Patient Safety and High Performance Leadership Summit
Issues in Governance, National Collaboratives, and H.I.T.:
Global Patient Safety Education and Awareness

April 27, 2012
Webinar Transcript

Charles Denham: Professional audience and our WebEx audience, we are coming back to start our next panel. We will be starting in about 30 seconds. The hashtag is #HITTMIT, and for those [who] have logged on now, please go to www.safetyleaders.org to access the streaming video if you have a fast line. If you have a slow line, go to our WebEx. If you are unable to hear over audio, then you can select the button in the lower left-hand corner of your screen and access a telephone line.

So we are going to ask our studio audience here at the National Press Club to settle down, and we have a great panel, and the topic that we are addressing is Global Patient Safety Education, and Awareness. We had the real pleasure this year to make, I guess, two or three trips to Switzerland, and had the wonderful opportunity of collaborating with the World Health Organization. Ed Kelley is the leader for their patient safety program, and our 5 Rights Program for imaging, for those that are not on the streaming video, we have a number of leaders [who] are on the stage, and our 5 Rights of Imaging Program™, we are collaborating with the CT and Radiation Safety Group. We are collaborating with Ed's group regarding their patient-safety curriculum. We had a wonderful opportunity of meeting leaders of the students around the world in multiple areas.

I would like Ed to kick off our panel by describing the activities of the World Health Organization. In our earlier panels, we have a very clear idea that patient safety is a common denominator across all nations. We have about the same number of people harmed in our OECD countries [as] in America. This is a global pandemic of harm and waste and one that is crippling every nation, and so the World Health Organization has identified education as a wonderful opportunity to have great impact. Would you please kick us off and give us maybe an overview of what the WHO is doing and how you are taking a standardized approach nation by nation?

Edward Kelley: Yeah, well, first, Chuck, thanks for even considering the global aspect of this besides the fact that it does bring you to Switzerland for some nice cheese and wine. I mean, the tendency, I think, is to look at safety as a local problem. I mean that, sort of what we teach people – to look at data and look at it locally and, you know, come up with solutions locally. If you look, there are 7,000,000 healthcare-associated infections in the U.S. and Europe. There are 234,000,000 surgeries – more than childbirth – around the world, and there is somewhere on the order of 16,000,000,000 injections around the world. Now, you know, the rates of healthcare-associated infection are three to 20 times higher in some nations developing in transitional countries. You've got 70 percent of some of those 16,000,000 injections that are seen as unnecessary, so it is a huge, huge problem. I think your description as a tsunami is apt. The issue that you have frequently as an American and as the former director of the U.S. National Healthcare Report, which I worked [on] with Bill Munier, David, and other people, you know, the tendency is to look at it from the data that we have here and not from a solution-generation standpoint. The OECD data that's out there, the U.S. does not compare well, and we are actually not getting better, even. The problems that you have on reporting systems, on involving patients, other countries have been advancing on this, and I think it is something that we need to think about. For instance, I just came from a long flight from a meeting of 36 countries in Salzburg where they issued a statement and asked me to come to this meeting and read it out to people, saying that they were calling on countries, policymakers, governments, NGOs, providers, and patient communities to start to look at safety not just as what worthy issues that Jim Bagian, John Nance, and other people (Sully), have been highlighting here, which is improving the healthcare system, but actually as a global public health issue, as achieving more health for the limited

healthcare dollar that we get. I think that is a common denominator that you get across every single one of the 192 member states that we have at WHO.

Charles Denham: I'd like to make a pitch to everyone in our U.S. audience and our global audience to go to the WHO and download the curriculum on patient safety. It is outstanding. I mean we have a wonderful trustee from our Safety-Net Hospitals. What a great place to get free content that is evidence-based, makes a lot of sense, and is put together in a world-class way. We really commend you, Ed, also for making the trip to come to see us. The area I would like to address next is with Dr. Zeltner, Doctor, Professor, His Majesty Zeltner, who is a dear friend of ours, and we kid about him, was the former health minister of Switzerland, and they had many ways of introducing him. He is much a treasure because [for] 19 years [he was] their health minister – they deliver healthcare to 7,000,000 people for 60% of the cost that we do. They take care of their poor. I believe that their system – and as an entrepreneur, I can tell you it is much less socialistic than our system is, and I think Dr. Zeltner would agree. That is the issue that he commonly is asked to talk about. What I would like to ask him to talk about is an area for which we have a great passion. The AHRQ Report just addressed the fact that, from 600,000 of our U.S. staff [who] were interviewed, two-thirds of them don't trust their leadership. Two-thirds of them have distrust that if they announce that there may be an error on a patient, they'll be held responsible. A majority of them believe that if an error happens, it will be in their own personnel report. I know trust is a real passion for you. Describe your Five Elements of Trust that I think are really insightful on how patient safety fits in those five elements.

Thomas Zeltner: Well, thank you very much, Chuck, and thank you that I can be here. I think this is really a very important moment in patient safety. Let's assume you or I go to a hospital right now. What I actually expect, apart from being well treated, is that I can trust the doctor; that I can trust the team; that I actually can trust the system I go into. On the other side – and I love, you know, the way Bob Chapman has designed that – those who work in systems want to be trusted. I feel that there are, right now, major challenges [in] how to continue to build on that trust. I have really figured out as my personal vision on that, reviewing that, five elements which are in the air and where leadership at all levels is really awful. Point one is really patient safety, and we have been talking about that extensively. How can you believe that people feel comfortable coming into an organization where, luckily now, there is much more transparency than in the past? Transparency generates this element of doubt, and we have to work with that. The second one – I think nobody talks too much about this – is the explosion of knowledge. We know by now that it is very hard for health professionals to keep up with knowledge, but it is also hard for patients to not doubt that the person in front of him or her is really knowing what is the best practice. So that's the second thing. The third thing – and you just went through a very difficult debate here – is the limited resources and who gets what. We do not want to get into a death panel discussion but we are talking in the system of limited resources and that they need to be fairly distributed, and that there must be [a] mechanism. If we are not able to organize that, the trust in the system will break down. The fourth element is – and we have to realize that there is so much speaking about you can't reform the health system. It is a system out of control. You see that in many countries, above the level here in the U.S. with the healthcare reform, but you see it on the lower levels, and that is undermining the trust. If the population has the feeling there is a system that we have no control over it, that is no good time. The last thing, of course, is related to that, that special interests in the system are governing where decision goes. So I think that our major challenges, when it comes to leadership, leaders at the level of the hospitals, leaders at the level of the county or at the national and international level, have to look at these different elements and have to benchmark we want to keep the trust.

Charles Denham: So, Steve, we have talked about earlier, at earlier panels and for our audience that has just come on board, Dr. Swensen has been a fabulous leader at the Mayo Clinic in quality, and when you think of the concept "servant leader," you think of Steve Swensen. He is just it personified. He has now moved from quality to leadership. Steve, in education, now that your job will be the leadership development of those at the Mayo Clinic, how will you help educate – coming back to the global concept – how will you educate leaders about their role for patient safety? As you develop the leaders, connect for us your former life as the head of quality – and safety being really important and you being really good at it – to, now, leadership development. Help us. How do we connect those strands of DNA together?

Stephen Swensen: Transparency has been a big theme here; and I think, for leaders to transform our organization, that is the lever that they need to use the most. It is sharing the programs within with leadership, but it is also one of the themes here this afternoon, in this session, is patient awareness. So breast cancer is a major killer on this planet and we know that early detection makes a difference and saves lives. Yet you could go to a practice that detects 40 percent of breast cancers or one that detects 97 percent of them, but it is a totally opaque environment. A woman doesn't know if she is going to the 40-percent one or the 90-percent one, and she has a right to that. If we have the information out there, we would change the game because patients would have a choice and leaders have to make that choice. Maybe it's the leaders of the country. Maybe it's the leaders of the hospital center. Then, once those numbers are out, as leaders and patients, we can choose what needs to happen. There is a moral imperative to open the books and let patients decide and let leaders manage to excellence.

Charles Denham: Great. Now I'm going to the Cleveland Clinic. Dr. Henderson has done a terrific job of taking safety and quality and making it – you know, to say it in a more popular way – making it cool. He basically picked really good doctors in different divisions of the Cleveland Clinic and made it a valuable and a respected thing to be the person in charge of quality for that division as part of your institute. I think that was genius to do that. So my question to you about education is, how do we educate our up-and-coming doctors – and even old guys like us – but the young doctors to include patients that we have in this audience today on their teams, to kind of bring them in and say, "We want you to be part of the learning of the doctors so that we're not doing all of our learning over here, and here we prepare for our boards and the patients are in another part of the place, and then we're going to practice medicine and we're going to try to be really good in safety and quality"? Because you're doing such a great job of teaching your doctors, and I think the word that you came up with, "trust," and what we put in the film – which was really important – trust. They trust you, Mike, and you are teaching them. How are you getting them to learn about patient safety and how can we do it at the front line where we don't have Cleveland Clinic's resources? It is seen elsewhere where a hospital is a swap meet for business or a farmer's market, as John so eloquently describes it.

J. Michael Henderson: Yeah, I don't think it happens Easily, Chuck, is lesson number one. You know, when I got into this, I had been – as you said – I'm a surgeon. I'd been doing a lot of high-tech stuff. What I came to realize was that we needed to spread the new approaches to patient safety in a big way. I realized, in our environment, which is very procedural, operative-based, that a surgeon probably needed to step up and do that. I suddenly realized that this would impact a hundred times more patients than I had been able to do in a pretty successful surgical career. When I moved into this, I brought in all my buddies … my anesthesiologist, my radiologist, etc., etc.

Charles Denham: You needed a cool club.

J. Michael Henderson: Well, I said, "If I'm doing this …"

Charles Denham: You're gonna have to do it.

J. Michael Henderson: " … you're coming with me." They all said yes. That was step number one. The people whom I had clinically worked with a lot said yes. The first couple of years, it was pretty lonely. Our culture just wasn't at that level at that point. So having good people [whom] I really trusted clinically on board was a huge step. Passing through that to where we are at now – and I think everywhere goes through this sort of evolution – as leadership came on board, convincing our first hospital – and then Cleveland Clinic has 10 hospitals – that enterprise leadership is an important step one. Then it became much easier. When I first started, I said, "In each of these areas I like physician leads because the docs are always the hardest people to get on board." Then it was really the team-building beyond that, which is the space we're really at now, that there are a lot of docs on board who have committed time to do this. So it is giving people time to think about and do the right thing. Now, really, we are evolving to the point of how do we train at the resident medical student levels within our system? It is building on a fairly simple curriculum. As you know, I keep coming back to the basics.

Charles Denham: If you say it one more time, we're going to be calling you Dr. Basics.

J. Michael Henderson: … Yeah [laughter] ... but I've been so lost in the high-tech end of it that the realization that, in fact, this is about the basics, preventing errors about the basics … the medication things … and it's about the basics. Every time, you keep coming back to that. So it's really [that] everyone goes through a journey. When I first said this, I thought, "Oh, yeah. Oh, yeah. Sure." But it's true and it evolves. And I think how you start to train people depends where you're at on that journey. So it's getting the momentum going, building on that. And it's not going to be the same everywhere but it evolves. I think we're on a very accelerating part of that journey now, and that's really exciting. The first few years I thought, "Oh well, we really have …"

Charles Denham: We really think … you know, we've had some conversations over the last couple days here in Washington about the Choosing Wisely phenomenon of nine societies stating, "We're declaring that we're over-testing and here are five tests where overuse is an issue," and really kind of broke from the pack to do it, which I think is a tectonic shift. It has broken the surface tension of the stagnation of the physicians as leaders. I'd like to go to John Nance. We've hit you pretty hard with every aviation question and NTSBs and that kind of thing, but John is a gifted guy who is a lawyer. He is a former airline captain. He is also an educator at boards, but he is also a master storyteller and a bestselling author. Can you tell us, John? You are now using novels, literally a novel approach, using novels as an educational vehicle about patient safety and about culture. What tips can you give us who are just starting out? I mean, in our films, the one we just finished is our second feature-length. You know, most of it has been more educational, you know, and toolboxes and that kind of thing. Share with us how we can use storytelling to get the message across. Because this is a global panel, I am going to come back to Ed. What's the common denominator across the globe about storytelling? And you don't have to talk about airplanes at all.

John Nance: [laughter] … No matter whether we go back 50,000 years of human history and see people talking around a campfire and telling stories, or whether we're talking about the most sophisticated form of communication and doing exactly the same thing, this is how human beings transfer information in the most effective fashion. It was no brilliance on my part. I have been writing nonfiction like this a couple of times before. As a matter of fact, I didn't even figure out that I needed to do it the same way but, using the story of this fictional hospital to try to do something that – and I know you and I both had had the same feeling with our time on the National Patient Safety Foundation – we wanted to get a model out there of what a hospital that did all these things right would look like, but it had not coalesced. So that was the idea. But to do a model, you take reality and then you structure with a few names that don't exist, of people who, in essence, do – not using their individual stories but representative – and you show the interactions. You show the necessity, for instance, of training people in a hospital environment to the owners, not just involved but to the owners. You show how difficult it is for intermediate-level managers and directors to be nurturing of their people and then to get rid of the ones who can't do that if they can't be retrained because the nurturing of their people is really what it is all about. People get tired. They get upset. They get distracted. You have to show all these things on camera. Otherwise, there is always this barrier between the sterile effectiveness of a well-written paper that doesn't seem to involve human emotions and what really does, and that comes back to the nub of it. The reason that storytelling is effective not just in a book form but in any form of transparency where we take someone, for instance, who has actually been harmed, and we bring them into the board room, and we bring them in – like Julie Thao, for instance – or like so many others who have been brave enough to step forward. These individuals are real living, breathing humans; and to confront the effects on them of a medical mistake or to confront the effects on the rest of a group of surgeons of a surgeon saying, "I thought I was omnipotent and infallible because I was told I had to be, and yet here is what happened to me." These are invaluable. They can give you more in 10 minutes than we could achieve in six months of kind of pointing the finger and saying, "This is what we want to do."

Charles Denham: Fantastic. And I think that we're all learning to be storytellers. As a specialist coming from a really technical background – like Dr. Parda here in the audience, radiation oncologists – you know, we just love physics and 3-D models of dose delivery and a lot of boring, boring stuff. And it's a jump to start to say, "It's okay to tell a story." If you told me 10 years ago, even five years ago, that I would put on film going globally that I was praying with someone [who] just forgave a pharmacist in that healing

moment, I was choked up. I could hardly come up here after I saw it … what I had been looking at and we had been editing for months. I choke up right now as I think about it, seeing my own little boy on it. Breaking down the barriers of emotion to get to the heart is really hard for us to do. Especially the higher we climb in the medical field, the more scholarly and boring we have to be, and the more focused we have to be, and inviting patients into the board room is tough. It could be harmful and it makes us vulnerable. And, as we come back, because I want to come to David about education, about educating folks about these technologies and the common denominators. But this storytelling piece, carry that through, because I know you'll have some great insights as a great storyteller, David. I want to come back to you on the global because this is a global panel. React to what you are hearing from a WHO. You are the neurosensory system to what's going on in the world, and if we don't listen to you, I think we're blowing it. So I want to come back to you and then to David.

Stephen Swensen: Well, I think that this point about the storytelling has two sides to it because on the one hand, I think we are underutilizing stories in formal education settings in healthcare generally speaking; but we started a program on patient stories. Sue Sheridan, [who] featured in the first film prominently, was one of the people who did this. I frequently tell a story that we gathered from a patient in Rwanda who described the physicians: "They treat us like farmers. They raise us as if we are plants but it is really for their own good." So it's from an agrarian society; but then a quote that I always pair with it is from a young guy who lost his mom at the best liver transplant unit in New York City, where they made the rounds on the day she died and no one spoke word one to them as the entire surgical team walked in and out of the room as she was dying. There is something universal that is in Uganda, Africa, and the best hospital in New York City. There is something universal in how we are training our physicians and the work that we have done on our curriculum to start to try and address that, but it is not just an issue for trying to get that out there. It is an issue in the United States, too. Last year, 25 percent of office visits were attended by physicians who have a degree from another country. I think we should care more globally about the issue of education but it is an immediate issue here to make sure that, globally, people get the right education in patient safety.

Charles Denham: So we're hearing universal. We're hearing leadership. We're hearing we've got the same problems. We're hearing the power of storytelling. David, as [technical] as HIT is, you're a master storyteller. You know, Chris Jerry is standing back here, who went on camera and relived a terrible moment in order to save other lives. Can we use that in health IT? Can we use that in these cold war, technical areas or are we blowing it because we're not using it?

David Hunt: Oh, we can definitely use it. We stand at the cusp of a wonderful moment, and it's wonderful because we are saying now that the delivery of healthcare services no longer is going to be a game of "I've got a secret." Before, so often, that's what it was. I think I'm going to make a distinction, and I don't know if this is really a distinction, but I think we have two jobs, actually: to educate and to inform. With more information, we are going to be able to inform whole scores of individuals, providers. We are going to be able to inform patients about what is actually going on. I think one important element we've got to put into all of this is we've got to educate people on how to use this information. Just giving you all of the facts won't necessarily empower you until you begin to understand how to use that information. We had a session before about the board. So many times, the board of directors and hospitals, they have the power to actually act but they don't know how to use the information that they are given at the proper time, in the proper way. So I think that we have two jobs working ahead, and I think stories are actually the best way to, one, inform, but also educate on how to use these tools and this information.

Charles Denham: So, out of time; but what we'll be talking about as we go forward is the evolution of education. How many people in the audience here in the Press Club would be interested in a special issue of the *Journal of Patient Safety* on education and this conversion from just knowledge transfer to competency – which we didn't talk about – but verifying the competency of our caregivers, and using storytelling, and using some breakthrough methods? Show of hands of how many would like this via special issue? So, as the editor-in-chief, I can tell you that TMIT will now be making the investment in funding that, because I believe that this is really important. And we would like to have this panel be contributors, if they would, reviewers that the World Health Organization is a treasure and our former health ministers. We have been talking this week about all of these former health ministers who have

been dealing with many of these issues, and so much we can learn from them. We are really privileged to have Dr. Zeltner become our assistant editor and our head of global programs for the *Journal of Patient Safety*. We are so grateful to all of you for what you are doing in education, and the global education is so important. We are finding out that the world is getting smaller. It is flat and it's getting smaller. Thank you very much. So we will take a five-minute break for our next panel, and we want to thank you all very much. [applause]