Reflections, Predictions, and Admonitions

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As my physician wife (of the past 37 years) is fond of saying, “We are both rounding third base, heading to home” with regard to our long and fruitful careers as physician leaders. Therefore, when I am invited back to give a second plenary speech to any particular organization, it is an especially important opportunity. I had just such an opportunity to address the amazing junior faculty who make up the bulk of the membership of the Quality and Safety Educators Academy (QSEA). First, let me tell you a bit about QSEA, before I reflect on my plenary presentation.

QSEA, now in its sixth year, is a component of the Society of Hospital Medicine, the national hospitalist membership group headquartered in Philadelphia, PA. QSEA’s goal is to educate physicians in the principles of quality improvement and patient safety, recognizing that so few faculty members are trained in these disciplines. As leaders of QSEA noted in a recent article, “The QSEA itself is a three-day in-person academy to provide medical educators with the knowledge and tools to integrate quality improvement and patient safety concepts into their training program. The curriculum provides instruction in quality and safety, curriculum development and assessment, change management, and professional development while fostering peer networking…and mentorship.”

Two of the society’s leaders, and coauthors of the statement cited above, Jennifer S. Myers, MD, FACP, FAM, Associate Professor of Clinical Medicine, Director of Quality & Safety Education, and Patient Safety Officer from the Perelman School of Medicine, University of Pennsylvania, and Anjala Tess, MD, SFHM, Assistant Professor of Medicine, Beth Israel Deaconess Medical Center, were instrumental in inviting me to speak, as well as in helping me to sculpt my remarks.

I titled my remarks, “Reflections, Predictions, and Admonitions,” mirroring the 3 key components of my plenary address.

Recognizing that most of the attendees are new junior faculty members from a score of medical schools, my secondary agenda was to instill in them a deep sense of enthusiasm for the tough work ahead, and to give them context for our work in improving quality, given the current political climate.

Reflections

In the first portion of my presentation, I noted that historical giants in the quality and safety movement included notable physicians such as pioneering surgeon Ernest Codman, MD, FACS, and founder of the quality assurance model Avedis Donabedian, MD, MPH. In fact, everyone in the audience was, in some sense, standing on the shoulders of this great-grandfather and grandfather of our movement. I noted that Dr Codman’s now-classic article on measuring the quality of medical care celebrated its 50th birthday in 2016.

Although celebrating Dr Codman’s classic article is important, I also reviewed recent quality failures in our system, including a complete leadership change at the National Institutes of Health clinical campus that resulted from preventable complications related to drug therapy, and the investigation into 9 pediatric cardiac surgery deaths at a well-known hospital in my own hometown, Philadelphia. I reminded the audience that our colleagues, Martin Makary, MD, MPH, Surgical Director, and Michael Daniel, Research Fellow at Johns Hopkins, have recently reconfirmed in the British Medical Journal that medical errors are indeed the third leading cause of death in our country. While reflecting on these occurrences, I urged the group to continue to tackle difficult issues, such as these, and to not give up the fight.

I then quickly traced the timeline of public reporting of provider performance based on a timetable laid out in a recent issue of Health Affairs. I wove aspects of my own work into this timetable, including my now-26-year-old study comparing the outcomes of open heart surgery in the 5 Philadelphia teaching hospitals—a publication that was central to the launch of my early academic career. But my own review is modest compared with the number of accomplishments across the nation in compiling and disseminating critically important, hospital- and physician-specific outcomes information.

However, I challenged the group to assess and further reflect on the questions, “What is the impact of public reporting about our work, and does it really improve the quality and safety of what we do at the bedside?” I summarized the extant literature (which we will not do here) and concluded that public reporting from a provider...
perspective is vital for performance improvement, and yet the report cards themselves are rarely embraced, at any deep level, by the actual consumers of care.

Predictions

In the second part of the presentation, I challenged the QSEA attendees on 3 critical points. First, I emphasized how important it would be for their organization to help to define a core curriculum in quality, drawing on the work of Annette Valenta, DrPh, and her colleagues, in their recent assessment and synthesis of various national recommendations and key position papers about a core curriculum. We need to come together and agree on what the competencies are for a future leader in the quality and safety arenas.

QSEA should focus its activities on ambulatory measures of quality and safety, considering that there is such great variation in what we do in the office setting. Medical mistakes are a huge and regrettable part of ambulatory practice.

In addition, I urged the attendees to take the now-famous Association of American Medical Colleges 2013 report, “Teaching for Quality,” and to find a way to implement its key recommendations, namely, that every medical school clinical department should have at least 1 or 2 experts in healthcare quality and safety. Can you imagine if the public truly understood how few well-trained faculty members there are in our field?

Experts such as Robert Baron, MD, of the University of California, San Francisco, School of Medicine, and others indicate that we will need nearly 2000 specially trained faculty members to get us to the point when every medical school department can proudly say that it has at least 1 faculty member who is in a position to do research and teach healthcare quality and safety at the master level.

I closed this section with a final reflection that QSEA should focus its activities on ambulatory measures of quality and safety, considering that there is such great variation in what we do in the office setting. Medical mistakes are a huge and regrettable part of ambulatory practice.

Admonitions

Finally, in the third section, I described 5 very specific tasks that I believe need to be undertaken. I urged QSEA to work with sister organizations to eliminate or consolidate the various examinations in quality and safety. Groups such as the National Patient Safety Foundation, the American College of Medical Quality, the National Association for Healthcare Quality, and the American Board of Quality Assurance and Utilization Review Physicians must find a way to work together to review, evaluate, and disseminate examinations that make sense.

Second, I urged QSEA to follow the work that our college plans on doing by bringing together the 6 master’s degree-granting programs in healthcare quality and safety, and urging them to embrace a path for certification and accreditation. Third, I admonished the attendees to infiltrate their own medical school Appointments and Promotions Committee in much the same way as Thomas Staiger, MD, and his colleagues have done. I believe QSEA members have a great deal to contribute to the Appointments and Promotions Committee process.

Fourth, I hope that the Accreditation Council for Graduate Medical Education will continue to evaluate the impact of the Clinical Learning Environment or Clinical Learning Environment Review evaluations. Fifth, I hope that the QSEA will help us to redefine “professionalism,” whereby the term includes a commitment to the scholarship of quality and safety, and a renewal of our commitment to do no harm.

Finally, I admonished the attendees to nurture the “guerilla movement,” meaning they should commit to more intensive education in quality and safety, promote junior faculty in this arena, and generally, change the culture of the day-to-day practice.

In the conclusion, I reminded the attendees that the board of trustees in each of our delivery systems bears the ultimate fiduciary responsibility for the quality and safety of the care we deliver. As such, it may be of value for QSEA members to approach board members directly, through appropriate channels, of course, to influence the organization’s culture. Very specifically, in my institution we were able to convince our board to pass a resolution whereby each clinical department will be compelled to follow the recommendations of the Association of American Medical Colleges 2013 Teaching for Quality report and to find a way to support the training of at least 1 faculty member in each department in quality and safety.

I closed the presentation with a quick update about the Kaiser Permanente School of Medicine and the dream we all share about creating a new medical school from scratch—a medical school that may be devoted to
building the doctor of the future: a doctor who recognizes this need innately, such as Frank Davidoff, MD, who told us that every doctor has 2 jobs: job one is the job of doctoring, and job two—improving job one.15

It was a distinct honor and privilege for me to address the sixth annual meeting of our colleagues at QSEA. What are your junior faculty doing to improve their knowledge of quality and safety, and what is your organization doing to create a just culture for the future?

As always, I am interested in your views, and you can reach me at david.nash@jefferson.edu.

References
5. Makary MA, Daniel M. Medical error—the third leading cause of death in the US. BMJ. 2016;353:i2139.