

**Institute for Healthcare Improvement**

**November 17, 2004**

Operator: Hello and welcome to today's Institute for Healthcare Improvement Staff Call, "To Err is Human". My name is Megan and I will be your conference operator for today's call.

Right now all participants are in a listen-only mode. Later we will conduct a question-and-answer session and instructions on how to participate will follow at that time.

As reminder this call is being recorded. If you should need operator assistance at any time, please press star zero on your touchtone phone. If you should get disconnected at any time during today's call, please dial (800)282-9233 and enter the PIN code of 9045 followed by the pound key to reconnect.

I would now like to introduce your moderator for today's call, Madge Kaplan, Senior Communications Strategist and former Editor and Health Correspondent for National Public Radio. Madge you may go ahead.

Madge Kaplan: Good afternoon. I am Madge Kaplan for the Institute for Healthcare Improvement, and I want to welcome everyone to a discussion on the current state of improving patient safety in U.S. hospitals.

Our conversation as most of you know is taking place on the fifth anniversary of an Institute of Medicine report published in November 1999 called "To Err is Human: Building a Safer Health System". The agenda was as groundbreaking as it was disturbing, drawing attention to the stark reality of tens of thousands of deaths each year in U.S. hospitals due to medical errors, and also the report issued an unprecedented challenge to U.S. healthcare leaders to do something about this.

Today, we're going to try to take stock of what sort of progress has been made to ensure patients don't fall victim to avoidable mistakes and where efforts are lagging.

Now, we're fortunate today to have three people with us who were directly involved in the research and writing that led to that bold IOM report and some subsequent reports that have emerged from the Institute of Medicine. Dr. Donald Berwick is President and CEO of the Institute for Healthcare Improvement based here in Boston. Welcome Don Berwick.

Don Berwick: Thanks Madge. It's great to be here.

Madge Kaplan: Janet Corrigan is Senior Board Director for Healthcare Services at the Institute of Medicine. Welcome Janet Corrigan.

Janet Corrigan: Hello Madge.

Madge Kaplan: Dr. Lucian Leape is Adjunct Professor of Health Policy at the Harvard School of Public Health. Welcome Lucian Leape.

Lucian Leape: Nice to be here, thank you.

Madge Kaplan: Carol Haraden is a Vice President at the Institute for Healthcare Improvement. She is responsible for patient safety initiatives, and she's with us as well this afternoon. Welcome Carol Haraden.

Carol Haraden: Good afternoon Madge.

Madge Kaplan: Also on our call today are two people who might never have known one another were it not for a tragic series of errors at Johns Hopkins Hospital and Health Center. Almost four years ago, Sorrel King lost her 18-month-old daughter Josie while the child was a patient at the hospital. Today Sorrel King is a patient-

safety activist and founder of the Josie King Foundation. Thanks so much Sorrel King for joining the discussion.

Sorrel King: Thank you Madge. It's good to be here.

Madge Kaplan: And Doctor Peter Pronovost knows Sorrel King well. He's an Associate Professor of Anesthesiology and Critical-Care Medicine at Johns Hopkins University and Medical Director for the Center for Innovations in Quality Patient Care, also at Johns Hopkins. Welcome Peter Pronovost.

Peter Pronovost: Hello Madge.

Madge Kaplan: All right, I just want to remind people how the call is going to work. I'm going to be moderating a discussion with our experts until around 2:30 Eastern Time, at which point we'll open up the lines for questions. I should mention that there are over 400 of you, or 400 lines on our discussion today, which is just terrific. This also includes reporters, and a reminder this call is on the record.

I want to begin with Janet Corrigan with the Institute of Medicine and go back in time to when "To Err" was published. That was in the fall of 1999 as I said. How would you, Janet Corrigan characterize the concerns at the time regarding patient safety, and what did you hope "To Err", would do?

Janet Corrigan: Well, I think prior to the release of "To Err is Human", there was not a great deal of concern about patient safety, except in the case of a few individuals, Lucian Leape being one who had really done pioneering research and had an extensive understanding of the issue. But for the most part, the American public and policy makers and leaders within healthcare were really not aware of the issue. It wasn't on their radar screen. And indeed, I think that was probably the one thing that "To Err is Human" really accomplished better than anything else, and that was to draw national attention to this issue.

Just after the report was released, the Kaiser Family Foundation did a poll of the American public, and they found that over 50 percent of Americans said that they closely followed the news coverage about medical errors.

Madge Kaplan: . Lucian Leape, I recently read about the report and that the authors wanted to create "a new culture of safety in the American healthcare system, a system in which it is hard, to make a mistake and easy to do the right thing." Has it gotten harder to make a mistake and easier to do the right thing?

Lucian Leape: Well, I think so. Not as much as we'd like but there's been a lot of improvement in a lot of places. Literally thousands of healthcare workers, doctors and nurses are making changes in their systems and each of these is having an effect. What we want, of course, is to have everybody a part of that. But I think we can say that healthcare is a bit safer now, just not as far along as we'd like to be.

Madge Kaplan: You know there has been a certain amount of media coverage about the IOM anniversary and a lot of focus on the hope for 50 percent reduction in patient deaths. And I wonder Lucian Leape if you could also speak to that. Was that an unrealistic goal? Is it wrong to be too preoccupied with that?

Lucian Leape: It is wrong to be too preoccupied with it. I don't think it was unrealistic, but people forget the second sentence, which was "We think there could be a 50 percent reduction in medical errors if we made a national commitment to do it". We were thinking of something of the nature of a moon shot, in which there was a real effort made to do everything we can to have, and the government would put its muscle behind it, and put its money behind it.

That didn't happen, and so without that kind of direction and without that kind of support, you can't get that kind of improvement. What we've seen instead is what I call safety by good intentions. We have, as I said before, thousands of people who are working on safety because it's the right thing to do, because they want to make healthcare safe, because they want to work in a safe system.

But they're not getting the kind of support they should have. I still believe if we had that kind of support, we could reach that kind of a goal. We know we could reach it in specific areas, such as nosocomial infection and preventing wrong-site surgery and that sort of thing.

So the goal was not unrealistic, but the resources have been lacking.

Madge Kaplan: Okay, well we're going to come back to this issue of what kinds of prods and pressures might help accelerate the pace of change. Don Berwick I want to turn to you. You and IHI, the Institute for Healthcare Improvement, are often credited with taking the aims in "To Err", as well as a subsequent report, "Crossing the Quality Chasm" and breathing a lot of life into the goals with a real agenda for improvement. And I'm wondering have these concepts provided a sort of moral imperative for working on patient safety perhaps as well as an organizing principle for tackling problems?

Don Berwick: Well, the credit belongs to thousands of people led by Janet and Lucian and others on this call and many others who are trying to make this problem reach the front screen. The Institute for Healthcare Improvement has the privilege of working with the faculty on the phone and others to try to make progress.

And the good news is there's tremendous progress. I think that since the report was issued, at least everyone on this phone call all the faculty confidence has grown as to how much we can achieve because places have done it. As Lucian said, though it's really I think he used the word "thousands" of people, and that's exactly right. But we are in an industry with millions of people in the workforce and tens of millions of people depend on us. And what really needs to be the case now is that the combination of the awareness of the problem and these tantalizing dramatic successes in small pockets should create a sense of imperative, absolute duty to do this everywhere now.

Madge Kaplan: Carol Haraden, a movement of sorts has grown up to take on medical errors in sometimes it seems a take-no-prisoner fashion, but at another level the urgency of the situation does seem to wax and wane. And I think that's part of what the media grab hold of. The focus on patient safety is reignited by tragedies of this sort that do bring Sorrel King to us today. How would you characterize the past five years and what appears to be an ebb and flow of a sense of urgency?

Carol Haraden: Well, I would characterize the last five years as full of hope, but that hope is not yet fulfilled to its full potential; again, as others have said, some really superb work is being done in small areas. I see some of the variation in uptake of those projects similar to even the variation in uptake of best practices from nurse-to-nurse or doctor-to-doctor within hospitals. There is I think often a belief that we are practicing at our best and so paying attention to those doesn't seem like it's going to affect our practice, I think is a piece of that.

And there's I think also a pervasive in medicine and in healthcare in general a belief that we are truly different, our hospital is different, our healthcare system is different, and our region is different. And so there is some skepticism when one looks at those best practices, and I think not enough urgency to say we need to take these and try them and in truth, that hospital, that healthcare system isn't that different than what we have here.

So while people have sort of an edgy anxiety about it, they don't translate that into a let's go ahead and try what we see working in other places. They're waiting.

Madge Kaplan: Carol Haraden, it also seems as though we're sometime surprised to hear about serious medical errors at some of this country's most celebrated medical institutions. But should we be surprised?

Carol Haraden: No, healthcare is enormously complex, and that complexity is everywhere regardless of how wonderful or how august the organization. It's still comprised of a series of processes that grew of sort of willy-nilly as healthcare grew, as new innovations and new technologies were developed. They were added on to a healthcare system. There really never was an opportunity to stand back and do a grand design. And we're all so busy all the time that we don't take the time to do that. So I don't think we should be surprised at all.

Lucian Leape: Madge?

Madge Kaplan: Is this Lucian Leape?

Lucian Leape: Yes, rather than we leave this on a totally negative note...

Madge Kaplan: No, we're going to keep going, and we'll get more positive perhaps. But go ahead.

Lucian Leape: Well, I think we have to realize what an immense challenge this is. We're trying to change a culture, a very entrenched culture, some of us think a dysfunctional culture. But a culture in which we have to change literally hundreds if not thousands of behaviors. And that sort of thing never goes quickly.

What we have seen in the last five years is a very definite change in the conversation. There was a lot of denial; there was a lot of questioning of the numbers and that sort of thing when the IOM report came out. You don't hear that any more. There's nobody who thinks we don't have a problem. Everybody now says it's systems, not people. They may not know what that means, but at least they are beginning to think in those terms. And we have made a lot of progress in defining this as an issue we need to deal with. And so the question is no longer whether we should do it, but rather how we should do it.

And we've moved the cause ahead in another way that I think that doesn't get much attention, and that is with the small amount of funding that the government did provide, we have established an academic establishment, we have attracted people into it from academia and given it legitimacy at that level, which is very important for furthering the cause.

So I think a lot of things have happened to change the climate. We're just all frustrated that we're not moving as fast as we could.

Madge Kaplan: So you're suggesting that working on healthcare improvement and medical errors has a legitimacy that it didn't have before.

Lucian Leape: Absolutely, you can get your papers published, you can get promoted, and those are the currency of the realm in academia.

Madge Kaplan: Sorrel King I want to bring you in. You are coming up to a very different kind of anniversary, and that is your young daughter's death four years ago due to medical errors. Progress or the lack thereof seems to be very much on your mind when you recently wrote a letter to the head of the Children's Center at Johns Hopkins. And I wonder if you would mind reading a paragraph from that letter. It begins, "Every ounce of the energy".

Sorrel King: Sure Madge. It reads -- this is to George Dover, the head of Children's Center at Johns Hopkins. "Every ounce of the energy from my anger and sadness has been put into making something good come from Josie's senseless death. My goal has always been crystal clear. I do not want what happened to Josie to ever happen again at Johns Hopkins or any hospital. I've worked hard these past few years and there have been days where I would like to shut the door on it and pray that all of you in the medical world will find a solution. But I can't walk away because I know we are far away from where we need to be, and that Josie's death was just one of 98,000 that year."

Madge Kaplan: Sorrel King can you tell us why you wrote this letter? A lot of it reads as a message to all hospital leaders.

Sorrel King: Right, I wrote the letter because it has been almost four years and also because of the fifth-year anniversary of the IOM report. And George promised me when Josie died that the hospital was going to become safer and that the money I gave them would go towards that. And I've been working closely with Hopkins over the years, and myself included we've all talked a lot. I talk, I tell my story, I go around to hospitals, I talk

to doctors and nurses. I communicate with these people via email. And I just wanted to sort of have him, as a leader at one of the best hospitals in the country to sit down with his paper and pen and write me a letter answering my four questions. How has the culture at Hopkins changed? Are nurses and doctors reporting errors? Would Josie be alive today if she was in the hospital now?

And like you said, I also thought I would want to take my questions beyond Hopkins and ask every CEO that I know at these hospitals to think about these questions and answer these questions. Because frankly Hopkins owes it to me to answer the questions, and frankly the CEOs of these hospitals out there owe it to the families that have died from medical errors to answer these questions because that's what we want. We want the system fixed.

Madge Kaplan: Peter Pronovost, this seems like the perfect moment to bring you in. You wrote your own letter to Sorrel King, although it wasn't a reply to the one that she was writing to Doctor Dover. But you listed a number of improvements that have been made at Johns Hopkins since Josie King's death. You talked about a new system for staff to better identify and improve and report problems with patient care. Do a lot of the changes there, and maybe you could even speak broadly, add up to the scope of change that Sorrel King is talking about?

Peter Pronovost: Thank you Madge, this is Peter. I was frankly haunted, and still am by a question that Sorrel asked me when we first started working together, and that is could I tell her that Josie would be less likely to die. And when we started working together, I couldn't and I found that frankly unacceptable. And our organization, like many has been struggling with this. And what I've seen over the five years is that I've seen many healthcare leaders become engaged in this issue of safety. I've seen pockets of the healthcare community become invested in educating themselves and understanding the sciences and the new culture that will be needed to improve safety.

However, despite there being great examples of people executing interventions and achieving really dramatic results, for the most part, we haven't evaluated all that much. In the pockets that Don mentioned the results that we've achieved have far exceeded our expectations in some areas, but they haven't been as widespread and as diverse as we need.

Madge Kaplan: When you say we haven't evaluated, explain what you mean by that.

Peter Pronovost: Well, if I were to ask many healthcare leaders around this country to tell us how do they know they're safer, I suspect you'd either get no answer or I believe I am, or a whole variety of different measures. And as a country, I don't think we've really put the investment and the resources to say what does that mean to be safer, and how are we going to know that as an industry so that we could move forward.

And really to go back to Lucian's point of the investment, the one area that we do know well and have had dramatic improvements in improving are hospital-acquired infections. And to do that we have an infrastructure with a federal agency, with people in hospitals who monitor and focus on improving those, and then staff who partake in improving it.

Madge Kaplan: Don Berwick I want to extend this point on to you. Do you think we're lacking in ways of knowing what kind of improvement we're actually making and whether hospitals are safer today?

Don Berwick: Yes, I agree with Peter. At the individual institutional level, if we decide now to make medications safer, we know how to do that and the institution can measure. The IHI has on our website a trigger tool. Any organization can use it, and they can track their medication errors. Peter mentioned infections. We know how to do that.

But as a nation, we don't know. There isn't a federal or a national commitment to studying safety as a property of our system. And therefore, we have a lot of trouble making policy and consolidating intent.

The other general problem we have is that the government systems, I mean especially Boards of hospitals,

really lack windows on the safety of their own institutions, partly because they haven't asked for those windows, which needs to be changed. But even when they've asked, we've got a hard job to do to come up with ways for those institutions to know absolutely chapter and verse that in their institution, Josie King would not have died.

Madge Kaplan: This question really is for any one of you. One of the comments that's often made by people inside and outside the healthcare improvement community is that there are many single examples of improvement at a particular institution or a particular medical practice, but things don't spread.

The evidence that we're raising all boats is not there as a result of the good work that's done in any one place or another. And I'm wondering why is there such a piece-meal approach? What do you think is standing in the way of things spreading to become more the norm? Anybody want to take that on?

Janet Corrigan: Sure, this is Janet Corrigan Madge. I think there are a couple of sizeable barriers that are slowing down our progress in the spread of innovation. I also think that we're making some progress in addressing them though. And one of them is the, what I will call poorly-aligned financial incentives. Right now, our payment systems don't provide the strong incentives and rewards for those who do the right thing, who make the right investments in patient safety.

Oftentimes, that means investing in information technology, new care processes, new organizational supports. And those things do have an up-front cost and our current payment systems, whether it's DRG-based payment for hospitals or fee schedules for providers of small-practice settings, we really don't reward the providers for those kinds of investments. In fact, sometimes they're worse off at the end of the year.

Now as I said, we're making some progress on that one. There is a lot of innovation going on both in the public and the private sectors, and demonstration projects and pilot projects, and some very intensive work on how to redesign our payment systems.

The other major barrier that we have, and I think if we could make progress on this one, we would probably see a big jump in patient safety, and I think it's the lack of a comprehensive information technology network that will allow all providers in a community, and patients and their families to have access to complete information on the patient, and to share that, and to have good communication. It would greatly enhance coordination of care and probably reduce many types of errors.

But to do that, we have to set up an information technology infrastructure that allows for data sharing, and we also have to have investments in electronic health records. That's another area where we're starting to make a good deal of progress with the appointment of the Office of the National Coordinator for Health Information Technology at the federal level. And we're seeing steady investment, although slower than what we would like, steady investment on the part of hospitals, physician groups, and others in electronic health records.

Madge Kaplan: Carol Haraden do you think there's a lot of hope that surrounds this kind of investment and information technology? And I'm curious what you think about some of the pay-for-performance or pay incentives.

Carol Haraden: Janet is absolutely right around the pay incentives. We always talk about the business case for improvement or safety. In fact, there are multiple business cases, depending on how you're paid. At times, readmission is recognized as a separate event, and you may be paid for that. At other times, you're not paid for that. So it's very difficult. And while we would like to say stand up and do the right thing regardless of payment, it puts an organization at some jeopardy given their current reimbursements rates. So I think it's unrealistic to expect folks to do that without having some alignment of incentives. So I think that's absolutely right.

Madge Kaplan: Where would that come from? What would propel changes in that department?

Carol Haraden: Well, I think it's going to have to probably be the coalitions and the government is certainly a huge payer.

Everybody in their organizations have Medicare and Medicaid populations that top 35 to 40 percent of their patient population. So clearly, that's an enormous payer. We're going to need to see some change in reimbursement in that arena, although at times now Medicare can be our best payer. But clearly, the private insurance I'm hoping that these employer alliances that are very strong, that are working together to try to understand and drive improvement in healthcare can see some of the pragmatic issues regarding this work and be willing to be influenced and therefore, to influence the insurance industry from whence they buy a huge amount of insurance for their employees and retirees.

Madge Kaplan: Lucian Leape, maybe I'll just throw this one to you also about information technology, and what Janet Corrigan is discussing. I know some of you were all at a meeting last week in Washington discussing the next phase of work. Can one put too much stock in what information technology can do for healthcare improvement?

Lucian Leape: Yes, one can but look at it the other way around. I think many of us think the single most important thing we could do to improve safety and quality of care is to get a computerized patient record on every doctor's desk in every hospital. That and computerized physician entry have tremendous potential for improving quality. And the sticking point has been financing it.

I want to refer to this financing issue in a slightly different way. When you use the term "incentive", so many people say, "Well why should doctors need an incentive to do what they ought to be doing anyway?" And that's not what we mean. What we're really saying is that we're asking people to make some very major changes in the way they do things, and that's hard for them to do. And we need to provide pressures for that to happen. We need leadership, but we also need to have forces that make it happen. And one of them is financial pressure, if we could indeed have a financing system that did reward quality and safety and penalize when there's an absence of it, then I think we would see the pressures rise and things to happen.

We have an incredible paradox where you can have an intensive-care unit in a hospital that achieves virtually zero central-line infections and another intensive-care unit in the same hospital will not adopt those same practices. And it's because we have so much of this what I call the "NIH Syndrome", not invented here, and we all think we have to do it our way, and the only way that's going to change is with some major pressure.

Information technology is one way to make that happen. I think the private payers are going to end up paying for that. The Government certainly doesn't seem as interested in it, and the payers are the ones that get the financial benefit if they'll step up to the plate and put the computers in offices, I think it will happen.

Don Berwick: Madge, can I ask Lucian a question here?

Madge Kaplan: Yes, sure Don Berwick, go ahead.

Don Berwick: Your probing about the importance of technology couldn't be more apt, and I agree with Janet and Lucian. If I could wave a wand and do one thing that would change healthcare in this nation, it would probably be an electronic record as a standard now. That would be a platform. But Lucian, you and I both know this is a cultural matter, that unless we get better teamwork, better communication, more openness, more humility really in the system among caregivers and between caregivers and patients, we're unlikely to make really astounding progress in quality. So how do we reconcile the investment of technology with an equal investment in culture change?

Lucian Leape: I think it's a very good question Don, and the problem with your question is it's easy to get people to pay for technology, and they look at culture change as fuzzy in thought. What we're seeing is a great deal of interest in teamwork and team training. We have major healthcare systems, Kaiser among them that are doing team training for all of their physicians. And my hope and I have to say it's just a hope, is that this will have legs. That is, we will see the obvious benefit, and it will spread. The use of simulators is helping

in that. But again, it's a high-tech thing that everybody gets romanced about. But one of the main things that simulating experiences does is it teaches people to work in teams.

So I think it's going to happen that way. I haven't been able to figure out any way to get anybody to pay for it frankly. But I think it may be one thing that happens on its own. I certainly hope so.

Madge Kaplan: Sorrel King, when we've talked before, and I think was in some of your letter to Doctor Dover, you've expressed a lot of concerns about the workplace culture in hospitals. And I'm wondering what have been your observations and what some of your concerns are?

Sorrel King: Don you took the words out of my mouth just now. I sort of see this all from my sort of simplistic view of things, and that's what I try to do. I mean, if I had my magic wand I'd like to have every nurse, every doctor, every CEO be thinking about patient safety, how am I going to prevent the next patient from getting hurt. I would love to have them all working as a team, patient safety, quality, someone makes an error, if there's a near miss, their first reaction is "Oh my gosh, I've got to report this. Oh my gosh, I've got to share this information. Someone could learn from my mistake."

I don't know, I think that is happening in some places. I wish it was happening in all places, and I wish everyone was thinking in that way. I have, what I try to do is I try to get into the heart and in the minds and souls of every single caregiver that I can get my hands on. And I've got my hands on hundreds and thousands of them through my video of telling my story and my cry for help. And I just can't tell you the emails I've gotten from a lot of the people that are probably on this call saying, "Oh my gosh, your story is changing the way I touch my patients. Your Josie didn't die in vain. You're changing things. Your story is changing things."

I get emails like that and I realize that there are nurses and there are doctors out there that really want help and their hearts have been touched and their minds have been touched and their souls have been touched. And I think they need tools, they need help. They need a road map. And I look back at the last four years, the last five years since the IOM report. The talking and the action maybe are moving forward. It could be, "Okay, what are we going to do? Let's put words into action. How are we going to move forward? How are we going to change the culture? How can we teach the medical and nursing students about this stuff and how many people dies a year from medical errors?"

Does that answer your question?

Madge Kaplan: Yes. I wonder, Peter Pronovost are there some things that are being worked on at Hopkins that you think get tools especially into the hands of nurses, who sometimes face a lot of complications around speaking up?

Peter Pronovost: Sure Madge, but before I get into some specific tools, I want to get back to this question of why is spread so hard. And I say this from the perspective of a practicing doc who is still in the trenches. And one of the things that I think we need to do is make sure we develop interventions or programs that are meaningful for the front-line worker who is actually delivering care.

And second that we manage dissemination, that we actually have an explicit strategy of what our cookie-cutter, or what our dissemination strategy is. And when you do those things, the excitement and the willingness to spread is amazing. We packaged an ICU intervention that we developed with the IHI and the VHA and piloted here at Hopkins. And now we have 110 ICUs in Michigan, 55 in New Jersey, we just started 44 in Maryland, and are planning to start Rhode Island and the Province of Ontario. And people are hungry for this. And I think the reason is because it's packaged in a meaningful way for people on the front-line staff.

Now, in our tools here what we've found, and a part has been some of our learning that we tried training and stuff from aviation, but our staff said, "Give me tools." So we have packaged a couple of very simple tools. One I'll share with you is a shadowing experience, where we have our residents and our nurses do

somebody else's job for two hours and come back and answer the question, "What will I do differently now that I've just done this?" And it sets up a dialog and a culture, and we've been packaging a tool kit literally that are exercises like that that our staff could begin to train.

And another exercise is we have somebody observe rounds on one patient, or sometimes they'll do two patients, and at the end of those rounds, they give feedback that says, "Let me tell you what communication was like." And it's extremely humbling and informative, and it's a way for us to continually build skills at communication because most of us in healthcare are trained very poorly at it.

Madge Kaplan: Anyone who wants to take this up, do we need national standards, benchmarks, anything that starts to wrap up the best work that's going on into some real blueprint

Janet Corrigan: This is Janet Corrigan. Yes, I think the answer to that is absolutely. I don't know if I would say standards are what we need so much as benchmarks and comparative data and information on what different institutions are doing. If we don't have some sort of central repository, if we don't have benchmarks, goals, and standards, it's going to be even more difficult to spread all of the good work that's taking place out there to many other institutions.

Don Berwick: This is Don Berwick. In the original report that preceded "To Err is Human," although Janet Corrigan was the Executive Director of this report also, that was the report of the President's Advisory Commission on Consumer Protection and Quality in the healthcare industry back in 1997/'98, there was a call for a national aim-setting methodology, which I still wish we had as a country. Like Lucian said earlier, if we really, really could set a national goal around safety and commit across the society or the Government to that, I think it would make a big difference.

I'm not sure about benchmarks or standards, but I'd say goals would be extraordinarily helpful at this stage.

Madge Kaplan: What sorts of goals?

Don Berwick: Well, goals for lives saved might be a good place to start, or at least with respect to some of the things we do monitor in national infection rates and so on, goals that we really own. There are various objectives put out by CDC and others but not a national policy to say, "This will be the American infection rate and nothing higher in three years," or "This will be the rate of errors occurring in medication use in hospitals." We could do that now. We're in a position to do it. And the IHI is going to announce a campaign on December 14 at our forum to save 100,000 lives in America, and I'm going to announce it because we can do it. And it's just a small step forward, but it would be a chance to really consolidate I think the intentions of a large number of places around goals. We could do that across the nation if we chose to.

Carol Haraden: One of the differences -- this is Carol -- is the difference between benchmarking and goal setting is oftentimes the unified performance around a particular aim is not terribly good. So one can look at the data and feel quite comfortable that I'm within the benchmark. But I think one of the things that I've been heartened by, continually heartened by, is when you share with people what's possible, give them a new sense of what's possible, which has nothing to do with benchmarking really. It's all about ambitious goals and ways to reach them, it's amazing how people resonate with that.

At first they're a bit incredulous, but I think that's where benchmarking can fall short. Some people will look at a benchmark and see how far they are from it, and that find that quite motivating. But many people really need some what we call raise-the-bar or groundbreaking goals out there that are in fact, and we can prove that they're achievable. That can be enormously motivating, and I think change their mental model from we need to change our system a little bit to really we need to fundamentally change if we're going to get that far.

Janet Corrigan: This is Janet. If I could just add one comment.

Madge Kaplan: Janet Corrigan, yes go ahead.

Janet Corrigan: I think that we do have, one of the accomplishments of the last few years with the leadership of Carolyn Clancy at the Agency for Healthcare Research and Quality, we now have in place a national healthcare quality report. And that report card or report is coming out on an annual basis. The second one will be released soon. Some of the measures in that national healthcare quality report do relate to safety, not as many as we would like to see, and in part because they're working off of existing data sets as sources of information. But there are some there at this point. What we need to do is to set those goals, and then we need to measure our progress and produce a report each year that reports to the nation how much progress we've made, whether we're moving towards achieving our goals.

In addition to that, what we would like to get in place as we go forward is the ability to roll that down to the community level so that whether you're in Boston or San Diego or you're in Omaha, you would like to be able to look at your community and how well you're achieving the goals.

Lucian Leape: Well, this is Lucian. I want to add one more point on this because I think it's a very important issue, and that is we have some of these measures right now. And the classic example we've already referred to is nosocomial infection. But if the Department of Health and Human Services were to say, "We have a goal in this country to reduce nosocomial infection to some specific level," it would be possible with current methods to measure the level of nosocomial infection. Every hospital in this country using the methods that the CDC has had in place for a number of years, and we could have a national report with 5,000 points on it, one for every hospital, and it would be quite apparent whether we're achieving that goal, and it would be quite apparent to the people what they need to do to improve.

So the idea of goal-setting is not pie in the sky. But what it takes is somebody to do it. And that's what we're lacking. We don't have this call to action that calls us to do things that we know how to do.

Peter Pronovost: Madge, this is Peter Pronovost. I want to just echo that I fear in the absence of goal-setting at the ten-year anniversary of the IOM, we would be sitting here and not be able to answer the question, "Are we safer?" Because it's such a broad concept that could be so diverse, and our efforts now in many ways are like Brownian Motion, we're going in many ways. And I believe we need goals, very clear measurable goals as in country to say, "Here is where we're going to prioritize. Here is where we're going to make the resources available to achieve those goals." And at the end of five years, we will all be held accountable for achieving them.

Sorrel King: It's Sorrel. And this is to Don and Lucian and everyone else on the panel. Do you think part of this slow progress is partially because of public awareness, the general public needs to be demanding more from their hospitals? Maybe the general public isn't, maybe everyone isn't aware that a lot of people are dying from medical errors. You hear about Mothers Against Drunk Driving. Everyone knows what MADD is and what their purpose is because everyone is going to get in a car today and they're going to pray to God that they don't get hit by a drunk driver. But yet -- do you get where I'm coming from?

Don Berwick: Yes, this is Don, if I can start. I agree with that point Sorrel. I mean, it's a tough line to walk. We need a public angry enough to get people's attention, but workers resilient enough in healthcare to respond positively instead of defensively, and it's a very tough line. But at this stage in our country, I wish there were far more public outcry for the kinds of things Peter and others are talking about, which is let's get this job done that you're so eloquent about Sorrel.

At some level, it's accessible. Number one, I've never published a paper on patient injuries without getting a raft of letters and emails, including from healthcare professionals who say, "Let me tell you what happened to my mother or to my brother or my child."

And second, Sorrel did a generous thing in joining me in teaching a course that I teach at Harvard College this year. We had about I think 18 or 20 sessions. But that one with Sorrel was absolutely rated by all of

the students at the top in terms of what they wanted to know, what they wanted to hear about, and it made me wonder at the end of the day, "Where does that energy go when these people become doctors and nurses and healthcare administrators?" The passion must be there somewhere and we have to access that.

Madge Kaplan: Anyone else want to respond to the issue of what sort of public pressure is needed?

Lucian Leape: This is Lucian. I want to put in a negative note. I don't think that public pressure is going to do the job. And the reason is I don't think there's any way to get it mobilized into a big enough force to change things. If it didn't do it after the 98,000 came out, if it didn't do it after what happened at Duke and so forth, I don't think it's going to do it.

I think where public representatives, such as Sorrel and some of the patient advocacy groups can have an effect is on the Boards of their hospitals. And I think they have to work at the local level. But we have not been able to sustain any kind of public appealing on this for any period of time. We have to find some other way.

Madge Kaplan: Sorrel King, what have you found when you have gone out and done a lot of speaking to families and consumers and patients? Are people looking for ways to have more influence?

Sorrel King: When I do my speaking, which gives me more wrinkles and more grey hair than a 39-year-old should have, it's mainly to doctors and nurses in hospital groups. My communication with family members is generally on the telephone and on email. And you know what? Most of these people are sort of stuck. I would have to say all of them, the hospitals have never apologized. The hospitals have rarely admitted their mistakes. A lot of them are in the middle of nasty lawsuits. Some of them have been swept under the floor. Some of them are too grief-stricken to even think about doing anything. But all they want is they want an apology, they want to know what happened and they want problem to be fixed.

And unless those three things can happen, I don't think there's going to be much progress from people like me. And I was -- and I can't stand using this word -- lucky enough, fortunate enough, I don't know what I was, I mean Hopkins did the right thing. But every hospital, I wasn't lucky. Everyone should be treated that way. They're not. I don't think it's happening. So that whole disclosure piece, all that openness, that's a whole other issue, that's a whole other part of it that if doctors aren't even admitting that they're making mistakes, how are they going to fix the problem?

Families know that doctors and nurses didn't mean to hurt their children. They all know that, I think we know that. But how do you fix a problem if you can't admit that you made a mistake?

Janet Corrigan: Madge this is Janet Corrigan. I think it's really important that we keep trying to communicate with the public at large on this issue and we keep providing them with a steady flow of information, whether it's about particular errors that occur in patients that are injured. Or whether it's more aggregate data that shows how frequently these things are occurring, these events, whether it's to also try to provide them with various tools and suggestions for what they can do to make the environment safer.

I think the jury is really out on whether or not patients and their families can drive the system. My own bias is that I think they have a very important role to play. They can't do it alone. There are all kinds of other things. We need changes at many different levels. We need very strong health professional leadership. We need strong administrative leadership in governing boards. But don't forget, as we think back over the last 50 or 60 years, really the whole history of our health system, we have been telling patients and the public we have the best healthcare system in the world, everything is just fine. You're going to get very high-quality care. You can't change that overnight, and we need people to begin to understand that we do have absolutely exemplary and wonderful things about our healthcare system. We want to preserve those. We want to make them stronger and make them better. But at the same time, they have to begin to realize, and it's going to take a period of time for them to do that, that we have some very, very serious problems and deficiencies.

Madge Kaplan: Carol Haraden I'm wondering how do you reconcile all the discussion about patient satisfaction that the system seems quite preoccupied with, as well as getting more information, ratings, rankings, all the other ways of looking at quality that consumers can have access to, with the sense that there's a juggernaut of what would really make the difference in preventing errors.

Carol Haraden: Well, I think several people have spoken to it. We have a system of healthcare that has taken hundreds of years to develop into where it is now. And that is that it's a fairly paternalistic, hierarchical organization. When patients come I think by either overt agreement or certainly by tacit agreement we turn our lives over to caregivers, doctors and nurses, pharmacists, occupational therapists. And I think to even when you start to talk to patients about being active caregivers, it smacks a little bit of, "Can't you keep me safe? Why must I come in worried about this?"

And somehow, I think we have to get beyond that dialog to, "How do we become active partners together in your care," that it isn't about being a human shield. It's about actively understanding that there are, in a complex system, all of us have to be at our very best and have to be contributing. And that the patients have a role as well. I think to date, patients honestly are not terribly thrilled with that idea, an awful lot of them, besides the fact that they can be terribly sick when they're in the hospital. And neither are our healthcare providers, and that is we're not as a rule all that welcoming of having someone question our decisions and embrace having patients fully activated in making their own decisions, particularly if we don't agree with them.

So I think right now, we are at a juncture where we need patients to come and be active partners with us, but we're really unsure how to invite them in without frightening them. And I think they're a little unsure of how to come to this partnership as well.

Madge Kaplan: The Institute of Medicine report called for a mandatory public reporting system for serious medical mistakes. There are House and Senate Bills that have to be reconciled right now that call for a voluntary medical error reporting system. There's still no Federal legislation either way, voluntary or mandatory. Where are we in the thinking about that? Is mandatory still a good idea?

Janet Corrigan: This is Janet. I'd like to clarify one thing Madge. The IOM report actually called for both mandatory and voluntary systems. It was the thinking of the committee that for the most serious errors that result in death or very permanent serious harm to the patient that those kinds of errors, those kinds of events should be mandatorily reported. It should be a requirement that they are reported and that a root-cause analysis is conducted, and that the organization or individuals involved we make sure proper actions were taken to improve the system so it doesn't happen again.

Then the report also called for voluntary reporting systems for near misses, those events that don't result in harm to the patient or they result in very minor, temporary harm to the patient. And in those cases, in the latter cases what we were really striving for was the development of learning reporting systems, ones where you would essentially be accumulating a lot of information and a lot of events, be able to see trends or things that were occurring and to analyze those and to feed the information back to the healthcare sector to act on it and improve systems before serious harm occurs.

Madge Kaplan: What has happened though is that there is a voluntary medical error reporting Bill that's emerged in Congress, if one is going to happen at all, regardless of the nature of the error. And I'm wondering if anybody has any comment on what that will provide should it become a law.

Don Berwick: Madge this is Don. It's a controversial topic, and I'm not sure people will agree with me. I think we've gotten diverted into the reporting arena a little too much. I do want mandatory reporting in this country, and I want voluntary reporting, and those will help. But somehow, we ended up debating about reporting instead of forcing the issue of actually making care safer. And I think we've got to keep both issues alive. Reporting is by no means enough. It's not even close to enough. It's only the very first step that one takes in the journey to improvement. And somehow we're treating it as if it is the whole issue.

So I'm distressed at the amount of attention that issue is getting. I just want to get on with it. You can't improve safety without transparency. That's absolutely clear. But a reporting system is just a small step towards progress.

Lucian Leape: This is Lucian. I second what Don just said. I feel exactly the same way. I think it's been tragic we've had so much energy devoted to the reporting issue. But there's been a new thing happening recently that's worth our talking about. Mandatory reporting systems in this country have been run by states, and none of them have been worth much because no state has been willing to put in the money it takes, not to collect the reports but to analyze them and learn from them and feed back information, and in the absence of that kind of response, reporting does very little to improve safety.

We've just had a new player come on the scene in Pennsylvania, where they passed mandatory reporting law but gave it two things that give me a lot of hope about it. Number one is it's confidential, and that is the reports don't even include names of patients or doctors or nurses. But the second thing is they put in a means for funding it through an assessment on hospitals. And so they have enough money to do the analyses. They have contracted the analyses out and at several months in, they've already begun issuing advisories. I think we're going to see in the Pennsylvania model a way to use reporting, mandatory reporting in a positive way that will make a difference. So we ought to watch that experiment.

Madge Kaplan: Briefly before we turn this over to questions, let's start with you Lucian Leape, how about just tick off some priorities that you have for the next phase. You can take it one year at a time, or the next five years, but what kinds of things do you hope to be working on?

Lucian Leape: I think there are two or three things that are going to happen sort of in spite of us. I do think the electronic medical record is going to come. I think, as I mentioned team training is going to come. And Sorrel I think full disclosure is going to come. People are talking about it seriously now. People are trying to figure out how to do it. They're doing some very interesting experiments in Colorado and in Michigan with full disclosure apology and early settlement. I think this is going to accelerate.

So I feel very upbeat about disclosure, which is long overdue, and apology, which as far as I'm concerned is the central part of it. And I think the Joint Commission is going to continue to push ahead on pushing us to increase implementation of safe practices.

I guess the question is whether we're going to get any further direction from the Government, and most of us are fairly pessimistic about that. I think we'd all like to see some standard-setting at that level. Clearly the payers are going to be playing a bigger and bigger role, and we'll have to just see how that plays out because it could be the major factor.

Madge Kaplan: Okay, Janet Corrigan.

Janet Corrigan: Well, my first priority I think that I would hope for in the next five years or so is major, major advancement on the electronic health records and the personal health record. We shouldn't leave the patient and their family caregivers out of this. These records and electronic means of communication need to extend into the home.

The second priority would be pay-for-performance, and I'm very optimistic actually that we will begin to see our payment systems revamped so that we provide stronger incentives to everybody to really focus a lot of attention. Those two together could be very transformative tools that would help to really open up I think a lot of opportunity to make some rapid progress.

The third thing that I am less optimistic about, but that I remain very hopeful that it will happen is that we will see some really collaborative leadership across the health profession, medicine, nursing and pharmacy in particular. And I mean leadership to accomplish two things, one to really make some major changes in health profession education and training. We need to build safety right into the curriculum and the learning

experience of residents and nurses and pharmacists and other health professionals.

And then second I hope that we'll see that real collaborative leadership across the profession to change the healthcare delivery system. And the two really go hand-in-hand.

Madge Kaplan: All right. Peter Pronovost.

Peter Pronovost: Hi, this is Peter. I see three real clear directions that need to go. The first would be what I would say building capacity to do this type of work, and that is as Janet said training our house officers and further training the research community who could lead these efforts in building those sources.

I see two as better understanding clear goals and measures for those goals. I think that as an industry, both at a national level and at an institutional level, we don't have a really clear idea of what it means to be safer, and we need to. And I'm optimistic that we will.

And the third is I believe communication, and I would put IT infrastructure as part of that because I see it not as a tool to just help link us better, but a tool that has to be coupled with this culture change and enhancing our ability to work together as human beings.

Madge Kaplan: Sorrel King, what would you hope to see... what you might be dedicating yourself to in the next phase?

Sorrel King: The ten-second version or the ten-minute version?

Madge Kaplan: Maybe ten seconds, but we'll get to more in questions.

Sorrel King: I just don't want to throw my hands up in the air, but I guess just to sort of buckle down to work and let's, we've talked about it long enough. I've told my story long enough. I want to get out there; I want to help people find tools that work. I want doctors and nurses to be aware of this stuff. I want to get into their minds. I want to get into their hearts. I want to get to the CEOs. I want to get them thinking about it. I want people to disclose. I want every insurance company to be thinking about this. Not just putting payouts, but saying, "Okay, what are these hospitals doing to prevent us from having to do these payouts?" I want families to be treated in the right way, and the whole culture thing. That's what I hope changes, and I'm all for the IT stuff, and I hope it all happens together.

Madge Kaplan: Carol Haraden and Donald Berwick briefly and then we'll go to calls.

Carol Haraden: I guess I'd like to see us stop waiting for the electronic system. It's going to come. It's marching along. It's still a ways off, and for some hospitals, it's quite a ways off in the course of patients' lives and all that's happening right now. We don't -- there's so much to do. Pick something and get moving on it. Stop waiting.

Madge Kaplan: Don?

Don Berwick: I want to do everything I can to encourage our national and regional and local leaders to set goals for improvement and really stick by them. In our own camp, we're going to launch this campaign on 100,000 lives, which will be the total focus of my attention for the next 18 months.

I think Lucian said earlier we need to reach Boards of Trustees. I'm going to put a little bit of energy in hoping we can get governments more concerned.

And what Janet said about professional education is exactly right. I think the public might be very surprised to learn how little young doctors and nurses -- although not young pharmacists for whom safety in pharmacy training, it's pretty deeply embedded,... but in medical and nursing training, not yet.

Madge Kaplan: Okay, Peter Pronovost are you going to be able to stay with us, or do we lose you now?

Peter Pronovost: No I'm here with you.

Madge Kaplan: Okay, good. Don't want to say goodbye prematurely.

We're going to now turn to questions from people who have been listening in. I want to thank everybody who does have a question who is in the queue. If you could just please say your name and where you're from, and if your question is directed to one person in particular please state that also. Since there are so many on the call today and we want to get to as many people as possible, if you can make your question as succinct as possible, that would be great too.

Okay, let's go ahead.

Operator: Great, thank you. Ladies and gentlemen if you would like to ask a question, please press zero one on your touchtone phone. This will place you into a queue and I will then open up your lines one-by-one so that each of you may ask your question.

If your question is answered or you wish to no longer ask it, please press zero two to be removed from the question queue.

So once again, if you would like to ask a question, please press zero one on your touchtone phone.

Our first question comes from Pam with Assante. You may go ahead.

Pam: Hello, thank you. What I didn't hear discussed is really the internal nitty-gritty of what's going on inside our hospital system. And I am a manager in a hospital system on a clinical unit, and what I see is that we continue in a hospital system to say, "This is what we should be doing. This is how we should be doing it." But there is no regulation. There is not regulation at the hospital level. There is not regulation from the insurance companies. And there is no regulation from JCAHO.

My main push here at our institution is I want us to follow the standards of care. I want us to follow the standards of care set forth by evidenced state practice, set forth by national experts, and there is no force behind what I'm asking. And I'm someone inside of the system saying how come we can't just say follow the standard of care?

Madge Kaplan: All right, thank you for that question. Anybody want to take that on? Lucian Leape?

Lucian Leape: I think she's absolutely right. That's the fundamental problem. We have no accountability at any level. The doctors don't have to do it if they don't want to. The hospital doesn't have to do it if it doesn't want to, and I couldn't agree with her more. And the question is who is going to do that?

Sorrel King: It's Sorrel. And tell me if I'm wrong. Doesn't this come from the leadership of the hospital? I mean if the leadership of Pam's hospital stood in front of the caregivers and said, "Patient safety is important. Everyone use these tools, or let's make this happen," the CEOs, if the leaders stood up and talked about this, would that help?

Madge Kaplan: What do others think? I mean, leadership Lucian Leape, this is something you've thought a lot about. Others, I think all of you have. Where are we in terms of leadership and what needs to happen there?

Lucian Leape: I think most of us would say that is the key problem and we've been struggling to figure out how to get it to happen. Don you've had more experience with this than anybody.

Don Berwick: We don't see improvement at all in safety in important ways without key leadership, and I think that's where the thing starts or stops, in the Executive Suite, pushed however by their morals, by their staffs, by their Boards or by the Joint Commission.

I would say a word about the Joint Commission. I think if one takes the historic view of where that body is, it is making progress. We're starting to see safety standards emerge. They're starting to get more and more interested in the problem. And I predict that the circumstances on behalf of the Commission are going to change pretty dramatically in the next couple of years and I think those hospitals that anticipate it are going to be in much better shape.

Peter Pronovost: This is Peter.

Madge Kaplan: Go ahead Peter.

Peter Pronovost: One of the real underlying themes that question highlighted was this need to curb individual autonomy in healthcare. And that's an issue that we really haven't been willing to wrestle with, that we have placed such value on what I would call the art of medicine at the expense of the science and haven't been really confront to say that we need to standardize the way we do things like we have in aviation. So just because you're top of your class, or you're a skilled physician doesn't give you the freedom to do things your own way.

Madge Kaplan: Yes, Janet Corrigan do you want to jump in?

Janet Corrigan: Yes, I think Peter has made a very, very important point in terms of autonomy. It should not be used as a shield against accountability. We need accountability as well. It's absolutely critical.

I think in terms of the leadership issue, it really needs to come from several different sources and several different levels. As you recall in the Crossing the Quality Chasm Report, what we spoke to there was really the need for fundamental change at many different levels. We need to see change at the Federal level, the national level. We also need change at the state level. We need change in the health profession. And then we need change in the healthcare delivery system at the community level and the local and in the micro-systems.

And that's one of the -- the issue here I think is how do we get coordinated leadership from all of these different major stakeholders? A couple of years ago, the Institute of Medicine released a report "Leadership by Example," which called on the Federal Government as the largest purchaser of healthcare services, well over 40 percent of healthcare is purchased by the Federal Government, as the largest regulator, and also as one of the largest healthcare providers with the Veterans' Health Affairs that they are really in a very unique position to provide a great deal of leadership.

And I think that some of the recommendations in that report have been followed, and we are seeing some very good leadership right now on the part of the Department of Health and Human Services and CMS in particular, really trying to think through how best to standardize performance measures and use that information, whether it's through QIO programs or pay-for-performance policies. This is tough going.

We also need very strong leadership though within the health professions. And we have had some changes as far as board certification and recertification efforts under the leadership of David Leach and others. The American Board of Internal Medicine is doing some very good work in this area as well. So I wouldn't say that we haven't had strong leadership in some areas. It's beginning to emerge. We just need a whole lot more, and we need it in each one of these major levels and stakeholder groups.

Madge Kaplan: Okay, let's go to another question.

Operator: Our next question will come from Sue with Elliott Hospital. You may go ahead.

Sue: Hi, I have, my question is -- the first question was absolutely right. At the patient care delivery level, there is no accountability. We're faced with holding physicians and nurses accountable, but nobody will even accept practice guidelines, never mind implement them. And when you do force physicians to be

accountable to something, you are then told that this is a big practitioner. He's bringing lots of patients into the system. Don't make him angry. How are we going to deal with this at the ground level?

Madge Kaplan: Carol Haraden, I'll turn to you.

Carol Haraden: Yes, I'm thinking very much about what Peter had said as well, and that is every industry that has become safe has had to switch from what we would say a craftsman's attitude to an equivalent act or attitude. For instance, when we get on a plane we don't check out the credentials of the pilot. We take for granted that we've got a skilled pilot from flight to flight. We don't worry about that. And yet we're nowhere near that with practitioners, nurses or doctors. I think we worry about individual issues.

Really, it comes down to a leadership problem. I hate to say that, but I really do believe it's true. I was just meeting with some clinicians not long ago, physicians and nurses as well. And they were discussing the same problem, how do we get people to do this? And at some point, I mean you can provide marvelous data, and I think that's very important. You can provide a compelling case for change, and that's really important. I think people being able to look at their own data compared to best in class often helps them understand, well this is a bigger problem than we thought individually.

But at the last, at the very last it is a leadership problem. We are going to have to agree, and I don't think without clinicians agreeing with us. It's almost like class warfare. You need to be able to say, "This is the way we are going to practice medicine here," or "This is the way we are going to practice nursing here." And it isn't only physicians. I hate to say it, but I think nursing is almost as guilty of not following their own practice guidelines, and they don't love standardization either.

Don Berwick: Madge, this is Don. I want to add a word about, since there are probably several thousand people on this phone call listening in, in their rooms, individual doctors and nurses who are hearing this are wondering what they can do. Do they have to wait for the executives to act? I can't overstate the value of individual doctors and nurses who just on their own begin to say, "I'm not going to let this happen. I'm going to make my place safe. I'm going to act safely first on my own behalf." They become the examples and teachers, bridge builders to clinical cultures, and they're very, very important. And they're the people I get to work with all the time that keep my optimism up.

Peter Pronovost: Don, this is Peter. I want to add one point. It's an indictment of the research community, of which I am a big part, and that is our output of the standards has been 100 to 200-page guidelines that are uninterpretable and nobody reads. And I think we need to begin to say, "Let's cull those out into checklists, or groups of things we ought to do." We call those at the Institute a bundle, and we have packaged them in digestible chunks. They are used and people do use them. And so part of it is we need to learn or refrain how we package this for caregivers so it's easy for them to access.

Madge Kaplan: All right, next question.

Operator: Our next question will come from Ken with Medical Economics. You may go ahead.

Ken: Hi, my question concerns how malpractice laws have to be changed in order to improve safety, both in the hospitals and in the ambulatory practice settings.

Madge Kaplan: Okay, thank you. Anyone want to take on malpractice?

Lucian Leape: This is Lucian. I'll take a shot at that. We haven't mentioned that, and malpractice is the 800-pound gorilla in the room. The threat, the concern about malpractice litigation is a very major barrier for physicians, or at least many of them think it is in terms of participating and reporting errors, discussing and analyzing them, and it's been a major problem. Again, I think it's a myth but it's a reality in the sense of the way physicians feel about it, keeping them from being fully honest and apologizing to their patients.

Most of us don't think there's much change of fundamentally changing the malpractice system. Most of us

don't think that caps on settlements are going to make nearly as much difference as some of its proponents think. But there are two things going on that I think do offer some help. One is, as I mentioned before, I think we're going to make some real progress on full disclosure and apology, and that's going to have a huge impact. The major reason people sue is not for money, it's because they're angry. And if we can handle patients the way they should be handled, I think we're going to see a big improvement in that.

But the money thing is the other part of it, and we're also making progress there. The Medical Practice Study, which started us all off now almost 15 years ago, recommended that we go to a no-fault compensation plan for medical injuries. That never has gotten anywhere, but it's now beginning to happen with some of the payers. I mentioned experiments in Colorado and Michigan where patients are being given immediate financial settlements, as well as the full disclosure. And my hope is that that will grow, and if so I think the malpractice issue is going to diminish a great deal.

Don Berwick: This is Don. I agree with Lucian. What kind of drives me a little bit crazy about malpractice solution is I think we kind of know what it looks like, and we just need a state or a pilot somewhere to say, "Let's try this out for a few years." As Lucian said, it has to include absolute disclosure, and you're out of the system if you don't disclose. Apology to the patient, as Sorrel mentioned, is the most important, dignified, healing thing we could add to the system. Compensation, fair compensation to people that are injured, which is reliable. It doesn't waste money in transactions costs, and it has to have a lesson-learned component so that the odds for future injury go down. And all of that must be borne at the enterprise level.

That's what it looks like, and we need some components, political components of our country to get about that and prove that it will work.

Madge Kaplan: Okay, how about we'll turn to a new call.

Janet Corrigan: One last comment, this is Janet.

Madge Kaplan: Go ahead Janet.,

Janet Corrigan: I think an overhaul of the malpractice system is what we need, and I hope it's what we get. But if we don't, I do think that there are some improvements and enhancements that could be made within the current system. I mean, for example if our legal deliberative process would consider whether or not appropriate safety systems were in place in hospitals before reaching a judgment about the guilt or innocence and how much money should be awarded, that would have a major impact. So for example, we know that computerized medication order entry systems can decrease adverse medication events up to 80 to 85 percent if you have a good system and it's used properly by all of the clinicians. Well, if that's the case, if a hospital has invested in one of those systems, or a small practice setting or a medical group, then it seems to me that that should be a very good defense in court. And if you have not, on the other hand it should be something that is taken into serious consideration as to whether you did have a system that was safe enough to be providing care to patients.

Madge Kaplan: All right, a lot of interesting ideas. Let's go to a new question.

Operator: Our next question will come from Artemis. You may go ahead.

Artemis: Yes, Don and Janet had started to touch on this, which is about professional education and I'm wondering to what extent some of this safety stuff has really seemed to penetrate upstream. And where do you think it's been the most successful, and where are the major barriers with penetrating into the curriculum?

Madge Kaplan: Don, do you want to tackle that?

Don Berwick: Yes, only to Lucian's solution because he's been struggling with this. There are a number of medical schools especially that are meeting now, and a few nursing schools that are starting to figure how to put it in. But we are way, way behind the curve on this one. Innovative efforts on introducing safety into the

curriculum as a stable and important part of the curriculum are still way behind. Lucian you know more than I do about that.

Lucian Leape: We're all, of course, believers that we need to do that, and it's really amazing how hard it is to get it started. Medical schools are even more refractory than hospitals I think. I think one little bright ray of sunshine, though, we had a very successful experiment just last year of having joint learning sessions in the third-year medical school with nursing students and medical students working together on case problems and so forth. And everybody was very enthusiastic about it so much that we're expanding it this year. I think if we really want to teach people to work in teams, they should learn it in medical school or in nursing school, and that this is a good start.

Madge Kaplan: Is that Harvard Medical School?

Lucian Leape: Yes.

Madge Kaplan: Okay.

Don Berwick: I can't help giving our guests a gift. A group of medical students at Harvard has started a website on this called [Improvehealthcare.org](http://Improvehealthcare.org), which has learning materials and case studies on it. And then they're basically saying, "Well, if we can't get it formally in the schools, then we'll do it ourselves." And it's really terrific.

Sorrel King: Madge, can I say something?

Madge Kaplan: Sure. Sorrel King.

Sorrel King: Don that's exciting news right there. A few years ago, Peter and I talked to fourth-year medical students, and Peter said, "How many of you have heard of the IOM report?" Not one single person raised their hand. I thought I was going to fall off my chair. I couldn't believe it. And I think, and I understand it takes many, many years for medical schools and nursing schools to put things in the curriculum, but I think what Don is talking about why can't we create some sort of online something-or-other medical patient safety information place where people go and they read the statistics, they hear speeches from Don and Lucian and everyone on this phone call, and they learn, and you know what? Maybe they hear some real stories about people that have been harmed by medical errors. I mean, at least something like that should be out there and it sounds like that's what's happening, or beginning to happen.

Madge Kaplan: Well, we should put some people in touch with the folks who are working on [improvehealthcare.org](http://improvehealthcare.org), because I think they have a lot of bold ideas in that direction.

Operator: The next question will come from Cary with Middlesex Hospital. You may go ahead.

Cary: One comment, listening to everyone speaking I think that what we want to see happen here is change, rapid change and meaningful change. And yet we're all pointing out to each other how difficult and complex the system is. I think, everyone is talking about the things that go unsaid, the 800-pound gorilla in the room, other things that we still don't want to talk about. I think that we have to be honest with ourselves and we have to say that the system is so complex that we can only make baby steps and we can only make changes in a slow, methodical way.

I think that those like you who are looking at the very, very big picture, the grandiose picture in some sense, you're hurting your cause because I think those of us who are taking care of patients every single day know the complexities, and yes we want things to be better. We want things to be better in a hurry. But I think we have to realize and acknowledge the fact that we are going to have to, that this is going to take a very, very long time, no matter whether we get leadership from our President, from our Board of

Directors, or whatever. I think that it's going to take time. And the lady that lost her daughter, I mean I wish I could honestly tell you otherwise. I just don't see it happening; it's such a complex system.

That's my comment. My question is the public reporting, the public reporting my impression is that the vast majority of physicians don't feel as though public reporting will accomplish anything. The vast majority of the public believes that it will. And so how do we bring those two very, very different concepts, or very different ideas and opinions together?

Madge Kaplan: Thanks very much. Who wants to take on the merits of small steps to begin with?

Carol Haraden: Can I take on that.

Madge Kaplan: Yes Carol Haraden, go ahead.

Carol Haraden: Being a clinician myself and working with front-line teams, people who are on the front line day in and day out, that's what I do. I work with faculty who do that, and the faculty are people like Peter Pronovost who are out there every day facing patients. They are not people in an ivory tower. And I would say it doesn't need to be nearly as slow as what I'm hearing you suggest. I think it can be much faster, and a complete transformation of the system is going to take years. But as far as committing to deep and lasting change, we're seeing organizations take on enormous improvements, zero ventilator-associated pneumonias, zero central-line infections, 75 percent reduction in surgical site infections. And they're doing that within a year.

And much bigger than that, there are organizations out there now who are seeing a tenfold reduction in adverse drug events, and I don't mean errors. I mean harm to patients where they're actually measuring, they're looking at their data, measuring it with us. We are looking at it with them, and I'm struck by how slow we're going. I'd like to see us go faster. I understand how complex the system is. I live in it too, and still I don't think we have sufficient will right now to say we just need to go faster. It is absolutely possible.

Madge Kaplan: Anyone else want to weigh in on the question of the pace of change and how you go about it?

Peter Pronovost: This is Peter. One of the things I really like about the comment is that there's always the risk for harm whenever we change something. And so the idea of that, at least I took from the comment is that we need to be aware and cognizant that when we perturb a system that there may be some unanticipated negative effects. And we have to try to be thoughtful of those and think of them and protect against them or measure for them.

At the same time, though it's also important to realize that the status quo is causing harm. And so that, at least for my own personal journey, drives my urgency because there's, it shows these happening every day. And I need to change but I have to try to do it in a wise way, and that's sometimes hard in healthcare.

Don Berwick: This is Don. I join Peter and Carol in that sentiment. The question is respect for the difficulty I absolutely share, but I don't agree that it has to be slow and methodical. I think there's fast and methodical. And I think what we need is some better sense that a clock is ticking, and while we learn it's our patients that are paying our tuition, and we need to lower than cost. So we're a great country and a great industry, and when we decide to do something and it becomes really a sense of urgency it gets central, we can move. And I think we can in this field. We just have to decide to do it.

Madge Kaplan: Okay, Janet maybe just briefly any thoughts about this sort of reconciling different sentiments or needs regarding public reporting if you're talking about the physician, community, or the consumer public?

Janet Corrigan: Well, personally I think public reporting is important from both perspectives. But I fully appreciate how threatening and how disturbing it can be to many who are in practice. I think that we have to look at the issue a little bit differently though. We are here to serve the public, we're here to serve our patients and the members of our communities that use our hospitals and come for our services. And it's critical that we be

honest and up-front about what it is that's taking place and that we engage them as partners in the effort to make improvement happen and to make our environment safer.

So I really think that public reporting, when it comes to certain types of information, not everything, there needs to be a safe harbor for a good deal of information, but at the same time a steady flow of information is also necessary.

Sorrel King: Madge can I throw in something?

Madge Kaplan: Go ahead Sorrel King.

Sorrel King: It sounds like what Pennsylvania is doing is a great thing. The key component is learning--learning from the things that people are reporting. I mean, if we can learn and share that information, then we're making progress it seems, one would hope.

Madge Kaplan: Okay, we probably have time for one, maybe two, but let's go to the next question.

Operator: Our next question comes from Skip with Region Hospital in St. Paul. You may go ahead.

Skip: My question is to the panel, and it has to do with measurement in general. Until continuous quality improvement is a core competency across all the sharp ends, we are really bounded in our quality improvement resources. What can be done at the national level to eliminate duplication of measurement as NPSF, NQF, Leapfrog, the states, JCAHO, CMS put their requirements upon us to send in measurements?

Madge Kaplan: Okay, interesting question. Anyone want to go for that?

Janet Corrigan: Well, this is Janet Corrigan.

Madge Kaplan: You're brave. Go ahead.

Janet Corrigan: There have been many attempts over the last ten years to try to harmonize the different measurement instruments, and the measures that we use, the various measurements at the different levels. I think we have started to make some progress in that direction.

The National Quality Forum, which essentially was established as a result of the recommendations by the President's Advisory Commission on Consumer Protection and Quality, which Don referenced a little bit earlier, the National Quality Forum was set up a few years ago as a public/private partnership. And one of their roles is to identify various standardized measurement sets and to encourage the use of those NQF-approved measurement sets.

We need to go a whole lot farther though because as we start to move towards measurement and reporting at the hospital level and the physician level, the small practice setting level, nursing homes, home health, a whole lot more harmonization needs to take place. And those measurement sets need to be able to roll up or down, whether it's from the community level down to the hospital down to the small practice setting. So a lot of work is underway in that area, and there is indeed a variety of collaborative efforts that are moving forward. The Federal Government, CMS in particular will play an absolutely critical role in this area because they are the largest purchaser, and to the extent that they can work collaboratively with the Leapfrog Group and some of the others on the private side that represent the collectivity of many different private purchasers, I think that we could actually see a great deal of progress over the next few years.

Madge Kaplan: Okay, anyone else want to talk about lots of different measurement and reporting systems and how that might become slightly more rational? Carol Haraden?

Carol Haraden: There is a collaborative effort going on right now of looking at all regulators, as well as people like the Institute for Healthcare Improvement are at the table as well looking at pooling of these measures. And

there is, it probably doesn't feel this way but it's true, there's a lot of angst even at the regulatory level that they're wasting time asking you to collect disparate types of data. And they are not unaware of that, and I think not only are they not unaware of it, they are unhappy about it and working hard to try to make that difference there.

So there are a lot of efforts underway, and very actively meeting and planning and trying to make data sets talk to one another. And that's a bit of the problem, of course. We're limited a bit by technology as well, but I see a lot of effort and energy and worry about that right now. I don't see that going unchecked.

Madge Kaplan: All right. Well, we could go on, but unfortunately we are out of time. And those of you who still have questions and want to keep talking, we invite you to do so. And you can do some of this online. If you go to [www.ihl.org](http://www.ihl.org) on our home page there under the paragraph about today's call, you'll find a link to a discussion group that's called "To Err is Human Five Years Later."

Also a transcript of the call will be posted on [www.ihl.org](http://www.ihl.org) by late next week, and please feel free to share this with your colleagues.

So I want to thank everyone who has taken part in our discussion today. Our guests Donald Berwick, Carol Haraden, Lucian Leape, Janet Corrigan, Sorrel King, and Peter Pronovost. We really hope everyone has learned a lot. There was clearly a lot of food for thought and ideas going forward. We hope to be talking further in many different arenas.

Thanks to all of you. I'm Madge Kaplan, Good afternoon.