Conference Report

What is Working in Patient Safety?

Patient safety leaders and innovators from hundreds of health care organizations attended the third annual Partnership Symposium, co-convened by Partnership for Patient Safety; Premier, Inc; VHA Health Foundation Inc; and VHA Inc, in Washington, DC, on October 14–16, 2002.* The 700 participants explored cutting-edge approaches to reducing medical errors in an interactive 3-day learning laboratory. Continuing a tradition, Partnership Symposium 2002: Smart Designs for Patient Safety participants again examined the difficult issue of accountability for safety. The presentations at the symposium suggested that leaders of hospitals and other health care organizations were not allowing increasing demands for openness and escalating exposure to liability suits to chill innovation in patient safety and patient-centered care.

One of the models for the meeting was a science museum, where participants could interactively try things out. Conference sessions were divided into six learning tracks focused on promoting safety, technology, culture, facility design, work force issues, and employee safety.

Examples of the more than 50 learning laboratories the patient safety community participated in during this unique conference experience included the following:

- A smart infusion pump with a built-in drug library;
- A module based on the nation’s first hospital that was being designed and built around the concept of patient safety;
- A hands-on simulation laboratory that included several aviation-based training models;
- An innovative approach to conflict resolution and lawsuit prevention developed at the United States Naval Hospital in Bethesda, Maryland;
- “Lower-tech” simulation tools that used video-based storytelling to generate cultural change;
- An innovative approach that links experienced intensivists and seasoned critical care nurses to remote facilities via voice, video, and real-time data to reduce mortality and lower costs in the intensive care unit;
- A new program on the effectiveness of reusable blood-collection tube holders in preventing bloodborne pathogen exposure to patient and employees; and
- A new program to help hospitals rebuild themselves into “just” cultures.

Presentations by some of the foremost leaders in patient safety were provided throughout the symposium. In his opening keynote address, Lucian Leape, MD (Adjunct Professor, Harvard School of Public Health, Boston), arguably the conscience of the modern patient safety movement, explored a new formulation for “reciprocal accountability” designed to fill in the gaps in current checks and balances that, he argued, are now dysfunctional. As an example, Dr Leape explored accountability in the nursing profession. If a licensing board is going to hold nurses accountable for errors,

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*Premier, Inc (San Diego; www.premierinc.com) is a leading strategic alliance in health care in the United States, serving nearly 1,500 hospital facilities and other care sites. The Partnership for Patient Safety (www.p4ps.org) is a patient-centered initiative dedicated to advancing the safety and reliability of health care systems worldwide. VHA Inc (Irving, Texas; www.vha.com) is a nationwide network of 2,200 community-owned health care organizations and their affiliated physicians. VHA Health Foundation Inc (Irving, Tex; www.vahahealthfoundation.org) promotes leadership, knowledge, and innovative solutions that lead to healthier individuals and communities. Conference endorsers included the Agency for Healthcare Research and Quality, Healthcare Leadership Council, Joint Commission on Accreditation of Healthcare Organizations, Medical Group Management Association, National Business Coalition on Health, the National Patient Safety Foundation, and the National Committee on Quality Health Care.
nurses themselves should be able to hold the government reciprocally accountable for ensuring that the health care organizations in which nurses practice establish a working environment that supports safe nursing practice. As of January 1, 2003, all the professional licensing boards in Massachusetts will no longer operate independently but under the coordination of the state’s department of health.¹ This governmental reorganization is an important model that may encourage the kind of reciprocal accountability Dr Leape advocated.

Charles Inlander, founder of the People’s Medical Society (Allentown, Penn), contributed a consumer viewpoint in a challenging give-and-take session with the audience that reminded everyone of how hard it can be to move beyond blaming individual practitioners for errors that injure patients. Assuring consumers that there is sufficient individual, as well as systems, accountability for safety in the health care environment remains a major challenge.

In the closing keynote, Dennis O’Leary, MD (President, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Ill), reported on the viewpoints of hospital chief executive officers (CEOs) on the business case for safety, as gathered from a meeting of CEOs which had been held the previous month in Washington, DC.² The frustrating news was not only that health care system CEOs see no business case for patient safety at the current time but also that the reimbursement infrastructure actually provides disincentives against investment in patient safety improvement. The stark truth is that injured patients may actually generate revenue for health care organizations because their conditions often necessitate additional medical care. In contrast, health insurance reimbursement mechanisms offer few monetary rewards for safety innovation or the prevention of avoidable harm. Dr O’Leary’s thoughtful remarks were another sobering reminder that, 3 years after the Institute of Medicine’s designation of patient safety as an urgent national priority,³ funding for health care is far from aligned with systems thinking.

Partnership Symposium 2002 was also a venue for the debut of a new film, First, Do No Harm Part 2: Taking the Lead. The sequel to First, Do No Harm (produced for Partnership Symposium 2000), this dramatized case study with expert commentary explores how one hospital deals with tension, uncertainty, fear, and frustration in deciding what to do after a patient is seriously harmed. Drawn from the malpractice closed-claims files of the Risk Management Foundation of the Harvard Medical Institutions, this learning tool was designed to help health care organizations consider what it really means to be patient-centered.

First developed in 2000 in response to the Institute of Medicine’s call to action, the Partnership Symposia provided annual opportunities for every health care organization with aspirations to improve performance, every educator with an innovative approach, and every business engaged in developing patient safety solutions to join the convenors in disseminating ideas that can be literally life-saving. The conversations that have arisen at these events have not always been comfortable, but they have helped shake up old thinking, and they have been immensely invigorating for participants. The convenors found it rewarding to work together in making these annual forums happen, and we hope they advance progress in making the health care system more systems-based, evidence-based, and patient-centered.

Linda K. DeWolf, RN, is Vice President, VHA Health Foundation Inc, Dallas. Martin J. Hatlie, Esq, is President, Partnership for Patient Safety, Chicago. Gina Pugliese, RN, MS, is Director of the Premier Safety Institute, Oakbrook, Illinois, and a member of the Editorial Advisory Board of Joint Commission Journal on Quality and Safety. Nancy J. Wilson, MD, MPH, is Vice President and Medical Director, VHA Inc, Dallas. Please address correspondence to Martin J. Hatlie, Esq, mhatlie@p4ps.org.

References