First, Do No Harm® Part 3: Healing Lives, Changing Cultures

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CAPTAINS OF INDUSTRY®
Strategic Marketing Communications

Facilitator's Guide

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Cast of Characters

David Baldwin ..... Chaplain

Susan Baxter ..... Obstetrician
(Ariana Romanov's primary care physician)

Arthur Beckett ..... Anesthesiologist

Vinod Pradhan ..... ICU Intensivist

Douglas Feldman ..... Chief Resident, Obstetrics

Connie Goldman ..... Director, Risk Management

Janet Harper ..... Head Obstetrics Nurse

Jack Heath ..... Board of Directors member,
Chair of the Board's Patient Care Committee

Geri Heller ..... Chief Risk Officer for the Hospital

Mitch Johnson ..... Litigation Counsel,
retained by the hospital

Betty Jones ..... RN

Sarah Janowitz ..... Board of Directors member,
Chief of Oncology

Rachel Klein ..... Chief of Nursing

Terry McGiver ..... Chief Executive Officer

Michael O'Leary ..... Attending Surgeon

Daria Pannessi ..... Director of Quality Management

John Page ..... Attending Surgeon

Ariana Romanov ..... Patient

Tibor Romanov ..... Husband of patient

Janet Rothfield ..... Litigation Counsel,
retained by Dr. O'Leary's liability carrier

Barbo Stirbey ..... Translator

Mary Vetsera ..... Home Health Aide

Eric Walcott ..... Legal Counsel

Stan Wozniak ..... Investigative Reporter

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Introduction

First, Do No Harm®, Part 3: Healing Lives, Changing Cultures (FDNH3) is the third volume in the First, Do No Harm Interactive Video Series. It is also the conclusion to the story of patient Ariana Romanov, her family, and the community of healers who treat her.

Each film in the First, Do No Harm series portrays in dramatized case study format the experiences of patients, clinicians, healthcare administrators and other characters. While fictionalized, these are based closely upon actual events. Produced in 2000, First, Do No Harm, Part 1: A Case Study in Systems Failure (FDNH1) was drawn from the closed malpractice claims files of the Risk Management Foundation of the Harvard Medical Institutions. First, Do No Harm, Part 2: Taking the Lead (FDNH2), produced in 2002, and FDNH3 are based on an amalgamation of sentinel events and near misses compiled from malpractice claims files, depositions, interviews, survey data and patient safety literature. FDNH3 evolved in part from the discussion and questions elicited by FDNH1 and FDNH2.

The overall goal of the series is to assist healthcare providers in their efforts to shift from organization-centered, traditional healthcare delivery to patient and family-centered, patient-safety minded care. The series explores the role of leadership at many levels within a healthcare organization, addressing pertinent issues such as: responding to patients and families who have been hurt; caring for clinicians involved in medical system failure; and facilitating the growth of a culture and environment where patient-centered, highly reliable care can flourish.

Because the FDNH films are dramatized case studies based on actual events, **they do not model best practices.** Your audience should be reminded of this point, which is underscored in the opening credits of each film. FDNH3, in particular, illustrates the way one hospital community might begin the process of instituting change based on its values, the challenges it faces and the lessons learned after a sentinel event. **It is intended to stimulate discussion about what the best practices might be in any given organization in its evolution towards a patient/family-centered, patient safety-oriented system.**

In addition to the 26 minute dramatized case study, the interactive DVD/VHS contains over 61 minutes of interview material, which features patient safety experts and healthcare industry leaders discussing issues, ideas and strategies for meeting the challenges raised by the story. These are optional tools that may be useful to you and your audience in bringing your patient-safety discussions to deeper levels.

Overall Objectives

It is recommended that this video be used as part of a facilitated session. The facilitator's role is to encourage discussion among session participants. This works best if time is allowed for participants to formulate their thoughts before beginning the discussion.

The FDNH3 case study and expert interviews raise many issues, providing discussion material for several different educational sessions. We recommend identifying one or two main objectives to pursue in a typical 50–60 minute session.

In a FDNH3 session, participants will be able to meet one or more of the following overall objectives:

"Are you alright, Dr. O'Leary?"

1. Customize strategies for their organization or community to create highly reliable, safe, patient-centered, systems-based care.
2. Discuss examples of good and poor leadership at every level of the organization.
3. Identify strategies for alignment of leadership throughout the organization and at various levels in the organizational hierarchy.
4. Identify strategies for fostering or improving interdisciplinary and/or interdepartmental teamwork.
5. Examine the benefits of early intervention after an unexpected outcome.
6. Weigh the pros and cons of various disclosure strategies.
7. Discriminate between disclosure and apology.
8. Analyze the difference between an apology of sympathy and an apology of responsibility.
9. Assess the values of communication and transparency as strategies for creating and maintaining trust:
    a. with patients and families
    b. among clinical providers
    c. between clinical providers and others in the healthcare system
10. Recognize the need for trauma support for any and all people involved in a serious unanticipated outcome.
11. Evaluate ways in which a sentinel event can become a catalyst for change throughout the organization.
12. Develop strategies for working with the press after an unanticipated event.
13. Develop strategies for using public relations as a tool for ongoing interaction with the hospital's workforce community as well as its external community (e.g. public, press, policymakers).
14. Discuss ways your organization actively demonstrates (or fails to demonstrate) that patient/family-centered care and safety are a priority.
15. Discuss the establishment of cultures that are perceived to be "just" by healthcare workers, patients, and families.

Preparing for the Session

Since each hospital community is unique, there is rarely just one path to a goal or one way to solve a problem, and each person has his or her own perspective. For these reasons, everyone's contribution is important in uncovering the issues and developing a solution. With that in mind, it may be helpful to provide your audience with thought-provoking questions before showing the video.

In general, the following preparation sequence is recommended:

1. Determine the specific objectives for the session.
2. Determine the likely composition of the audience. The audience may include:
    a. Executive administrators (CEO, COO, CMO, CNO, CIO, General Counsel, etc.)
    b. Members of the Board of Directors
    c. Mid-level managers
    d. Medical staff, multi- or single-specialty
    e. Nurses, NPs, Pas, CNMs, pharmacists and other clinicians
    f. External audiences, such as consumers or community representatives
    g. Mixtures of the above.
3. Determine the length of time allowed for the session. It is recommended that the session last at least 50 minutes.
4. Determine whether the space for the session can accommodate the necessary equipment and the size of the audience.
5. View the video several times with the above information in mind.
6. Develop appropriate opening questions.

In our work with the FDNH series, we have encountered occasional reluctance to use these tools with audiences comprised of mixtures of the groups listed above. For example, sometimes medical staffs have expressed concern about the reactions of nurses or patients or board members. However, because the films explore difficulties in communicating or teambuilding across organizational divisions, we have found that they are particularly suited to facilitating better understanding among a mix of professions, organizational layers and stakeholder groups.

Using the DVD

The interactive DVD format provides the facilitator and/or reviewer with a variety of ways to use the program, enabling you to easily customize sessions for different audiences, time frames and objectives.

When you insert the DVD into the player, you will see the main menu. The main menu gives you these options:

- Play Drama
- Play Drama with Expert Interviews
- Scene Index
- Expert Interviews

If you select "Play Drama" and press "Enter," the drama will play in its entirety without suggesting breaks for discussion, though it can be paused at any time.

If you select "Play Drama with Expert Interviews," you will be given the option, while viewing the drama, to bring in expert commentary. At six points in the program, an onscreen graphic will appear, saying "Press Enter for Further Discussion." Pressing "Enter" will bring you to a submenu listing interview sections that provide expert commentary on issues addressed in that part of the drama. You may view some or all of these sections, pausing as desired. When you are ready to return to the drama, simply select "Resume Program."

In some cases, you may want to view a single scene. Selecting "Scene Index" will bring you to a submenu listing each scene by name and pictorial keyframe.

If you want to select a specific section of expert commentary, select "Expert Interview." This will bring you to a submenu listing each interview segment by topic.

Using the VHS

In the VHS format, you will first find the drama uninterrupted. This is followed by expert interviews, organized by topic in the order that the topics appear in the facilitator's guide.

You can use the VHS format to integrate discussion of both the drama and expert commentary or to focus on particular scenes or interview segments. However, you will need to manually cue the tape to each section. Since the counters on VCRs vary from one machine to another, we suggest pre-screening the video on the VCR you will be using, noting the relevant numbers in your facilitator's guide for later reference.

Presenting the Session

1. Introduce the video. All or part of the following introductory language can be used:

   This video represents one family's experience and one healthcare community's response to a sentinel event, which is recapped in a prologue at the beginning of the film. The actual story of systems failure is an amalgamation of three distinct events, all drawn from closed malpractice claims files of the Risk Management Foundation of the Harvard Medical Institutions. The cases were selected because they illustrate common and systemic causes of patient harm. The story told here is based in fact, changed only by combining several distinct events into one story.

   No party is immune from the self-questioning, the anger, the confusion and the sense of betrayal that result from trusted systems failing. The drama you are about to witness explores the values, concerns, goals, fears and actions of everyone involved as they digest and process the sentinel event and decide what to do now and in the future.

   Because the story is based on real events, it does not necessarily exemplify best practices. The organization portrayed is in the midst of an evolutionary process. Some actions or some decisions may strike you as impractical or just plain wrong. These areas of controversy or unfinished business are meant to stimulate discussion among us about our work, our community, and the way in which we are determining the values, goals, policies and practices that define us.

   As you watch the story, which lasts about 25 minutes, I'd like you to think about the following questions...

Then, pose questions based on the objectives you wish to explore in this session. For example:

- Which of the three disclosure approaches you're going to see seems like the most appropriate to you and why?
- Think about the teamwork initiatives this hospital is trying to develop compared to what we're doing here. Should we be doing anything more?
- As you watch the film, think about the support offered to clinicians and family members, and compare it to what we do. Are we doing enough?
- What are the benefits and drawbacks of the organization's approach to the media and how is it like or different from ours?

2. Observe the audience watching the video, noting any reactions that may help frame the opening question.
3. After the final section ends, let the silence sit for 10-15 seconds, either while you let the credits roll or after you have turned off the video equipment following the last section.
4. Lead with a question you posed before showing the film, acknowledge someone who appears ready to speak, or consider using one of the following opening questions:

   - What events shown in the video are similar to those we've experienced in our organization?
   - What issues raised in the video are important to talk about in our community?

How to Use the Expert Interviews:

Eleven leaders and experts with a wide variety of knowledge and opinions have contributed to this video. Their interviews can be used at breaks in the case study, after the case study is done, or after a selected scene that is the focus of your educational session. An expert interview may help you initiate discussion, provide an example or underscore a point made during the session, or introduce a new thought for the audience to consider in the midst of the discussion. In the following sections of this guide, you will find some suggestions about where in your discussion the different expert interviews work well.

Briefly, the experts are:

- David Seifert – a former hospital CEO who discusses the role of the CEO.
- Connie Crowley Ganser, MS, RN – a risk manager and quality improvement professional who has managed a number of high-profile sentinel events.
- Linda Kenney and Rick van Pelt, MD, MBA – respectively, a patient who experienced a sentinel event and the doctor who took responsibility for it. Each talks about their need for trauma support after the incident.
- Grena Porto, RN, ARM – former President of the American Society of Healthcare Risk Management (ASHRM) and a teamwork training expert.
- David Marx, JD – a lawyer and engineer who is doing seminal work on building 'just cultures' in healthcare.
- Carol Liebman, JD – a law professor and mediator who talks about the benefits of mediation and apology.
- Larry Tye – a writer who covered medical error stories for The Boston Globe. Tye gives advice on how to work with the press and use them to get your messages across.
- Nancy Wilson, MD, MPH – a patient safety leader now working with the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) to coordinate national patient safety policy. Dr. Wilson discusses culture change and high-reliability operation.
- Peggy Berry Martin, ARM, MEd – an educator and risk manager involved in harvesting the lessons learned from the malpractice claims that underlie this case study. She addresses the role of the risk manager.
- Martin Hatlie, JD – a lawyer who talks about what we can learn about safety and prevention from consumers and how we can move beyond the 'problem' of patient safety to more creative solutions.

See page 19 for more extensive biographies.

Section 1: Prologue & Scenes A-C

"We're going to need a transcutaneous pacer in here, please!"

Interview Segments

- David Seifert on the Role of the CEO

Description

A short prologue summarizes key plot points of FDNH1 and FDNH2 and identifies key characters from the earlier films.

The case study opens with an ordinary hospital scene triggering Dr. Michael O'Leary's memory of the Romanov event. He struggles to refocus on the here and now. Simultaneously, Terry McGiver, the CEO, continues to deal with conflicting perspectives among his board of directors about the appropriate action for the hospital to take. Meanwhile, patient Ariana Romanov codes, and her husband Tibor is ushered to a waiting room as staff try to save her.

Themes

- The impact of an event on caregivers.
- The differing perspectives on appropriate action.
- How personal interests color the perception and interpretation of a situation.
- How fear of litigation affects decisions.
- How families are treated during emotionally and medically critical periods.

Learning Objectives

- Describe the role of fear in limiting appropriate communication with patients/families throughout medically tense situations.
- Analyze the impact of the system available for emotional support for caregivers.
- Analyze the role of leadership in setting the tone for appropriate action.

Discussion Points

- How can a physician's reaction to an experience, such as the Romanov case, affect his/her performance in the short term? In the long term?
- How does professional education address the need for emotional support for healthcare workers involved in an adverse event? How effective is that education in the modern healthcare environment? What was, or would have been useful in your own professional training?
- How should concerns about litigation be considered in the communication process?
- How should concerns about community reaction be considered in the communication process?

Section 2: Scenes D-F

"Next Sunday my paper will be going to press with the first in a series of front page stories."

Interview Segments

- Rick van Pelt on Trauma Support— a Physician's View
- Linda Kenney on Trauma Support— a Patient's View

Description

The section opens with a meeting between Dr. O'Leary and two attorneys. The meeting is observed by a surgical colleague who then rebuffs O'Leary's offer to help with a procedure. CEO McGiver receives a package from Stan Wozniak, an investigative newspaper reporter. The package contains the records and reports from a number of purported medical errors that have occurred at his hospital. The accompanying letter advises the CEO that the report about this series of medical errors will be published as part of an exposé in a matter of days. Wozniak's letter indicates that he will call McGiver soon for his comment. We see Tibor being approached by the chaplain and the ICU intensivist. Tibor realizes that Ariana has died.

Themes

- Affect on staff not directly involved in an adverse event.
- The power of the press and its capacity to influence community perspective.
- Emotional support for families.

Learning Objectives

- Evaluate and describe the impact of an adverse event on staff relations.
- Discuss the responsibility of the press to educate the public and expose risks that are hidden from public view.
- Discuss a patient/family-centered system for preparing patients and families for the possibility of bad news.

Discussion Points

- How does the rumor mill function in your organization after an adverse event? What is its impact on individuals who have been involved? How does this informal communication affect the organization's efforts to change the culture?
- Look at the situation from a consumer's perspective. What is the responsibility of the press to educate the community about standards of care or healthcare risks that are hidden from public scrutiny? Can you think of examples where the press has done this responsibly and fairly? How would you like to see the press cover issues of patient safety and medical error?
- What considerations must leadership balance in order to protect the proprietary information of the institution against the community's right to know?
- What systems are in your organization to prepare people to receive bad news? What would a system look like that addresses people's emotional, spiritual, psychological and information needs?

Section 3: Scenes G-J

"If we don't make the call, these patients aren't safe!"

Interview Segments

- David Marx on Creating a Just Culture
- Nancy Wilson on Culture Change and High Reliability

Description

Resident Douglas Feldman, again confronted with the hectic pace of patient care, is reluctant to admit he is overwhelmed. Nurse Janet Harper insistently reminds him of recent discussions about the Romanov event and the organization's commitment to putting the patient first. McGiver is surprised to first learn of Ariana Romanov's death during a phone call with reporter Wozniak, who tells him that this is now front page news. McGiver bargains for time with Wozniak. Subsequently, McGiver is informed that Geri Heller, Chief Risk Officer, will be personally handling the case. He offers full support to the risk management team. CNO Rachel Klein visits nurse Betty Jones who is at home, devastated by her role in the event. Klein encourages her to realize that quitting nursing will do nothing to improve patient safety.

Themes

- Relationship between a sentinel event, changes in behavior and changes in culture.
- The role of leadership in times of crisis.
- How involvement in an event permeates personal and professional life.

Learning Objectives

- Define what is meant by the term "just culture" as it applies to corrective action, to employee and staff relations, and to the patient/family.
- Describe what is meant by the term "high reliability" as it is applied to healthcare processes or operations.
- Discuss appropriate assertiveness in situations where patient safety is at stake.
- Discuss how leadership can balance the need for thoughtful consideration of issues while dealing with urgent situations.
- Analyze the role that trust plays in effective organizational leadership.
- Describe the effects of trauma on an individual's perspective of themselves, their abilities, and their future.

Discussion Points

- Is your organization perceived to have a just culture by those who work within it?
- If your organization had a culture that people believed to be just, in your view what kinds of behaviors would be punished? What kinds would be protected from punishment? What kinds would be rewarded?
- How do you think harmed patients should be treated in a trusted, just culture?
- How can your organization's culture become a 'just culture'?
- What type of organizational support do clinical or administrative staff need in order to feel secure in speaking up to those with superior rank? How is that demonstrated in your organization? How can it be improved?

"It's not about fault, Betty."

- What are your organization's strategies for managing the media's interest in patient safety? What do you think should be said to the press about a sentinel event when the relevant facts are still unfolding?
- What type of support did Betty Jones need from the organization? What type of support is available in your organization in these types of situations?
- Was CNO Klein's visit to Betty's home appropriate? Why or why not?
- If you were Michael O'Leary or Betty Jones and had experienced what they did, would you continue to work in patient care? Why or why not?

Section 4: Scenes K-L

"I believe it's our systems that are failing, not our people."

Interview Segments

- Connie Crowley Ganser on Sentinel Events and Quality Improvement
- Larry Tye on Dealing with the Press

Description

Chief Risk Officer Geri Heller has called a meeting to discuss strategy in the aftermath of Ariana's death. Because of Klein's urging, Jones attends. (She had been noticeably absent from the earlier strategy meeting in FDNH2). Jones speaks up over O'Leary's objection and insists on refocusing the meeting to discuss the hospital's unreliable systems for ensuring safety. Heller challenges O'Leary to engage and help make systemic improvements in the organization. Meanwhile, McGiver and Wozniak come to an agreement. McGiver guarantees Wozniak an exclusive story in exchange for his promise to print the hospital's entire statement without editing it.

Themes

- Litigation preparation.
- Learning from sentinel events.
- Working with the press.

Learning Objectives

- Discuss the role of litigation preparation in a culture of safety.
- Discuss the role of honest communication within an organization to affect change in behavior and culture.
- Discuss the ways in which an organization can create a positive relationship with the press.

Discussion Points

- What is the role of litigation preparation in the context of a safe and just culture?
- How could Betty Jones's behavior in this meeting affect her future role in the organization?
- Does an organization have to have its own sentinel event in order to galvanize the will to make patient safety a priority? What else could be the source of motivation?
- How does the hospital's need to do "damage control" support or conflict with addressing family and patient needs?
- What are the steps an organization can take to develop a positive relationship with the press? What is your organization's relationship with the press?

Section 5: Scenes M-O

"We'd like to explain to the best of our knowledge what happened to your wife."

Interview Segments

- Carol Liebman on Apology and Disclosure
- Peggy Berry Martin on the Role of the Risk Manager

Description

Picking up from the first disclosure meeting, initiated by Dr. Susan Baxter in FDNH2, this section plays out three alternatives for the next stage in the disclosure process with Tibor.

In the first version, facts are honestly and carefully disclosed, although the medication administration error that could have harmed the new baby is selectively omitted as no injury occurred. Instead, the positive outcome of Tibor's healthy son is stressed. No apology or acceptance of responsibility is made. In the second alternative, identical facts are disclosed and the successful outcome of the neonate is again stressed. However, Dr. O'Leary starts by making an 'apology of sympathy,' stating how "sorry we all are this happened...."

> Please note: Tibor's reaction to this apology is not portrayed. This disclosure alternative is included to assist your audience in discussing what difference, if any, an apology of sympathy makes.

In the third alternative, seating order is changed so that the providers and the family are not seated across from each. O'Leary, Baxter and Heller make "apologies of responsibility" expressing their sorrow for the actions of the healthcare team. The medication administration error is described in a reassuring way and Tibor is invited to give feedback and ask questions.

Again, none of these alternatives is presented as the best practice. The alternatives are played out to raise questions for discussion and to help your audience explore how differences in disclosure approaches can influence how information is perceived and felt by the recipient.

Themes

- Apology.
- Disclosure and restitution.
- The value of early intervention.

Learning Objectives

- Discuss the difference among the three disclosure approaches.
- Analyze the effect of different disclosure approaches on the family's reaction.
- Describe the difference between an "apology of sympathy" and an "apology of responsibility."

Discussion Points

- Given that many people in the hospital community were involved in the events that led to Ariana's death, who should lead this kind of disclosure meeting? Was Dr. O'Leary the best candidate? Why or why not?
- The risk manager played a much more prominent role in this second disclosure meeting than in the initial meeting. Is that appropriate? Why or why not?
- Putting yourself in Tibor's place, how important would it be to you to receive an apology? Would it make any difference if the apology was "I'm sorry this happened to your wife" as opposed to "I'm sorry we made mistakes that harmed your wife?"
- What is the impact of non-verbal communication on disclosure? Were there any visible demonstrations of this effect?
- How appropriate was it to bring up restitution of "Tibor's needs" during this discussion? How do you think it influences a person in Tibor's position?
- How appropriate is an apology in a case like this? How risky is it? Will this influence a potential claim? Positively or negatively?

"What will happen to the people who made the mistakes?"

Section 6: Scenes P-Q

We rededicate ourselves to our mission of patient safety, and our oath, First, Do No Harm.

Interview Segments

- Grena Porto on the Role of Teamwork
- Marty Hatlie on Establishing Successful, Patient-Centered Care

Description

In this section, CEO McGiver appoints a multi-disciplinary leadership team and empowers them to improve patient safety. It's clear that O'Leary and Jones—recruited as leaders by McGiver—are already talking about methods to improve communication and teamwork among physicians and nurses. Next we hear McGiver's statement to the press, and watch as audiences both inside and outside the hospital react to the newspaper story. As we hear the CEO's words, we also see Tibor being taught to care for his new son by a home healthcare aide provided by the hospital.

Themes

- Organizational commitment to making patient safety a priority.
- Multi-disciplinary leadership and teamwork.
- Transparency as honest communication with the patient, family and community.

Learning Objectives

- Discuss the relationship between effective teamwork and patient safety.
- Discuss the relationship between transparency and patient safety.
- Describe the role of leadership (administrative and clinical) in the sustainability of patient safety efforts.

Discussion Points

- What are the pros and cons of transparency in healthcare?
- What are the barriers to transparency in your organization?
- How effective are patient safety efforts without fully engaged leadership?
- How can staff at other levels of the organization demonstrate leadership in patient safety?
- How can patients and families become more involved in patient safety in your organization?
- Where does the leadership for patient safety come from in your organization?
- What are ways that leadership can be developed throughout the organization to enhance patient safety efforts?
- What communication and teamwork efforts are being supported in your organization? How are patients and families being included in this effort?

Section 7: Epilogue

"I know we have a long way to go, but I'm really glad to be a part of the process."

Description

The hospital community's response to Ariana Romanov's death has led to positive change that is continuing a year later. Many people feel ownership of the change.

Themes

- The road to a safe culture is neither straight nor smooth.
- Each individual will interpret the progress from their own perspective.
- There is never an end goal in creating and maintaining a culture of safety; it is an ongoing process as new risks seem to be always emerging.

Learning Objectives

- Discuss the process of evolution for an organization striving to become a culture of safety.

Discussion Points

- How is an individual's perspective influenced by his or her personal involvement in a tragic event?
- Has your organization had an event such as the Romanov incident which resulted in sweeping, permanent changes? What kept those changes going? If the changes did not sustain, what contributed to that?
- If you have not had a situation such as the Romanov case, what has stimulated or prevented your organization from moving towards a culture of safety?

Expert and Advisor Biographies

Geri Amori, PhD, ARM, DFASHRM, CPHRM, principal of Communicating Healthcare, is a nationally known speaker, facilitator and consultant on risk management and communication issues in healthcare and patient safety. She promotes the development of risk management skills in administrators, workers and consumers through seminars, workshops and consultations. Her presentations feature role play, interactive dialogue and group involvement activities designed to teach effective communication. Geri is also director of the Patient Safety Theatre™, a unique educational product provided in partnership with Dana Yeaton, award-winning playwright and professor. Together, they have worked with patient safety leaders, insurance companies, policymakers and individuals to create and produce interactive performance pieces for patient safety conferences, healthcare organization programs and general education of the healthcare community. Dr. Amori is past president of the American Society for Healthcare Risk Management as well as past president of the Northern New England Society for Healthcare Risk Management. She served as risk manager at Fletcher Allen Health Care in Burlington, Vermont for twelve years. In the 1980's, she was psychopharmacology clinic and research coordinator with the University Associates in Psychiatry. Currently, she serves on the Board of Consumers Advancing Patient Safety.

Connie M. Crowley Ganser, MS, RN, principal of Quality HealthCare Strategies, is a consultant in the health-care industry, working with clients to enhance their organizational strategies in building safe and reliable systems of healthcare. Her consulting practice builds on over twenty-five years of experience in healthcare leadership roles in medical affairs, nursing, quality improvement, risk management, professional development and education and regulatory compliance. She brings both strategic and practical strategies to an organization, as well as a results-oriented, customer-driven style and a successful interdisciplinary team-oriented approach to resolving problems in the design and delivery of quality patient care. She is a founder of the Massachusetts Coalition for the Prevention of Medical Errors and its immediate past president. The coalition was founded in 1997 to create the forum for healthcare stakeholders to find common ground and collaborate in the design of a safer healthcare system. She is also past president of the Massachusetts Organization of Nurse Executives. She was one of the original developers of the Picker Pediatric Inpatient Consumer Survey and serves as a board member for a variety of professional journals and organizations.

Roxanne J. Goeltz is co-founder and president of Consumers Advancing Patient Safety (CAPS), a consumer-led non-profit organization that envisions a healthcare system that is safe, compassionate and just. The mission of CAPS includes being a collective voice for individuals, families and healers who wish to prevent harm in healthcare encounters through partnership and collaboration. Ms. Goeltz has been employed by the Federal Aviation Administration for twenty-four years as an air traffic controller/automation specialist. Her experience in a profession that requires situational awareness and decisiveness in daily tasks to keep people from harm gives her a unique perspective in the area of patient safety. Ms. Goeltz's involvement with patient safety began after the death of her brother in September of 1999 due to medical error.

Martin J. Hatlie, JD is president of the Partnership for Patient Safety (p4ps), a Chicago-based consulting firm established in 1999 for the purpose of working with healthcare stakeholders to advance the reliability of healthcare systems worldwide. Prior to developing p4ps, Mr. Hatlie coordinated the establishment of the National Patient Safety Foundation at the AMA (NPSF) in 1997 and served as its first executive director. Drawing on experience as a malpractice defense litigator, lobbyist and coalition-builder, he is active in both public and organizational policy development on patient safety, litigation reform and risk management issues. With Roxanne Goeltz, Mr. Hatlie is a co-founder of Consumers Advancing Patient Safety.

Linda K. Kenney founded Medically Induced Trauma Support Services (MITSS) in June of 2002 after nearly losing her life as a result of a medical trauma during surgery. In November 1999, she underwent surgery for a total ankle replacement at a major medical facility in Boston. Instead of waking up with a new ankle, Mrs. Kenney awoke several days later to find out that the nerve block had been accidentally delivered to her heart, triggering full cardiac arrest. Emergency open heart surgery saved her life. This incident had a profound effect on Mrs. Kenney, her family and friends, and—as she was later to learn—on the healthcare workers treating her as well. When Dr. Rick van Pelt, the anesthesiologist on the surgical team, reached out to Mrs. Kenney they came to an understanding, a peace and a friendship. She is committed to alerting hospital administrators and staff of the need to follow up and support patients, families and hospital staff after a trauma occurs. MITSS was founded specifically to provide a network that links those involved with resources that provide and promote healing through a variety of media.

Carol B. Liebman, JD is a clinical professor at Columbia Law School where she is the director of the Columbia Law School Mediation Clinic and the Negotiation Workshop. She also teaches professional ethics. She has mediated cases involving discrimination, medical malpractice, family issues, public agencies, community disputes, business conflicts and educational institutions and is a nationally recognized speaker and trainer in conflict resolution. She is the co-principle investigator for the Pew Charitable Trusts Demonstration Mediation and ADR Project and the author with Nancy Dubler of Bioethics Mediation: A Guide to Shaping Shared Solutions, published by the United Hospital Fund.

Peggy Berry Martin, ARM, MEd, is currently senior risk management coordinator for Lifespan Risk Services of the Lifespan Corporation, Providence, Rhode Island. In this capacity, she assists the risk managers of the member hospitals in proactively identifying areas of potential risk and helps them design interventions and educational programs. During her more than twenty-five years of experience in loss prevention and risk management education, Ms. Martin has held a variety of positions in healthcare facilities and captive insurance companies, the most recent of which was as director of education for the Risk Management Foundation of the Harvard Medical Institutions. She is currently president-elect of the American Society for Healthcare Risk Management, has achieved the Distinguished Fellow designation, and has served as chairperson of several committees and as a member of the board of directors. On the state level, Ms. Martin was the first president and one of the founding members of the Massachusetts Society for Healthcare Risk Management. She is currently immediate past president of that organization and was the recipient of their first Distinguished Service Award in 2000.

David Marx, JD, who has an undergraduate degree in mechanical systems engineering, began his career as a Boeing aircraft design analyst, conducting failure modes and effects analysis and probabilistic risk assessments on Boeing aircraft. At Boeing, David organized the maintenance human factors and safety group, where he developed a human error investigation process used by air carriers around the world. In 1997, David started a research and consulting practice focusing on the management of human error through the integration of systems engineering, human factors, and the law. He has served as an advisor to the Federal Aviation Administration's Human Factors Research Program, and currently acts as an advisor on patient safety to the Agency for Healthcare Research and Quality. For Columbia University's MERS-TM project under Dr. Harold Kaplan, David authored the document "Patient Safety and the 'Just Culture': A Primer for Healthcare Executives." Currently, he is focusing on application of socio-technical risk management techniques in the aerospace and healthcare industries.

Grena Porto, RN, ARM is a nationally recognized expert and leader in patient safety, risk management and quality improvement. She is the founder and principal of QRS Healthcare Consulting, LLC, a firm that specializes in providing customized consulting support to healthcare organizations. Prior to forming her own company, Ms. Porto was senior director of clinical consulting for VHA Inc., where she was responsible for directing engagements and providing services in the areas of patient safety, quality improvement, clinical care management and design and healthcare risk management. Ms. Porto served as president of the American Society for Healthcare Risk Management (ASHRM) in 1999. She is a Distinguished Fellow of ASHRM and has also attained the designations of Associate in Risk Management (ARM) from the Insurance Institute of America, and Certified Professional in Healthcare Risk Management (CPHRM) from the American Hospital Association.

David P. Seifert is a partner in the Healthcare Advisory Panel, a consulting firm specializing in strategy development, resource management, and executive counseling. He is the former president & CEO of St. Anthony's Medical Center in St. Louis, Missouri, an 812-bed suburban community hospital. Mr. Seifert's commitment to the highest quality patient care earned St. Anthony's recognition as a Top 100 Hospital in 1999. In the five years prior to his retirement in 2003, he remodeled and upgraded the medical center's entire infrastructure and facilities with a focus on service, quality and safety. Throughout his career, he has managed change and growth with an eye for the long term.

Larry Tye is the director of the Health Coverage Fellowship, a Boston-based program designed to help the media do a better job covering critical health care issues. Each year it provides nine days of intensive training—along with 11 months of ongoing tutelage—to 10 medical journalists from newspapers, radio stations and TV outlets. The program is sponsored by the Blue Cross Blue Shield Foundation of Massachusetts, the Endowment for Health in New Hampshire, and a consortium organized by the Maine Health Access Foundation. From 1986 to 2001, Tye was a reporter at The Boston Globe, where his primary beat was medicine. He is the author of several books on a wide variety of topics.

Rick A. van Pelt, MD, MBA is currently on staff at the Brigham and Women's Hospital serving both clinical and administrative functions. He attended Amherst College and the University of Massachusetts Medical School. After spending a year as a research fellow at the National Institutes of Health, he spent two years as a surgical resident before transitioning into and finishing a residency and fellowship in anesthesiology. Dr. van Pelt went on to attend Harvard Business School to further develop the skills necessary to serve as an effective leader at the institutional and industry levels. Since completing his MBA in 1999, Dr. van Pelt has been actively involved in healthcare improvement initiatives, including patient safety, in academic and private healthcare settings as well as in the healthcare industry.

Nancy J. Wilson, MD, MPH has a joint appointment with Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) as special assistant for patient safety. Dr. Wilson is a 1976 honors graduate of the University of Pittsburgh. After a first career in nursing, she earned her MD from Johns Hopkins School of Medicine in 1986 where she also completed her medical internship and residency in 1989. In 1994 she completed a general medicine/health services research fellowship at Harvard Medical School while obtaining her MPH at the Harvard School of Public Health. Previously, she served as director of quality for the Veterans Health Administration and as vice president and medical director for VHA, Inc., a nationwide network of 1,900 leading community-owned healthcare organizations and their affiliated physicians.

Program Chart

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SECTION 7	Epilogue	

Additional Resources

Agency for Healthcare Research & Quality
www.ahrq.gov

American Society of Healthcare Risk Management
www.ashrm.org

Captains of Industry
www.captainsofindustry.com

Consumers Advancing Patient Safety
www.patientsafety.org

Communicating Healthcare
www.geriamori.com

Institute of Medicine of the National Academies
www.iom.edu

Joint Commission on Accreditation of Healthcare Organizations
www.jcaho.org

Medically Induced Trauma Support Services
www.mitss.org

Outcome Engineering, LLC
www.outcome-eng.com

Partnership for Patient Safety
www.p4ps.org

Patient Safety Advantage
www.p4ps.org/about_psa.asp

QRS Healthcare Consulting, LLC
www.qualityrisksafety.com

Risk Management Foundation of the Harvard Medical Institutions
www.rmf.harvard.edu

Larry Tye, Author & Journalist
www.larrytye.com

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