Chapter 4
Coming Together: The Annenberg Conference

1996 was the year that patient safety began.

One day in the early spring of 1996, Marty Hatlie, a lawyer and lobbyist at the American Medical Association (AMA), called to invite me to participate with the AMA, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Association for the Advancement of Science (AAAS), and the Annenberg Center for Health Sciences in planning a big meeting on preventing errors.

I didn't know Hatlie, nor was I aware that he had been a diligent opponent of our work on drawing attention to medical error! He was the lead lawyer for the AMA dealing with malpractice issues. When the Medical Practice Study came out in 1991, he coordinated the AMA attack on the study, questioning the methodology and therefore the results. When *Error in Medicine* was published, he coordinated the attack on that as well.

The AMA then, as now, saw its role as advocating for doctors and opposing anything that seemed to be against their best interest. Discussion of errors, or even admitting that they happened, was seen as extremely threatening. The AMA's approach was to deny that doctors made mistakes, to stonewall any investigations, and to push for federal tort reform, the centerpiece of which was a cap on liability payments.

To that end, Hatlie led the AMA's intensive lobbying effort in 1995 in support of federal legislation that would limit the dollar amount of tort settlements in malpractice cases and make it more

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difficult for patients to sue. He was joined in this effort by the American Tort Reform Association and the Healthcare Liability Alliance, a coalition built by Hatlie that included the major hospital associations, liability insurers, and Big Pharma. Together these organizations spent tens of millions of dollars lobbying Congress for the legislation.

Despite these formidable efforts, legislation failed to pass. The timing was bad. 1995 was the year that the public conscience was shocked by stories such as *The Boston Globe* journalist Betsy Lehman's death from an overdose of chemotherapy, the amputation of "the wrong foot" of Willie King in Florida, and a seemingly endless series of mishaps. It was also the year that our research was published that documented that these cases reflected a deeper problem. Although the AMA was successful in the House, the Senate would not cave to the powerful special interests.

With the congressional defeat, Marty and the AMA needed to regroup. Although he later admitted that he began to change his thinking after reading my *Error in Medicine* paper, he was still a skeptical "hired gun." However, he could see that it would help the AMA's somewhat tarnished image if it could show some interest in patient safety.

Jim Todd, executive vice president, and Nancy Dickey, incoming chairman of the AMA Board of Trustees, were easily persuaded to take a new approach. Supporting the Annenberg Conference was just what they needed to improve their image. Todd, a surgeon, had fought,

Marty Hatlie. (All rights reserved)

and lost, a battle to change the tort system from court battles to negotiated claims settlements; after the latest setback at getting tort reform legislation, he was ready for a new approach to the malpractice problem. Hatlie had another prominent ally within the AMA orbit who was a sincere, even passionate, truth teller about patient safety: George Lundberg, editor of JAMA who had published *Error in* Medicine and strongly favored the AMA acknowledging the evidence and changing its position.

The idea for a conference on medical error came from Jerod Loeb, head of research at JCAHO, and Mark Eppinger, the Annenberg Center program director. They approached Deborah Runkle of the American Association for the Advancement of Science (AAAS) in the hope of getting an issue of *Science* magazine dedicated to the topic. The AAAS had a session on medical injury at its annual meeting the year before where Richard Cook, an anesthesiologist and early thinker about patient safety, spoke and I presented the results of the MPS.

Jerod and Mark had developed the proposal for a conference focused on patient safety but had not succeeded in getting funding when Marty approached Jerod about collaborating. Marty convinced the AMA leadership to fund the conference. He also recommended the organizing group invite me, which they agreed to do.

When Marty asked me to join the planning meeting, I accepted without a second thought. Although we had never met, I was sure glad he called me! It was the beginning of a long and productive friendship in the fight for patient safety. Marty remembers that I had one condition: that they invite Jim Reason, the world's leading expert on human error, and pay for his first-class air ticket from Britain, which they did. When Jim accepted, Marty recalls him saying he'd been hoping for such a call for 20 years!

I will never forget the scene as I walked into my first meeting with the planning group at JCAHO headquarters in Chicago in early 1996. When I saw who was there, I suddenly realized that I was not only the sole physician in the group but also the only one who knew anything about medical errors! I was relieved not to have missed it. Clearly, this could be a big deal. They wanted to invite people from numerous industries as well as healthcare, which I thought was a terrific idea. The decision was made that Annenberg would host a program in the fall at the Annenberg Center in Rancho Mirage, CA.

A nationwide call for papers was put out on May 17 for the conference on October 13–15, 1996. To our surprise (and relief), we received an avalanche of proposals for presentation: over 200. To facilitate the review and selection of those we would have on the program, I suggested the committee meet for several days at our vacation home in Newfane, Vermont, in August. That turned out to be great fun and an efficient way to get the job done.

The Conference brochure listed the objectives as:

- Develop an agenda for further research into errors, identify educational or other approaches to their prevention, and target next steps for stakeholders.
- Promote greater understanding of the occurrence of errors and strategies for preventing them.
- Generate candid discussion of accountability in healthcare and explore alternate ways to respond to errors.
- Provide an opportunity for networking in a multidisciplinary setting.

The conference opened on October 13, 1996. Preregistration numbered 274; more than 300 ultimately attended. It was truly a mixed group. Almost 20% of the speakers were scientists and scholars from non-healthcare fields, such as psychology, engineering, and organizational behavior. Another 20% were nonacademic and also not from healthcare, such as lawyers and representatives of patients and families.[1]

The atmosphere from the start was electric. It was the first time that those who were concerned about errors in medicine had ever met together, and to do so with leaders in safety from other industries was exhilarating. I had the privilege of giving the opening keynote address, which I dedicated to the memory of Betsy Lehman. This was followed by a panel presenting different perspectives and an address by Jim Reason on lessons from other sectors. John Nance, pilot and aviation

[1] Lead faculty for the conference included, in addition to me and James Reason, Donald Berwick, IHI; Marjorie Beyers, American Organization of Nurse Executives; Victor Cohn, *The Washington Post*; James Conway, Dana-Farber; Nancy Dickey, AMA; Linda Emanuel, AMA; Linda Golodner, Nat'l Consumers League; Brent James, Intermountain Health; John Nance, Alaska Airlines; and Dennis O'Leary, The Joint Commission.

reporter for ABC News, gave his usual stem-winder talk at dinner, telling the riveting story of the crash of the KLM and Pan Am airplanes on the runway in Tenerife in 1977 that killed 538 people.

The second day opened with a presentation of the case of Ben Kolb, a 7-year-old boy who died from a mix-up of medications in the operating room at Martin Memorial Hospital in Stuart, FL. The clinicians involved in the case described the investigation and their despair. What made it memorable was the hospital was transparent from the first conversation with Ben's parents. Driven by the belief that the kind of error that took Ben's life had probably happened many times before in many other hospitals, the hospital CEO, anesthesiologist in the surgery, and risk manager jointly promised Ben's family they would share what they had learned. It was almost unheard of at the time (and, it should be noted, still a challenge 25 years later).

The audience was very moved. It was the part of the conference that most people remember clearly years later. It was also years later that I learned Hatlie had "found" the Ben Kolb case through his contacts at MMI, a liability insurer that wanted to honor the hospital leadership's promise to Ben's family to tell his story so others could be saved. Marty urged it on the program committee because he could see the public interest value of a story where providers communicated openly with the family. That judgment was validated when *USA Today* made it the lead story the next day [1], and the *New York Times Sunday Magazine* featured it as the cover story a few months later [2].

The rest of the meeting consisted of breakout group sessions, where more than 50 presentations were given on issues related to patient safety: education and training, communication, legal issues, organizational processes, human factors, fatigue, drug use, anesthesia, surgery, and medication errors. And, of course, "networking" as attendees found others who shared their interests and concerns.

Dennis O'Leary, president of JCAHO, announced that in an effort to be less punitive, the Commission was changing its response to sentinel events from "Conditional Accreditation" to "Accreditation Watch." The 3-day event concluded with a compelling plenary address by Don Berwick, the founder of the Institute for Healthcare Improvement (IHI).

But the part of the program that would have the most significant long-term impact came on the second day of the conference from

something the program committee had not anticipated: a surprise announcement by Nancy Dickey, the incoming chairman of the AMA Board, that the AMA was founding and funding a National Patient Safety Foundation. Modeled on the Anesthesia Patient Safety Foundation, its objective was to fund innovative research projects to move the needle on patient safety and provide a forum for discussion. The JCAHO was a co-sponsor. Patient safety was no longer just a good idea. We would have a gathering, a focus, and a strategy for going forward. It assured that there would be more "Annenbergs."

And indeed there were. The second Annenberg Conference was held in November 1998. The original conveners and the new National Patient Safety Foundation (NPSF) (with Hatlie as its first president) were joined by representatives from the Department of Veterans Affairs. Don Berwick gave the keynote address outlining the components of a safety system. I chaired a panel on Creating a Culture of Safety. The conference focused on the challenges of replacing a culture of blame and punishment with one of cooperation and curiosity that exposes errors as opportunities to change the systems failures that caused them.

Several hospitals reported success in eliminating sanctions for reporting errors. Other presentations included use of information technology to support safe practice, the use of national incident databases as in aviation, and the impact of sleep deprivation on physician performance. There were calls for greater involvement of regulators, legislators, and patients in the dialogue, as the Massachusetts Coalition for the Prevention of Medical Errors was doing.

At the first Annenberg Conference, the memorable event was an uplifting case presentation of hospital transparency after an error. At Annenberg II, it was a depressing story of three nurses who were prosecuted for criminal negligence for their role in a fatal medication error. The audience heard from all parties, including the prosecuting attorney, followed by a presentation on the importance of not punishing individuals for systems failures. It was a stark reminder of how far we had to go to implement the fundamental principle that it isn't bad people, it's bad systems.

The third and final Annenberg Conference, *Let's Talk; Communicating Risk and Safety in Health Care*, was convened in May 2001 in Minneapolis. As the title suggests, speakers and panels addressed the human and legal issues surrounding disclosure. After this meeting, the conferences were sponsored annually by the NPSF and were called Patient Safety Congresses.

"Annenberg," as we all later called the first conference, was the birthplace of patient safety—in the USA and, truly, the world. A number of us on the faculty, Don Berwick, Brent James from Intermountain Health, and I, as well as researchers Richard Cook and David Woods, Jeep Pierce and Jeff Cooper of the Anesthesia Patient Safety Foundation, and Jim Reason and Charles Vincent in the UK, had been speaking out and writing about error prevention for years. Annenberg was the first time we all came together to exchange ideas and make common cause.

For us it was exciting and validating to interact with experts outside of healthcare and reinforce our commitment to the science of safety. It gave weight to our efforts. For others with less experience, some of whom came just out of curiosity, the demonstration of industrial concepts of human factors principles and the efforts to apply them in healthcare by anesthesia, IHI, and others was enabling and energizing. For all, it was a powerful shared emotional experience.

The meeting brought into focus the challenges of the next decade in research, reporting, standardization, changing processes, technology, and culture. It empowered the attendees to continue their work and "carry the word" to a larger audience. The quest for safe healthcare had finally begun.

References

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