on the average, about 40 staff hours to analyze one incident. That means if you do 12 a year, that’s a quarter of an FTE (full time equivalent employee). That’s nothing. No manager manages their time so carefully. They do not know where a quarter of FTE went in their entire organization. More
people worry about and spend more time on what happened on “Teen Idol” last night on TV than a quarter of an FTE. So, let's get serious. Tangible benefits come out of these RCAs. For instance, we’ve had ventilator/humidifiers that are FDA approved that can result in the drowning and death of patients. When we did the root cause analysis on this and understood it, we found out there are actually humidifiers for ventilators that not only will not drown the patients but also, for a 300-bed hospital, can give you an average savings of approximately $114,000 a year on a recurring basis. That’s real bottom-line money that now is available for other things. It more than pays for the cost of a patient safety manager forever because it's a recurring savings.

We find, with airway management, that you learn ways of optimizing where you’re using the CO₂ detectors and esophageal detectors, which cost you about $150 for every detected esophageal intubation. What is the average cost of an esophageal intubation? In our facilities, it’s about $25,000 in additional care. That doesn’t count the tort claim or the human suffering; $154 to save $25,000. I don’t know. I’ll have to get my calculator out and I’ll try to figure out if that makes sense. Maybe you can help me.

Things like the electronic medical record (EMR): if you look at the President’s Information Technology Task Force report, they found that one in five laboratory tests is reordered because people can’t find the results from the previous laboratory test. One in seven hospital admissions occur because they can’t find the records on the patients. They say “What the heck. Let’s admit them.” In the VA, we have a very highly sophisticated computer medical record system. We spend $78 per patient per year for the whole system. I wonder if this means it pays to avoid one in five laboratory tests and one in seven admissions. I think it probably does.

We can look at the fact that they all pay the same. I think there are actually studies in the private sector looking at surgical care costs for an uncomplicated surgical case where, on the average, the hospital takes in approximately $14,000. For a complicated case, they collect approximately $22,000 (Dimick JB, Karia RJ, Das S, Weeks WB, Campbell DA. Who pays for poor surgical quality? Building a business case for quality improvement. In review.) Unfortunately, the cost for the uncomplicated one is about $10,900; $10,900 means they yield approximately $3100 and the profit margin is 23%. On the complicated one, however, the cost is about $21,200. That means they yield approximately $800 profit for a margin of 3.4%. Does it cost more? Sure it does. Do they make more? No they don’t. Who does it really cost big time? The insurers pay 54% overall more and the hospitals make less. That’s not smart business.

There are indirect costs like brand equity. What does it cost to have your brand tarnished? Hospitals spend tons of money to show they are better and that they are the hospital you want to go to. We heard some hospitals’ names earlier in the morning. You can bet they would like to be out of that spotlight. What does it cost to do that? Just avoiding the negative spotlight is worth money and you don’t even have to count that. No CEO wants to be on the front page of the paper or be interviewed on ‘60 Minutes’ as to why they transplanted the organs into the wrong patient.

Finally, it just makes sense. You don’t have to have an I.Q. much above room temperature to see the numbers add up. The thing is, we need to do it. Not only is it the right thing to do, but it pays for our patients, our staff, and our institutions in general.

Dr. Denham: Now for messages from the front line and leading experts regarding the business case.

Business Case Video Montage

Nancy Foster. Senior Associate Director, Policy, AHA and NQF Representative.

There is a strong business case for patient safety. Not for everything, not for every action a hospital might take. Sometimes they’ll engage in patient safety improvements that will simply be for the benefit of the patient. But in many cases, hospitals have reported to us that the patient safety programs they have introduced have really solidified the processes that they’re using in the hospital. As they are improving those processes, the end result is that they have reduced the cost of caring for patients as well.

Lowell Kruse. CEO, Heartland Health Care. St. Josephs, MO.

A defining moment for us in our organization was one particular January. This was in the middle to early 1990s. We lost somewhere in the area of $800,000–$900,000. I can’t remember the number, but I remember going down to the Chief Operating Officer’s office and saying “You know, if this happens again or if this doesn’t get reversed in some fashion, either you’re not going to be here or I’m not going to be here or neither one of us is going to be here. We’ve got to do something different.” And that particular day—I remember it like it was yesterday—we said “We are going to do something different.” We didn’t know exactly what that was going to be, but we committed ourselves to focusing on internal quality improvement. We felt like that was the only thing we really could control. The thing we’ve learned is that this continuous improvement notion is just a continuous learning process and you have to start with the passion and commitment of the board and the leadership of the organization and then never let up.

Dr. Denham: Leapfrog represents more than 160 Fortune 500 companies, and other large private and public sector healthcare purchasers who represent more than 34 million covered lives. Wielding more than $62 billion annually in purchasing power, the Leapfrog Group has clearly caught the attention of hospitals and caregivers.


Our goal is to save lives and reduce preventable medical mistakes by giving consumers the information they need to make more informed medical choices.

Arnie Milstein, MD, MPH. Co-Founder and Board Member, The Leapfrog Group.

My message to CEOs is if you bet your job on high-yield performance improvement, the market will reward you.

Dr. Denham: In 2004, more than 1000 hospitals participated in the Leapfrog survey, addressing the NQF ‘Safe Practices for Better Healthcare.’
Dr. Kizer: There is no question in my mind whatsoever that what Pay-For-Performance does is make quality improvement your essential business strategy.

Dr. Denham: Chris Querem, you have a very rare perspective, being not only a representative of the purchasing community, but a board member of the Leapfrog Group, a board member with JACHO, and a board member with the NQF. Would you say, to a CFO today, that they should be concerned about revenue preservation if they are not seeking to improve quality in patient safety?

Chris Querem: Absolutely, because I think that purchasers, both public and private sector, are beginning to rethink traditional ways of reimbursing, which is to buy volume of services and begin to look at ways to buy quality and to create incentives for hospital organizations to improve.


Joan Davis, one of our trustees and I were on The Cooper Health System Board in the mid and late 1990s when we were experiencing significant financial turmoil. Literally, we were measuring cash by the hour as opposed to the normal fashion of measuring cash. The direct link between what we do and the benefits that we realize from a quality perspective have, in their very essence, provided us with significant financial benefits that really are driving and have driven, over the past 3 years, the turnaround that has occurred here.

Dr. Denham: Many hospitals in our TMIT test bed are experiencing this same impact of quality and safety on the bottom line as Cooper Health has. These stories abound across the country. We think this is an overused excuse and it is time to set the record straight.

CAPACITY AND RESOURCES

Dr. Denham: Lillee Gelines, would you please frame for us, the typical excuses articulated by operators and COOs regarding this tradeoff of capacity and resources and mapping those together in the context of today’s constraints?

Lillee Gelines: There are seven letters in the word “excuses” and seven big tradeoffs between quality and capacity. Ever heard these excuses? We can’t make this just a business case. We can’t measure the value of good people. We can’t correlate turnover with morbidity and mortality.

Our first big excuse is no money. We have to cut our way to a black bottom line and we get less and less each year; so this is the way we have to manage.

Second, we have to take care of what physicians want, first at the expense of the work force and the safety of patients, because without the doctors we’re out of business. We can’t possibly have quality report cards for each physician. We don’t want to go there.

Third, we hire warm bodies because we have no choice. We can’t possibly hire for values and character. Hire for attitude and culture? Train for skill? You’re kidding.

Fourth, fatigue and error don’t really apply in health care. We have employees work 10- and 16-hour shifts all the time. Patients never ask their nurse “How long have you been working before you start my I.V.?”

Fifth, we tolerate nonsense all the time. Why do we benchmark, with each other, things like “What’s the benchmark for medication errors?” That would be zero.

Sixth, we can’t focus. We thrive on fad-surfing and flavor of the month. We are bored with the consistent approach. Look how many times we’ve changed what we call quality improvement initiatives. I’m 63 years old and I can give it away in my history: quality circles, TQM, CQI, 6 Sigma. Our excuse: Let’s focus on what we call it and not on what we do.

Seven, we discount administrative evidence. The Institute of Medicine has put forth how to keep patients safe. In 2001, the Joint Commission published on the role of nursing in preventing sentinel events; and yet, I find less than 25% of all Chief Nursing Officers in America have read it. Linda Aikin published, in JAMA in 2002, those famous words “at present staffing levels, more than 20,000 patients will die each year.” Have we applied that administrative evidence to the clinical picture? Our biggest excuse is that we don’t recognize that our ultimate patient safety problem is “no people, no care.” At Walt Disney World they say that fantasy is a necessary ingredient. Well, I guess, that’s our current approach to work force and resources in health care.

Dr. Denham: Dr. Daley, would you expand on the excuse of capacity and resources?

Dr. Daley: The number of these excuses is growing everyday. One is: “We can’t afford it.” The truth of the matter is that unsafe care costs much more than doing the right thing the first time, every time. Just consider that, with a few simple interventions, we can prevent most cases of ventilator-associated pneumonia. One case of ventilator-associated pneumonia prolongs the patient’s length of stay by 10 to 14 days and adds $40,000 to the cost of the admission; not to mention that nearly 50% of patients with ventilator-associated pneumonia have permanent serious sequelae or die as a result. On average, one bloodstream infection from a central venous catheter prolongs the length of stay by 7 days and adds an incremental $4000 to $30,000 depending on the situation. Patients with bloodstream infections from central venous catheters are one out of three times more likely to die as a result of the infection. Physicians are inherently skeptical. They do not respond to exhortations to “do the right thing”; however, they do respond to well-analyzed, accurate information about how they practice in comparison with their peers. They will change their practice when compared objectively with others. It is essential to show them their own performance in comparison with their peers to drive change in behaviors. It also requires good data, good analysis, and a strong physician champion to keep the physicians motivated to promote change.

Excuse two: “Let’s hire crummy staff.” Hiring staff with minimum skills, who lack the values and character consistent with the healthcare organization’s values, is an extraordinarily expensive strategy. In a typical 180-bed community hospital with average vacancy rates of 12% for pharmacists, nurses, radiology technicians, and other professionals and a turnover rate of 30%, which is representative of many hospitals, the annual replacement costs are $4 million per year, which is 20% of the entire HR budget for those employees. Those costs do not include the costs of orientation and training in the first year on the job, which are estimated to run about $60,000 per
employee. Hiring the right employees with the appropriate skills and values and working to retain them in the work force is much less expensive in the medium and long term.

Excuse three: “It’s okay to be tired.” Scientifically sound studies of professionals working in high-reliability industries such as aviation and nuclear power plants have demonstrated dramatic increases in human error after 7 to 9 hours on the job. We have sound scientific studies of young doctors who are working in our academic health centers just in the last year that show sleep deprivation and long working hours result in significant increases in medical errors that harm patients.

Dr. Denham: Now for a clear message from the front line and cross-industry experts.

Capacity and Resources Video Montage

Julie Ann Morath: As the Chief Operating Officer of Children’s Hospitals and Clinics of Minnesota, I have the responsibility to deliver the bottom line of the organization. So, I am managing and balancing resources and capacity everyday. When our organization made the decision to prioritize patient safety as job one and weave it into the fabric of everything we did, we realized improved operational, financial, and clinical outcomes.

Ann Rhoades: Throughout my career, I’ve always heard the argument, whether it’s a hospital administrator or the CEO of an airline, that capacity and resources are issues when they are talking about quality. The fact of the matter is that in the very best companies that I’ve ever had the pleasure of working with, and that’s Southwest and Jet Blue, they understand that you never give up on quality. Eventually what happens is that in those organizations that get it, that put quality first, they understand that it will also show up on the bottom line and they’re the two making money.

Allan Frankel, MD. Director of Patient Safety, Partners Healthcare System, Boston, MA.

This issue with capacity and resources is tough. The safest hospitals are going to be running at about 80% capacity. We know that our good institutions are forced to run at 105%. We have to have the greatest conscientious efforts toward safety and quality as the hospitals become more full.

Ramin Khorsani, MD, MPH. Vice Chairman, Department of Radiology, Brigham and Women’s Hospital, Boston, MA.

At a time when Medicare is running out of money to pay for our health care, we’re spending $75 to $100 billion a year in medical imaging and we know at least 10% to 20% of that is wasteful. Imagine what we can do with money in our system. The Institute of Medicine has documented waste in that is wasteful. Imagine what we can do with money in our system. The Institute of Medicine has documented waste in hospital can boss around everybody else, but not the doctors. Things can never change. I know the mission statement of many hospitals or healthcare organizations may read “safety and quality,” but perhaps it should say “at some point they’ve got to retire.”

There are a few examples of organizations in which the doctors do work for the system and patient safety does feel like a team effort. I think Kaiser Permanente and the VA are really the best examples of that; but these are the exceptions. In fact, those institutions that spent the 1990s buying doctors’ practices—largely because some smart healthcare consultant said this was a good idea—are now hiring those same consultants to sell off these practices as quickly as they can. Those consultants have some great job.

Sure I heard all about how the pilots got religion about safe practices and culture change, but they don’t need a business case for safety. They have the “Will I get home tonight to ever see my family again?” case. We can’t match that one.

Finally, all of this no blame “It’s the system,” stupid stuff sounds good; but it’s more of the politically correct “I’m-fat-because-nobody-at-McDonald’s-told-me-the-cheeseburgers-were-fattening” dysfunctional modern American culture stuff. It’s just “feeling good” pap designed to get everybody all warm and fuzzy when everybody knows the problem relates to incompetent doctors and nurses. But the providers, particularly the docs, wield all the power and nobody’s going to be able to get them to make hard changes until that reality changes itself.

Take the time-out before surgery? Nice idea Dr. O’Leary, but I’ve heard from plenty of doctors who’ve come up to me and said “Are you supposed to hug the nurse and Kum-by-yah?” Let’s get on with it? Well, let’s get on with that.

Dr. Denham: Thank you. Dr. O’Leary, could you please frame, for us, the argument for overcoming that panoply of colorfully described excuses.

Dr. O’Leary: I do think we have to acknowledge some hard realities. The preoccupation of certain medical staffs, boards, and CEOs with power and autonomy is literally

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becoming cost prohibitive for each of these parties. Abraham Lincoln’s admonition of an earlier time that “a house divided against itself cannot stand” applies equally well here. Here there is no glory in becoming head of the household. Those who win the growing numbers of these battles are eventually the real losers. For better or worse, the Joint Commission labors in this vineyard every day. I can tell you that while today’s problems are quite real, the recognition of the need for change is also quite real.

That recognition is reflected in the ongoing quiet but intense discussions among key leadership organizations, such as the American Medical Association and the American Hospital Association. And it is reflected by the varied interested parties who are participating on a Joint Commission task force that is charged with creating a new leadership standards framework that will delineate the responsibilities and accountabilities of the medical staff, governing body, and management in relation to each other.

None of these parties or other leaders in the organization—Chief Nursing Officers, Chief Financial Officers and Chief Information Officers for example—really have any viable alternatives to working together to become an effective team. Each group, in fact, is bound to the others by common ethical commitments to the provision of safe, high-quality care, and each group brings specific skills and resources to bear on the effective delivery of care. There are no powerless players and those that play on the periphery—playing one practice setting against another—will eventually be driven to choose the team of which they will become part. That will happen through the deployment of electronic medical records and other information technology (IT) support initiatives. You are only going to be in one system. It will happen through the evolution of alternatives to the medical liability system that will progressively bind hospital and physician interests together. And it will happen through the evolution of Pay-For-Performance systems that truly align the incentives of all of the players, just as the Institute of Medicine’s Quality Chasm report urged almost 5 years ago.

Most organization leaders and clinicians want to work in environments where it is safe to report adverse events and near misses, where action will be taken to improve safety when opportunities are identified, and where they can be involved in the improvement process. They will increasingly seek such environments in which to work. The force will be with us.

Dr. Denham: Again, the messages are clear from the front line.

Power and Autonomy Video Montage

Dr. Denham: Power and autonomy are significant issues in hierarchies where it feels safe to speak up. They are approachable. You would feel comfortable asking them a question or seeking help and the reason you can do that is because you know it is safe.

Dr. Olivia: Power and autonomy are significant issues in hospitals; however, when you hold professionals accountable for patient-centered care, then you don’t have to be directed from above.

Julie Ann Morath: Power and authority are part of the human condition; but power and authority can be a major barrier to patient safety. When an organization focuses away from individual power toward the power of teams, we can truly deliver patient-centered care, which is foundational to safe care.

Chris Queran: In my experience, the leaders who demonstrate the greatest effectiveness in this area have certain characteristics. They have a passion for providing the right service at the right time to the right patient. But more importantly, they have a humility and a willingness to acknowledge that we have far too many mistakes in how we provide care.

We have far too much variation from evidence-based practice and we have cultural norms that reinforce autonomy at a time when providing care, particularly in the acute care environment, is incredibly complex, multidisciplinary, and team oriented.

Dr. Frankel: Every front-line provider is so busy now, the comment they’re going to make is “I don’t have time to improve my environment. I’m just being told to deliver care.” But if you organize safety and quality departments so that they’re enablers for front-line providers to feel like “Yep, I’ve got an idea. I now have a little bit of resource or assistance to help me improve,” that goes a long, long way and it’s do-able. Great organizations are doing it. We’ve got examples of those.

Gladstone McDowell, MD. Director, Task Force Leader, TMIT. Physician Specialist in Urology, Hematology/Oncology, and Anesthesiology at OhioHealth Pain Management Center.

As a practicing physician outside the hospital, I can tell you that the power and autonomy issues are major barriers to patient-centered care. But I’ve seen that through teamwork and a common focus, we can really overcome power and autonomy issues for the benefit of patients. That is a very exciting challenge and opportunity for us.

DISCLOSURE

Dr. Denham: This final excuse is a sore point for many of us, especially for those of us that have had family members who have been harmed by the healthcare system. For those of us who are creating documentaries of such patients and families’ stories, it’s engraining to hear these stories over and over again as we go through the editing process. This is a very tough issue that truly demands immediate action. Dr. Bagian, could you address and frame for us this excuse of avoiding transparency and the issue of disclosure?

Dr. Bagian: The author thanks Dr. Denham for the disclosure in the beginning that we all were not in favor of the things we were making excuses for, because this enrages me as well; but I’ve heard them a lot. Let me see if I can role play
them and feed back to you, the kind of baloney I’ve heard from people in the past. “You know? We’ll get sued. The award will be higher,” or “Our risk managers won’t let us,” “Our attorneys won’t let us. You know, we have to listen to what the attorneys tell us to do.” “Our insurance carrier won’t let us. You know, it’s their call.” “The patient was old and sick and it was kind of an expected complication, anyway.” “It will unnecessarily worry the patient and their family. It would really be better if they didn’t understand what happened.” “The patient will lose confidence in us.” “The community will lose confidence in us. It will tarnish our reputation.” “It will ruin my career.” “My—you fill in the blank—my superiors, my peers, the patient, the press, the community won’t or can’t really understand this and they won’t really treat us fairly. So, that’s a good reason not to tell them.” “I’ll lose face.” or “I’ll really understand this and they won’t really treat us fairly. So, issue?

Dr. Denham: Thank you Dr. Bagian. Sue Sheridan, you’re probably one of the most uniquely equipped people to address this issue of disclosure. Could you give us the reality from the patient’s and family’s perspective on this critical issue?

Sue Sheridan: Actually, this is a difficult topic to talk about. As I mentioned, my son suffered brain damage from jaundice, untreated and untreated jaundice. A normal phenomenon in newborns. Cal suffered brain damage in our arms and before our eyes in the hospital and little did Pat and I know that we witnessed the onset and damage to our son’s brain. Because of unusual neurologic behavior while he was in the hospital, we requested an MRI. We were told by a jubilant team that his MRI was insignificant and my son was discharged as a well baby. Only did we learn 16 months later from a team of university doctors that the MRI clearly indicated kernicterus by the radiologist and that was never shared with us. No one told us.

In Pat’s case, he had a tumor on the base of his skull. They successfully and beautifully operated to open his spinal canal and remove the tumor. They indicated it was exactly what they thought it was going to be. It was, as they communicated to us, a slow-growing schwannoma, which is a benign tumor. Little did we know that the pathology that was done had actually gotten lost. The correct pathology was a synovial cell sarcoma. The original pathology report, that piece of paper, that document that was put into the mail to the neurosurgeon, either was misplaced, was lost, or was put into the physician’s file without him seeing it. So, when the tumor returned, it returned the size of the surgeon’s fist and during that time of no treatment, it grew into my husband’s spinal cord. When they took it out the second time, they told us that it was a sarcoma this time and we were led to believe that the tumor had become malignant over the past 6 months. But we later learned, when I went to the medical records, that the tumor, indeed, was malignant the first time. Again, no one ever told us.

The errors were undoubtedly unintentional and true mistakes. My husband and I always believed that. But the decision not to disclose those errors to us was calculated, deliberate, and by far the most disturbing experience in my life. It is so hard to articulate the profound sense of betrayal and abandonment that my family felt. I can only describe it as a hit and run in medicine. My family was abandoned at the side of the road, injured and traumatized by a well-meaning motorist who fled because of legal and personal fears. We were left to seek out help on our own with our own resources. No one looked back. It was pretended as if nothing had happened, including those eye witnesses on the side of the road.

A hit and run, in our world, is considered a hit and run. Why is it okay in medicine? The nondisclosure of medical error is the most destructive phenomena in health care. Trust and confidence disappears in a heartbeat. Disclosure and transparency is simply a new kind of glitzy way to say the word honesty and I know of no other industry where honesty is optional.

Dr. Denham: Your courage is a wonderful example to us. Thank you.

Disclosure Video Montage

Sol Park. Founder, Josie King Pediatric Patient Foundation.

We’re doing what we’re doing because Hopkins said “we made a mistake. We’re sorry and let’s work together and we’ll fix it.” Had they, for one moment, thought or decided that they might lie to us or that maybe they wouldn’t return our phone calls or maybe, they wouldn’t give us the medical records, or for one instant had they behaved in any way other than the way in which they did behave, in our anger we would have done anything we could to destroy them.

Julie Ann Morath: With disclosure, the early evidence is that there are less law suits, there are less claims, and there is less contention between the parties involved. It is early, but very promising. But, most important is that it’s the right thing to do.

Edwin Fisher Jr. Former CEO, Medical Malpractice Insurer.

In the insurance industry, particularly in the medical malpractice arena, we are seeing increasing claims. One of the drivers is the mistrust that the patient has with the institution or with the clinician and that can only be exacerbated by nondisclosure of harm to a patient. We find that if you have disclosure to the patient, it significantly mitigates the risk of subsequent claims and law suits.

Jennifer Dingman. Co-President, PULSE, Colorado.

It just appears that when things happen, unfortunately, disclosure isn’t on the top of the list, predominantly after a medical error occurs and the people that have experienced medical error or something that they think might have been a medical error have a lot of trouble finding out exactly what happened in the situation because of the silence coming from the providers.

Dr. Frankel: Disclosure is a terrible problem. We are trained physicians, nurses, pharmacists to always be vigilant and to do our best and the term “failure” is unacceptable to us personally. Once trained like that, to then go to a patient and say “we failed and in the process we hurt you” is something that, even when we’re ostensibly taught how to do that, everything else that we’re taught in medical school and nursing school is how not to do that. The ability to disclose to patients
is very difficult for front-line providers. It takes skill. It takes training. It is an absolute mandate that hospitals have to teach their front-line providers how to disclose and what to say. It is not that difficult.

**Dr. Denham:** Pete Conrad, the third man to walk on the moon, died the preventable death of a system failure. However, the injury went much farther than the error.

**Nancy Conrad.** Chairman, Community Emergency Healthcare Initiative (CEHI) Development Board, TMIT.

Pete Conrad’s caregivers could have done three things that could have helped me so much. They could have told me what happened. They could have told me how their care could have been different and they could have told me what they would do so that it would never happen again.

It’s very ironic. As an astronaut, Pete spent his entire life in complex dangerous systems that were high performance and built for safety and yet he died a preventable death of a system failure.

**SUMMARY**

**Dr. Denham:** We will now give our speakers an opportunity to close with a direct and personal summary message to hospital leaders.

**Dr. O’Leary:** All of us up here and many of you out there and around the country are working hard on patient safety issues, and I think some progress, some significant progress, is being made. From a Joint Commission perspective, we have a somewhat unusual relationship with patient safety because our accreditation process is really designed as a risk reduction activity. So this is kind of a pig/bacon relationship. Last fall, Bob Wachter was kind enough, in his look-back on 5 years since the IOM Report, to give the Joint Commission an A- for its effort; but I’m reminded, in this environment, how quickly you can move from an A- to an F, because people are not really interested in what you did yesterday. They want to know what you are going to do for them tomorrow and that is really our collective challenge. It is very clear that if we are to succeed, we are going to have to work together with others toward common ends. We are committed to doing that, and I know that many others are as well.

There is no dearth of issues nor opportunities to be part of the solution. The issues at hand include the need to create cultures of safety in our organizations, which are fundamentally counter-cultures to the continuing blame-and-shame society in which we live. There is a fundamental need to invest in systems improvements in our organizations; that is, improvements in how we do things so that patient care is a safer exercise. There is a need to better train our physicians, nurses, pharmacists, and organization CEOs so that they at least know something about systems thinking, about human factors, and about teamwork. There is a need for greater engagement with the public and with patients and for greater transparency. We have to do something about the tort system. It continuously undermines our patient safety efforts. We need patient payment system reform, as we have set out, and we need to pay a lot of attention to staffing. It’s not that our good people are disappearing. Soon, all of the people who support this system will disappear unless we create positive work environments, we invest in training, and we begin to recruit actively to this beloved profession.

In these efforts, there are important roles for everyone because somebody or some bodies have the answer to each and every one of these challenges. The respective leaders simply need to step up and get moving.

**Dr. Daley:** What I find myself going back to is the people who will be harmed today, May 5, 2005, in our hospitals. It won’t be because caregivers set out to do that. And the families of those patients—like Sue’s family—will suffer forever because of what happens. Many of these “bad things” that happen to patients are preventable. I also reflect on a second group of people whom we routinely abandon and betray; that is, the caregivers who are involved in these incidents. I think it is fair to say that anyone in this room, who hears this presentation, who is a clinician, has experienced such an episode. I remember, when I was a resident, misplacing a thoracentesis needle on the wrong side of the chest of a patient who had breast cancer and malignant pleural effusions. Ultimately, the patient wasn’t harmed from it; but, I still have nightmares about it. I still think about it. I will never forget that woman. When working at the Beth Israel in Boston, I had the privilege of precepting in primary care clinic. I had a young man who was absolutely the most outstanding resident I have ever met in my life. He was compassionate. He was knowledgeable. He was energetic. He cared. He decided to become an oncology fellow at the Dana-Farber, which is where he should have been trained. He is the same oncology fellow who was vilified in the stories of a serious medical error at the Dana-Farber that resulted in the death of a Boston Globe health reporter. He was abandoned by every single person in the Harvard Medical community who knew him. Few people called him. No one spoke to him and he’s since gone to England where he does research. Only 10 years later has he returned to clinical practice in the United States. If you look deeply into healthcare organizations you will find people who have been injured in their souls because they have been part of these systems failures. We owe it to them, as well as to our patients and the patients’ families, to make these systems safer so they don’t have to suffer that the guilt and shame of being part of serious medical errors.

**Dr. Wachter:** I want to focus, in my last few minutes, on the issue of safety culture, which has come up and really been an undercurrent of much of what we have heard. People mean different things when they talk about safety culture. Some people mean “Do nurses and docs report their errors?,” others mean “Do we have a no-blame environment?” More recently, people have talked about disclosure as one of the metrics of whether you have a safety culture. Still, others say, “Whatever... we just passed JCAHO.” There have been elaborate safety culture surveys developed. Probably all of your organizations use them.

Well, I have a test for safety culture and it’s much simpler. It actually is just a single question. Let me walk you through it. Think of the person in your organization who is lowest on the cultural totem pole—perhaps the new young clerk on the medicine ward. Try to get that person in your mind’s eye, maybe seeing her walking into work with her
I-Pod. Someone calls her from the Cardiac Operating Room saying that they are ready for her patient. She takes the call, but something seems amiss. Perhaps the patient’s consent is missing from the chart or the patient is not on that morning’s log of anticipated cases. She knows that double checking is going to take a few phone calls and might delay the patient going to OR for 10 minutes or so. Let’s go on. The surgeon that day is the Chief of cardiothoracic surgery. He usually has two or three rooms running at a time. He brought in $6 million of business to the hospital last year. He drives a Hummer and parks it in his prominent parking slot, the one closest to the hospital. In the words of my own governor, this is not a “girly man”. Now, there are a few more things you need to know about this surgeon. He has a temper. He has been known to throw things in the operating room. And he has great aim. Stay with me. Despite all of this, the clerk remains concerned about whether this patient is the right patient and she musters the courage to delay the case, make those calls and check out whether, in fact, this patient is really supposed to go to the operating room. It turns out he was. Everything was correct. It was just a little paperwork snafu. This really was the right patient.

So here is your test. What happens to this clerk? I don’t mean in the Human Resources “Does-she-get-fired-sense.” I mean in the “Sociology 101,” “kids on the playground” sense. Do her colleagues shun her at the water cooler or mutter just out of earshot that “Oh, she’s the one?,” or does the CEO or Chief Medical Officer or Chief Nursing Officer come by later that day, pat her on the back and make her Employee of the Month. If it’s the latter, then I would say you have a safety culture. I’d like to do a quick test. Please raise your hand if your institution would pass that test today. All right, Judge Denham, I know the video may not be able to show it, but let the record show that I think 5 people out of 1000 raised their hands.

People ask me all the time what we need to do to fix our patient safety problem. Yes, it’s about computers, implementation of best practices, reporting, JCAHO, and all of these other things; but I would say “Let’s all focus on seeing whether we can pass our little test.”

**Lilee Gelinas:** I want to focus, in my conclusion here, on performance excellence, because it is achievable and we know it’s do-able. Performance excellence is inherent in a safe, quality organization. I have to tell you personally, Jim and I were sharing yesterday; I was in shock when I went from military nursing into civilian nursing from a disciplined environment to an undisciplined one. It was truly a situational adjustment reaction. But we know now, having studied the record show that I think 5 people out of 1000 raised their hands.

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If you were to give yourself a test and grade yourself on a scale of 1 to 10 against what great leaders do, think in your minds, right now as I say these top 10 attributes. How you would judge yourself, high being 10, low being 1.

1. Are you highly visible?
2. Do you lead with uncompromising commitment to values and standards?
3. Do you hire the right people based on values and character?
4. Have you created an organization where people think and act like business owners, rather than just being accountable? An attitude of “We own the place?”
5. We share all relevant information?
6. We push decisions down?
7. We create a competency of business literacy throughout the leadership team with a serious commitment to learning?
8. We assure that all employees understand where they add value to the hospital?
9. and that their financial reward is directly proportional to their value?
10. We have a high-accountability culture, based on teamwork, where teamwork is the minimum specification of the place.

I don’t know about you, if you’re a clinician in the audience, but I never saved a patient in a code by myself and knowing that clinically, then going into the administrative suite and seeing silos prevail, rather than teamwork, I have to scratch my head.

Let me just leave you with a little bit of inspiration. When I gave these quotes to Dr. Denham, he said “Lilee, what are you going to do with these?” A great keynote presentation to start a phenomenal conference has to leave you with inspiration. So, my wonderful husband Marc of 21 years, who has a second-degree karate black belt, uses a wonderful Japanese proverb I would like to leave you with, “Fall seven times, stand up eight.” Thank you.

**Dr. Bagian:** I would like to discuss what we have talked about so far and that is the whole role of leadership because change does not happen without that. Leadership is absolutely essential if we’re going to move forward. One thing we’ve talked about a lot is that culture is important. Culture doesn’t change by fad or edict. It happens through leadership: by setting up an environment that is conducive to the culture you desire. You don’t do it at the point of a gun. You don’t yell at people to do it. Leaders lead by making choices, making appropriate choices. They need to communicate through both word and deed that patient safety is a priority, and actually the word isn’t so important because talk is cheap. The real issue is “What do you do, put up or shut up?” Show it everyday in what you do. You’ve got to walk the walk AND talk the talk. I think what Bob said a little bit ago about the test for the cultural survey is a good one. Would you reward the person

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that brings you bad news? I can tell you that week after next, the Under Secretary and I are flying to California to reward such a person. For the Under Secretary to go talk to somebody about this says a lot. There are other ways you can do it in any organization. You can manifest it by who does safety report to? Do they report down in the bowels of the ship or do they report to the COO or CEO? If they don’t, you ought to think about implementing change in the reporting structure. Is it on every agenda for both your management team as well as the board? It should be the first thing on the agenda at every board meeting.

“What’s happened in patient safety since last time we met? And the things we discussed last time; what’s been done about them?” If you don’t take the time, it’s not going to happen because time is your most valuable resource and the way you show you value patient safety is to spend some of your time in patient safety issues. You don’t delegate this to somebody else. I think that’s absolutely important and easy. If you don’t do this, then safety just becomes a buzz word. I think you have to think safety is really the foundation upon which quality is built. You can’t begin to say you deliver high-quality care if it’s not safe. Patients don’t expect to all be cured when they come to the hospital, but they don’t expect to be inadvertently harmed. They don’t expect that and that’s not acceptable. You’ve given numerous choices today about things you can do and you’ll get more choices over the next two days. You should consider them carefully.

I think there’s one final choice that’s probably the most critical of all and that is “Do you want to be a victim or spectator and watch what happens or do you want to be a leader and decide to make things happen?” It’s your choice. You can do it if you want. You don’t have to. I think one other final thing is that there is no dishonor in trying to do the right thing and falling short. The only dishonor is not to try.

Sue Sheridan: It is so often that, in patient safety discussions, consumers are left out. We are kind of dehumanized. We become data. We are labeled bad outcomes and the way you show you value patient safety is to spend some of your time in patient safety issues. You don’t delegate this to somebody else. I think that’s absolutely important and easy. If you don’t do this, then safety just becomes a buzz word. I think you have to think safety is really the foundation upon which quality is built. You can’t begin to say you deliver high-quality care if it’s not safe. Patients don’t expect to all be cured when they come to the hospital, but they don’t expect to be inadvertently harmed. They don’t expect that and that’s not acceptable. You’ve given numerous choices today about things you can do and you’ll get more choices over the next two days. You should consider them carefully.

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Sue Sheridan: It is so often that, in patient safety discussions, consumers are left out. We are kind of dehumanized. We become data. We are labeled bad outcomes and are often thought of as adversarial. As consumers that have experienced medical error in one way or another, we do ache and we have been tremendously, tremendously, saddened. Yet, we are passionate and we are determined. We are mothers. We are grandparents. We are sisters. We are newborns. We are from the United States. We’re from Brazil. We’re from South Africa. We are from Ireland. We are you.

You have heard this morning that there have been two medical errors in my family; both with devastating results and both completely preventable. As a widow and a single mom of a disabled little boy and an energetic 7-year old girl, I wonder what it would be like to have your child die as a result of medical error, to have your child suffer, for those who have been silenced, for those who have suffered, for those who have been undermined, for those who have been wronged, for those who have been shamed, for those for whom medical errors remain a mystery and for those who are soon going to be harmed by a medical error. I ask you, with regard to patient safety, to seize it with relentless passion and abandon these excuses that you have heard today, because as the title of this session implies, there are no excuses. Embrace it with urgency and honor. Be courageous. Be creative. Be adventurous and believe that you too, can make a difference so that these are the lives. So, within 4 days, 53 of us went to Disney World to grant Pat’s wish. During that time, and I must say it was a privilege to spend that time with my husband, we had discussions about how to raise our children without him and what I was going to do in the future without my husband of 17 years. Pat said to me “Sue, whatever you do, do not give up on patient safety.” They were very powerful words. So, I ask the same of you. Never give up on patient safety and do not retreat to excuses.

Today, I have the daunting task to be the collective voice of the consumer. So, I am here to give voice for those who have suffered, for those who have been silenced, for those for whom medical errors remain a mystery and for those who are soon going to be harmed by a medical error. I ask you, with regard to patient safety, to seize it with relentless passion and abandon these excuses that you have heard today, because as the title of this session implies, there are no excuses. Embrace it with urgency and honor. Be courageous. Be creative. Be adventurous and believe that you too, can make a difference so that these excuses—the elephants; live at the front line in every hospital every day in some way. It is clear that we must deal with them. The patient safety champions are our prophets who often have no honor in their own country. They need the concepts, tools, and resources to fight the good fight with systems failures and inertia. Finally, the MIAs; those hospitals missing in the action of survival need to be rescued and brought into the quality movement and patient safety initiatives. The evidence for action is clear and mounting quickly. It is time to act.
Our speakers have generously agreed to allow us to use video of their presentations to produce this program, which will be made available at no cost to front-line hospitals through streaming video via the NPSF and TMIT web sites. The many front-line interviews from the TMIT library will likewise be available at no cost as a DVD. Every hospital in America will receive a copy through NPSF and the TMIT Pay-It-Forward program.

It is through the social network of servant leaders at the front line that we can drive these messages into impact. Warren Buffett has said that “the chains of habit are too light to be felt until they are too heavy to be broken”—we know that we have a daunting challenge. However, to counter this challenge, F.C. Forbes said that the one common denominator of all great leaders he interviewed was enthusiasm. He said that “it is the internal sparkplug of life, the propeller of all progress.”

As we close, please go forward with enthusiasm. Face the elephants, be good prophets, and help rescue the MIAs. Thank you for your attention.

Closing Video Montage
A Helm to Grasp, a Course to Steer, and a Port to Seek

Dr. Denham: Ships are never built to just ride at anchor. Our hospitals were not built to ride at the anchor of cost containment and languish in the harbor of complacency. They are built to carry us on our mission—to restore our patients to better health as safely as possible. Our trustees and CEOs need to provide a helm to grasp, a course to steer, and a port to seek. Front-line clinical leaders and administrators are leading statewide and national specialty initiatives that are completely blowing the excuses away… A production-centered evolution got us here. A patient-centered revolution will get us out.

Susan Edgman-Levitan, PA. Executive Director, John D. Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital. Ms. Edgman-Levitan is Co-chairman of the NPSF 7th World Congress for Patient Safety and a national thought leader in patient-centered care.

Today patient-centered care is definitely on the map. However, there is a lot of fear about really engaging with patients and putting into place the systems that doctors and nurses need to interact with them optimally. There is also a lot of concern about what will happen to the doctor-patient relationship when it becomes more of an equal partnership. It is my hope is that eventually the doctor will be the coach rather than the guru and we’ll all be in this together, working to maximize a patient’s health in the ways that are most important to them.

Sorrel King: We spoke to first and fourth year medical students at Hopkins and we asked, “Who here has heard of the IOM report ‘To Err Is Human?’” I sort of looked out into the audience and was thinking everyone was going to raise their hand. Not one single person raised their hand. I couldn’t believe it. I was shocked and frightened, and then after I spoke, these students came up to me and said, “That was the most amazing hour of medical school I’ve ever had so far.” What that said to me is, “Oh my gosh! They’re not talking about this to medical schools!”

Julie Ann Morath: It’s time to take the blinders off and recognize that this is a serious epidemic.

John Whittington, MD, Patient Safety Officer, OSF Health System.

There is no reason to be stalling on this… there is plenty of opportunity to move and to move today.

Nancy Foster: There is definitely evidence for practical actions.

Dr. Frankel: There is just no excuse that there is not enough evidence.

Ginny Ueberruth: The bad news is that we have so many preventable deaths…the good news is that we have a way to solve it.

Lucian Leape, MD, Adjunct Professor, Harvard School of Public Health.

It is time to implement what we already know works. It is time to get on the basic business of safety, which is to implement safe practices.

Joan S. Davis, Trustee, The Cooper Health System.

You know…I like that. Some is not a number…soon is not a time.

Dr. Denham: Let’s get on with it. There are no excuses.

ADDITIONAL RESOURCES

Speakers’ presentations are available for viewing through the NPSF web site, as well as a list of highlighted resources that the speakers have selected as a “must see” list.

• Log onto the NPSF web site at www.npsf.org.
• Click onto the ‘No Excuses’ link under the ‘Let’s Get On With It’ 7th Annual NPSF Patient Safety Congress Logo.
• Go to the section for each excuse by clicking on the left-hand navigation table or scroll down the web page to see each excuse. The associated video link can be accessed by clicking on ‘click here to view video.’ Click on the ‘full bibliography’ link, for a full and recent bibliography or click on the ‘must see resources’ for a more specific list.
• A DVD of the program is also available from TMIT to hospitals for retreats and strategic planning sessions. Click on the blue ‘Streaming Video Resource’ link under the “Let’s Get On With It” logo.

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Disclosure References

APPENDIX
Speakers Presented in Videos
David Bates, MD, MSc, Chief, General Medicine, Brigham’s and Women’s Hospital
Donald Berwick, MD, MPP, President, CEO, Institute for Health Care Improvement
David Classen, MD, MS, Associate Professor of Medicine, University of Utah

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No Excuses

Nancy Conrad, Chairman, Community Emergency Healthcare Initiative (CEHI) Development Board, TMIT
Richard Davidson, Ed.D, President, American Hospital Association
Joan S. Davis, Trustee, The Cooper Health System
Suzanne DelBanco, PhD, COO, The Leapfrog Group
Jennifer Dingman, Co-President, PULSE, Colorado
Edwin Fisher Jr., Former CEO, Medical Malpractice Insurer
Nancy Foster, Senior Associate Director, Policy, AHA, and NQF Representative
Allan Frankel, MD, Director of Patient Safety, Partner’s Healthcare System
Ramin Khorsani, MD, MPH, Vice Chairman, Dept. Radiology, Brigham and Women’s Hospital
Sorrel King, Founder, Josie King Pediatric Patient Foundation
Kenneth Kizer, MD, MPH, President and CEO, National Quality Forum
Lowell Kruse, CEO, Heartland Health Care, St. Josephs, MO
Lucian Leape, MD, Adjunct Professor, Harvard School of Public Health

Michael Leonard, MD, Physician Leader for Safety, Kaiser Permanente
Gladstone McDowell, MD, Director, Task Force Leader, TMIT, Physician Specialist in Urology, Hematology/Oncology, and Anesthesiology at OhioHealth Pain Management Center
Greg Meyer, MD, Chief of Staff, Massachusetts General Hospital and Co-Chair of NQF Safe Practices Program
Arnie Milstein, MD, MPH, Co-Founder and Board Member, The Leapfrog Group
Julie Ann Morath, RN, MS, COO, Children’s Hospitals and Clinics of Minnesota
Chris Olivia, MD, MBA, President and CEO, The Cooper Health System
Chris Queram, MPH, CEO, The Alliance, Director, JCAHO, NQF and The Leapfrog Group
Ann Rhoades, President, PeopleInk. Jetblue founder. Southwest Airlines Leader
Charles Sessa Jr., Chairman, The Cooper Health Systems
Ginny Ueberroth, Trustee, Hoag Hospital. Newport Beach, CA