Chapter 16
Spreading the Word: The Salzburg Seminar

Salzburg! The name conjures up images of the annual world-famous Salzburg Festival and *The Sound of Music*, with its magnificent castle and the glorious singing of Julie Andrews. The birthplace of the divine Mozart.

What is less well known about this charming city is that it is also the home of The Salzburg Global Seminars, the "home to change makers" since 1947. Founded to bring participants together from around the world for weeklong meetings to explore a single subject, the Salzburg Global Seminar is an independent not-for-profit organization. (See Appendix 16.1 for the intriguing history of how the seminars came into being in the years immediately following WWII.)

The seminars are a mix of lectures, discussions, workshops, papers, and presentations held at Schloss Leopoldskron—the "Sound of Music" palace—an idyllic and secluded spot conducive to thought and insight.

In April of 2001, the Salzburg Seminar, *Patient Safety and Medical Error*, Session 386, became a reference point in the history of patient safety through the seminar on medical error.

This chapter is brief, but it illustrates how a single event—a weeklong intensive interaction on a single subject—can raise people's consciousness, alter their beliefs, and, in some cases, change their careers. All that happened at Salzburg in 2001 as the patient safety movement was getting underway.

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Schloss Leopoldskron. (Reprinted with permission from Salzburg Global Seminar. All rights reserved)

As with many things in quality and safety, having a Salzburg Seminar on medical error was Don Berwick's idea. He had attended an earlier one in 1998 organized by Tom Delbanco, *Through the Patient's Eyes: Collaboration between Patients and Health Care Professionals*, and thought it would be an ideal way to move thinking ahead in patient safety. I thought it was a splendid idea! Fortunately, others did too, and we were able to secure funding and attract a stellar faculty to plan the event.

Our announcement for the session was ambitious:

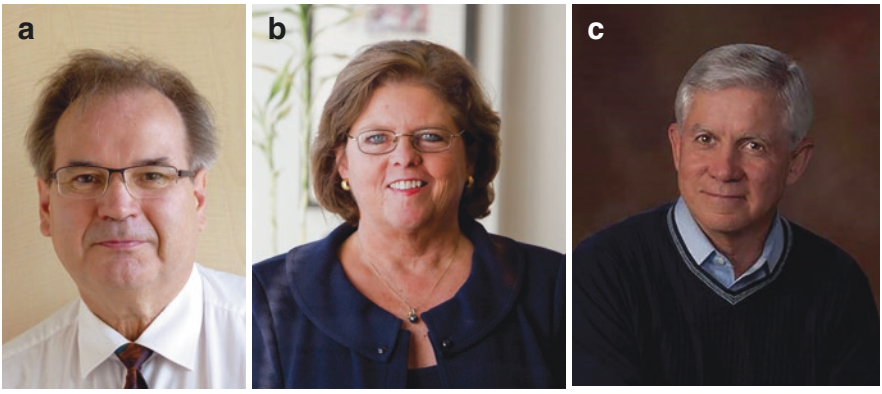
> The Seminar is "intended to provide a forum for an exploration of possible scenarios for making medical facilities safer places for work and for care. To this end, the session will examine the causes, consequences, and methods of improvement of patient safety, with particular emphasis on the American and European experience.
>
> Among the issues to be addressed: the sociologic and technical characteristics of medical care, and the systems that allow them to function as high reliability organizations; the role of effective cooperation, communication, and mutual support among the healthcare providers, the role of the patient in the healthcare process; the influence of individual human factors in healthcare delivery, such as professional training, psychological and physical stress, and principles of designing systems for safety.
>
> The session will seek to bring together a diverse group of individuals involved in various aspects of the medical process, including administrators, healthcare workers, representatives from regulatory agencies, as well as specialists in the field of safety."

The timing proved to be felicitous. The BMJ special edition on medical error the previous year got worldwide attention, bringing the issue to the forefront for the first time for many people. We attracted 62 participants ("Fellows") from 28 countries, including more than a third from non-western countries: Argentina, Armenia, Bulgaria, China, Egypt, India, Israel, Japan, Kenya, Malta, Mexico, Palestine, Philippines, Romania, Russia, South Africa, Sudan, Turkey, and Zimbabwe (Appendix 16.2).

The Fellows varied widely in their knowledge and experience. The environments from which they came and to which they would return spanned the spectrum of awareness and opportunity. But we all had one thing in common: in all countries, the response to an error was to blame the individual. That was a common language we all understood, and that was what we wanted to change.

Our faculty was from "central casting": the recognized thought leaders Jim Reason and Charles Vincent from the UK, safety guru Rene Amalberti from France, Tom Nolan from Associates in Process Improvement, Maureen Bisognano from IHI, Richard Cook from the University of Chicago, Don, and I. We took turns giving talks in the mornings followed by plenary discussions. The major work occurred in four working groups to which participants were assigned. They met in the afternoons for discussions moderated by the faculty.

The four working groups took on separate major challenges to making health care safe: Leadership and Culture Change; Education, Training and Supervision; Personal and Organizational Accountability;



(a) Rene Amalberti, **(b)** Maureen Bisognano, and **(c)** Tom Nolan. (All rights reserved)

and Design of Process and Systems. Interspersed in the afternoon sessions were occasional breaks, but we worked most of most days and continued discussions informally in the evenings.

Another important feature of the Seminar was a series of informal presentations by Fellows on subjects for which they had special expertise or experience. Eleven in all, these included regulation, working with consumer advocates, partnering with patients, sleep deprivation and working hours, reporting systems, improving safety in resource-constrained environments, and national funding of safety research.

On the first day, Richard Cook suggested to the faculty that we stimulate the workshop conversations by giving participants a simulation exercise in the form of a "news flash" about a serious situation: a tragic preventable death in their hospital that was published in a local paper's headline above the fold. The Working Groups were instructed to take on the role of C-Suite and Board to discuss their response.

The "news flash" came in the evening. The next day the teams were to make decisions about how they would respond, what their roles were, what they would say, and who would be the best spokesperson within the organization and to the public. Each evening, Richard would tighten the constraint by issuing ongoing press releases of more sensational and damaging speculations and actual findings about the event.

The simulation surfaced a number of issues: just how difficult it was to talk about failure, the state of transparency, accountability, fear of litigation, defensiveness of organizational reputation and assets, the role of the media and the public's right to know, responsibility to the patient's family, and the relationships between family, care team, and hospital.

For some Fellows, this proved to be overwhelming. The simulation succeeded in getting them to begin to understand the complexities of responding to disastrous errors, but how to respond was beyond the capacity of the majority of this diverse group of participants. Most of them were just beginning to think about patient safety and had no experience in dealing with complex issues or failures. For them, it was too intense and emotionally charged. It pushed them into a zone of discomfort and distracted them from what they came to the seminar to accomplish. We stopped the exercise on the third day.

The Working Groups benefited greatly from the diversity of the backgrounds of the participants. Some were experienced and had worked for some time in quality improvement and safety. For others,

it was all new. For all, the discussions were deeper—and longer—than any they had previously experienced. The insights and lessons learned were shared with the entire group in the final session of the week when each of the working groups presented their conclusions.

The Seminar had a substantial impact. In large measure it accomplished our objectives of expanding the understanding of patient safety and motivating leaders to advance the cause. It was an incredibly rich and mind-stretching experience in which everyone, faculty and students, learned a great deal and were motivated to work harder—and smarter—to reduce harm.

For many Fellows, it was a generative experience: they left with new lenses through which to view medical error, new ideas for change, and, for many, new commitment to the cause. They began to envision a world in which we stop blaming people for making mistakes and focus on designing sustainable systems to prevent medical error from harming patients.

A number of Fellows, such as Beth Pedersen Lilja of Denmark, Kristoff Viet of Germany, and Julie Morath, Tejal Gandhi, Allan Frankel, and Peter Pronovost of the USA, went on to become leaders who had a significant impact on patient safety. The Salzburg Seminar proved to be a defining experience, referred to years later with much affection.

Appendix 16.1: History of the Salzburg Global Seminars

The *Seminar* was the brainchild of Clemens Heller, a native Austrian attending graduate school at Harvard, who, in aftermath of World War II in 1946, "envisioned a cultural bridge spanning the Atlantic not only by introducing the demoralized Europeans to all sorts of American cultural achievements, but also by stimulating a fruitful exchange between European national cultures and America."

Harvard was unwilling to support the project, but Heller and several friends convinced the Harvard Student Council to be the official sponsor of the Seminar, raised the majority of funds, and obtained permission from the State Department for entrance into Allied Occupied Austria.

By great good fortune, Heller shortly afterward bumped into a friend of his parents, Helene Thimig, the widow of theater producer Max Reinhardt, who owned a summer home in Salzburg named Schloss Leopoldskron. Thimig agreed to rent them the Schloss for the purpose of a summer school.

The Schloss was built in 1736 by Count Leopold von Firmian, Prince-Archbishop of Salzburg. It remained in the possession of the Firmian family until 1837 and then passed through several owners until it was bought in 1918 by Reinhardt, who cofounded the Salzburg Festival. During World War II, the Schloss was confiscated as Jewish property, but after the war it was returned to the Reinhardt Estate.

The first session, officially called "The Harvard Student Council's Salzburg Seminar in American Civilization," lasted 6 weeks in the summer of 1947 and brought together men and women from 18 countries, including countries from behind the Iron Curtain. Faculty included anthropologist, Margaret Mead, economists Walt Rostow and Wassily Leontief, writer and literary critic Alfred Kazin, and others.

The Seminar was formally incorporated on April 20, 1950, by which time it had developed into more than a summer school, and session topics were expanded beyond American Studies. It acquired Schloss Leopoldskron in 1959 [1].

Appendix 16.2: Participants in Salzburg Seminar 386 Patient Safety and Medical Error

Working Group A
LEADERSHIP AND CULTURE CHANGE
(Maureen Bisognano and René Amalberti)

- Ross Baker (Canada)
- James Battles (USA)
- Ahmed Bayoumi (Sudan)
- Jocelyn Cornwell (UK)
- Sally Goebel (USA)
- Erik Jylling (Denmark)
- Harold Kaplan (USA)
- Mariana Lerner (Israel)

- Raymond Mayewski (USA)
- Nagui Mikhail (Egypt)
- Leonard Miron (Romania)
- Julianne Morath (USA)
- Norman Nyazema (Zimbabwe)
- Beth Pedersen (Denmark)
- Peter Pronovost (USA)
- Robert Wells (Australia)
- Alma Yearwood-Dixon (USA)

Working Group B
EDUCATION, TRAINING AND SUPERVISION
(Donald Berwick and Richard Cook)

- DeWitt Baldwin (USA)
- Norberto Barrera (Argentina)
- Guttorm Bratteboe (Norway)
- Allan Frankel (USA)
- Tejal Gandhi (USA)
- Lidia Georgieva (Bulgaria)
- Sandra Huddleston (USA)
- Mauricio Lopez Ramos (Mexico)
- Karine Martirosyan (Armenia)
- Patricia Ogle (South Africa)
- Yasemin Oguz (Turkey)
- Abdalla Shehata (Egypt)
- Richard Smallwood (Australia)
- Lourdes Tejero (Philippines)
- Helfried Waleczek (Germany)

Working Group C
PERSONAL AND ORGANIZATIONAL ACCOUNTABILITY
(Lucian Leape and Charles Vincent)

- Choi Chuen Ha (China)
- Dmitri Elioutine (Russia)
- Michael Fiene (Germany)
- Andrea Gerlin (USA)
- Sven Öhman (Sweden)
- Synnöve Ödegard (Sweden)

- Amos Otedo (Kenya)
- Gajendra Singh (India)
- Anthony So (USA)
- Marianne Sørensen (Denmark)
- David Swankin (USA)
- Kathryn Townsend (USA)
- Joanne Turnbull (USA)

Working Group D
DESIGN OF PROCESS AND SYSTEMS
(Thomas Nolan and James Reason)

- Susan Abookire (USA)
- Nancy Conrad (USA)
- Douglas Eby (USA)
- Kaj Essinger (Sweden)
- Martin Fischmeister (Austria)
- Carol Haraden (USA)
- Yuichi Imanaka (Japan)
- Avi Israeli (Israel)
- Peter Kennedy (Australia)
- Ronald Kirshner (USA)
- Liu Xiaohong (China)
- Mohammed Massoud (Palestinian
- Authority)
- Vin McLoughlin (Australia)
- Josephine Sollano (USA)
- Carina Svensson (Sweden)
- Christian Thomeczek (Germany)
- Josanne Vassallo (Malta)

Reference

1. Eliot T, Lois. The Salzburg seminar: the first forty years. Ipswich: The Ipswich Press; 1987.