

## Is Your Hospital as Safe as Your Bank?...Time to Ask Your Board

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The market forces, governance shortfalls, and a crisis of values that have led to the global financial collapse in 2009 have a frighteningly similar pattern to the collapse of hospital quality that has led to a crisis in patient care.

We have stated that you cannot defy the business laws of gravity—that quality, cost, value, speed, and trust are intrinsically interlocked and tightly coupled. Perhaps the most important of these is trust.<sup>1</sup> When we compare our financial collapse to our patient safety crisis, there are striking similarities.

### **RISK AND TRUST—COMMON TO BANKS AND HOSPITALS**

A common theme between running a hospital and running a bank is risk. Risk prevention, risk management, risk deferment, systems risk, compounding risk, and adverse events when the cost of risk comes due.

Braxton Rel was a 10-year-old fifth grader from the southwest. Like many kids his age, he loved sports and was an avid hockey player.<sup>2</sup> He went in to a local hospital for a “routine tonsillectomy” in early December of 2008. In a video interview, his father said Braxton was scared on the morning of the surgery. He comforted him by repeating the message from their caregivers to trust that “everything would be alright.” Braxton was a member of a loving family who brought him home and stayed by his side. What was not so typical was that 12 hours after surgery, he was found cold and lifeless in his bed. His father desperately tried CPR but to no avail. The family called both the hospital and the surgeon to ask what to do and for answers regarding his death. They waited for almost 4 months.<sup>3</sup>

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### *Many Contact Attempts...No Response*

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Furthermore, when his parents went to get his medical records, they were given an incomplete set and were told that nurses’ notes and anesthesia records were not kept after the day of the surgery. When Braxton’s Dad went to the hospital to get the records, he reports that he inadvertently encountered the surgeon who operated on Braxton—who was also his own physician, who had operated on him a year earlier. Mr Rel states that when the physician recognized him, a man he trusted turned his back on him and walked away. As of this writing, the cause of death has not been finalized. After scores of calls to the medical examiner, they were told that their son died of bleeding into his lungs. Mr Rel was told by the examiner’s office that they could not find a camera for their microscope and that this lack of equipment was holding up the process... for many weeks. As such, only a portion of Braxton’s remains were released to the family, leaving them few answers, no peace, no closure, and little comfort... for months on end. For 4 months, they did not seek a lawyer, they just sought answers from the hospital and their physician and waited by the phone for someone to call them back.

### **NO ONE SEEMED TO CARE**

One key question regarding the banking collapse is why no one seemed to care to take a lesson about risk from history. Elizabeth Warren, Harvard professor and head of the Congressional Oversight Panel that oversees 2009 bank bailout funding, has provided a clear picture of how history has repeated itself in banking.<sup>4</sup> In 1792, America was a young country and George Washington was a new president facing a financial crisis that was all about a credit freeze. It almost brought the country to its knees. Every 10 to 15 years throughout our history, we have a complete banking collapse, panic, crisis; they are called by different names. When the Great Depression occurred, we put just 3 basic regulations in place: first, FDIC insurance, second, the Glass-Steagall Act to make sure that the banks would be run like public utilities, not like gambling enterprises, and third, the Security and Exchange Commission. For 50 years, under these regulations, we then thrived without a major collapse. Then, no one seemed to care about the past and we started pulling the regulatory strings out one at a time,

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Sources of support: Funding support for this session was provided by Texas Medical Institute of Technology (TMIT).

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and we ended up with the collapse of the savings and loans, disasters like the Enron failure, and finally the current crisis. She states that “one of our greatest periods of growth and prosperity was a time when we had the strongest regulations in our financial sector. Well-done regulations protect us. Bad regulations cost us money.” She also states that good leadership is critical, and it is leadership that can define the difference between good and bad regulations.

### GOOD LEADERSHIP IS CRITICAL

History repeats itself—the 1907 crash was due to unregulated betting on equities in parlors called “bucket shops.” Investors could wager on the outcomes of equities without investing in them. These unregulated activities led to financial systems failures with disastrous outcomes to the financial health of all Americans. Sound familiar?

In 2000, President Clinton signed the final bill of his presidency, called the Commodity Futures Modernization Act of 2000 with bi-partisan support and that of Allan Greenspan.<sup>5</sup> This created the time bomb that brought us down. It defined the Credit Default Swap financial instrument, or what Warren Buffet would ultimately coin “A Weapon of Financial Mass Destruction.” Buffet said that they are easy to get into and almost impossible to unwind. He should know, as he took a US \$172 million loss on them in 1992 when he fashioned the term.<sup>6</sup> The legislation that Clinton signed into law specifically stated in a “preemption clause” that this financial derivative was unregulated and not subject to gaming regulators—that prosecution could not be undertaken with the “bucket laws. This is how a worldwide shadow casino was created with no requirements for anyone to have the money to back the bets. Not only could you insure your investment, but outside gamblers could make side bets on your win or loss without any investment in your equity. Coupled with further relaxation of the requirements for reserves of our biggest banks, we had the recipe for disaster. This casino of more than US \$60 trillion came crashing down when US home prices dropped. In the final analysis, banks were left on their own with only the morals of their governance boards and Corporate Suite leaders to hold their motives (some say greed) in check. Huge responsibility rested on the shoulders of bank boards and they failed. Huge responsibility and risk rests on the shoulders of hospital governance leaders.

### FAILURE: THE SAME DESTINATION

The path of hospital risk and finance management took an entirely different path; however, they may be heading to the same destination. In 1982, the Tax Equity and Fiscal Responsibility Act (TEFRA) passed, and during the Reagan administration, the game changed. Up to that time hospitals were paid on the basis of their cost, and administrators relied on the physicians to ensure quality of care. The not-for-profit organizations had significant donor income—cost control of care delivery was just not a critical issue.

With TEFRA, hospitals began to be paid in lump sums for specific patients. Simultaneously with this revenue cap approach, the cost of care delivery was going up, and most organizations were in a medical technology arms race to compete for business. As highly technical procedures moved out of acute care hospitals, so did the star physicians who had historically donated their time to their hospitals to maintain quality. Ad hoc meetings in the physicians’ lounge “before rounds” that had allowed quality issues to be nipped in the bud by dedicated community minded physicians did not occur anymore. With the

departure of these physician leaders, no one was left at the quality controls of the ship.

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## Suffering the Consequences of Financial Engineers Out-of-Sector

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According to Dr Chris Olivia, a leading hospital chief executive officer (CEO) and turnaround expert, “We are suffering the consequences of the *financial engineers* who came to power after TEFRA. The huge financial pressure that subsequently developed was an invitation to revenue cycle consultants and out-of-sector financial managers—a whole wave of *financial engineers* took the helm.” An oft heard phrase was “We are going to run these hospitals like a business” (Oral communication, April 3, 2009).

Many hospital CEOs will privately admit that they have become financial asset managers and that the hospital became a cash machine—“an investment life support system.” When times get tough, the hospital becomes a financial cost center where they have to stop the bleeding regardless of patient risk.

### THE RISK—WHAT WERE THEY THINKING?

Bill George, the business guru of leadership who led Medtronic from US \$1.6 billion to US \$61 billion in 10 years, says “The economic crisis is the result of failed leadership. It is not some economic tsunami, or hurricane that’s an act of God. These are acts of people who have failed as leaders. And I think we need a whole new generation of leaders so that we avoid the Enron, Lehman Brothers, and Bear Stearns experiences, where leaders are so egotistical, they cannot build their organizations for the long-term. We’ve had such failures in medicine, education, religion, and government. Authentic leaders know their principles and values. Under pressure, they don’t get seduced by big bonuses, they don’t get pressured and pulled off course and capitulate what they believe in. They stay true to what they believe in. And that’s the real test of a leader.” (Oral communication, February 3, 2009) The financial collapse and our own health care crisis beg the question of all leaders when they take have taken big risks—what were they thinking?

When we look at leaders and consider and compare the fully loaded risks in both banking and running hospitals, we are left with serious questions:

- There is broad consensus that bank leaders took reckless risks on derivatives such as credit default swap instruments without knowing much about the downside. How different is this than when a hospital CEO or board takes the risks of budget cuts directly affecting patient safety without knowing the impact?
- Bank board members and CEOs, like their analogs in hospital governance and administration have had little public accountability for the risks they take—how are they any different? Bankers were gambling with systems properties thereby compounding risks that may come due in future years. How is this any different than hospital boards that make decisions to cut short-term costs affecting long-term care from little more than a board report?
- Do hospital governance boards really know what happens after adverse events? Are they sure every event is handled per the protocol? Do they know whether boundaries have migrated and whether what we say we do is what we really do? Certainly, there must have been risk mitigation policies that bankers ignored.

- Hospital boards must ask whether there are “risk generating behaviors” at their hospitals by their legal teams, such as stonewalling, for example. These may be well-intentioned to reduce litigation weaknesses if a malpractice case goes to trial, yet this may, in fact, drive patient families to “lawyer up” just to find out what happened to their love ones.
- What about basic human civility—when will core values trump financial goals including asset preservation led by risk managers? Does a board know when an organization or its physicians treat patient families in the way that Braxton Rel’s family was reportedly treated? Did they know if caregivers wanted to talk to the family and did not because of some policy of risk management? Is your organization taking what the public would believe to be reckless risks with the most precious asset of our communities...its children, mothers, fathers, and parents?
- Do hospital boards know the risks that are being taken at the frontline, do they know the trade-offs that are made, and do they get any early warning information?
- How would a hospital leadership team know when their hospital is in “systems failure” or in a doom loop before a tipping point or a chain reaction cascade? Certainly, many bankers seemed unaware of this seemingly overnight phenomenon.

Braxton trusted his dad, he in turn trusted his physicians, all 3 trusted the hospital staff, and the community trusted the hospital. Regardless of the clinical details of the case, the way that this family reports that they were treated collapsed the critical foundations of care and is a catastrophic failure of civility. When physicians and hospitals stonewall patients after an adverse event, it becomes a betrayal of trust that is so vital to basic care.

Now that Healthcare Associated Infections are included in what we believe are hospital adverse events, patient safety leaders such as Dr Lucian Leape, estimate the incidence of adverse events to be 1 in 10 patients, making it the third leading cause of death in America (Oral communication, March 30, 2009).

Dennis Quaid, the much acclaimed movie star and pilot who played astronaut Gordon Cooper in the movie *The Right Stuff* has become a powerful patient safety advocate. After a life-threatening medication administration error experienced by his newborn twins, he has generously dedicated his time and energy to move leaders in patient safety. As captured in the movie that charted the beginnings of our space program, he believes that we must have great respect for when we are “pushing the envelope.”<sup>7</sup> He states that “hospital governance and administrative leaders need to know the boundaries of their safety envelope and where the systems faults exist in order to ever ensure that they are running safe organizations.” He, like many, believes that questions must be asked of leaders who constantly push the boundaries of cost containment—do they actually know when they are forcing caregivers out of the safety envelope? Do they understand the real risks in giving care, and that said, do they understand that investment in technologies and training can save lives and provide a safety net for human error?

### DO BOARDS KNOW THE EDGE OF THE ENVELOPE?

Hospitals bitterly complain about external oversight, yet the question is—do they have adequate oversight the way they are operated today?

Tom Van Dawark, the former chairman of the board of Virginia Mason Health System, during its incredible development as a leading quality organization states, “The first overall compelling issue is that the board is responsible for the quality and safety—they have an ethical, fiduciary, and legal respon-

sibility to insist on the highest level of quality. OVERSIGHT IS NOT ENOUGH. They must guide, support, and sometimes even demand that the safety and quality goals are met—we owe it to our patients.” He goes on to say that “board members need to know that preventable errors are occurring daily and even hourly—some are minor errors and some are sentinel events. Boards need to ask for trends of safety and quality. They must be briefed on the details regarding the most serious events and they must ask for stories from caregivers and patients directly. If they are getting few answers, then they have to demand the honesty and transparency that provides them what they need to ensure safety of the patients being served” (Oral Communication, April 2, 2009).

Julie Morath, RN, MS, the Chief Quality and Patient Safety Officer of Vanderbilt University Medical Center, offers words of wisdom: “Especially in these economic times, we must recognize that short term cost control strategies can put patients at risk long term. The board not only needs to know about the glitches, errors, and events; but it needs to be proactive—board members must learn from stories of other hospitals. They must ask—is this a safe place to give and receive care?” Speaking truth to power and telling the leaders what they might not want to hear is easier said than done. She goes on to say that board members must ask: “Do physicians and staff feel comfortable and supported to tell the truth across the power gradients” (Oral Communication, April 9, 2009).

Dr Olivia, cited earlier, states “The era of financial engineers is almost over and we are entering the era of the care performance leaders who will deliver high value outcomes that are fiscally responsible, safe, and ever improving” (Oral Communication, April 3, 2009).

Dr David Classen, a global patient safety and health care information technology expert says, “My message to boards is that the day of reckoning is coming and toleration of mistakes that cause harm and failure to leverage ALL capabilities including Health Information Technology to safely improve quality of care may be personally catastrophic to them. An era of transparency is upon us” (Oral communication, April 10, 2009).

Our future leaders will need to lead-from-values rather than manage-to-margin. Not unlike the auto industry, the transition from a now financially driven operating system will not be easy and will be a real shock to those who still believe they are in control of the game—some CEOs will likely have a surprising compulsory change in career path.

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### A Compulsory Vocational Paradigm Shift?

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Ann Rhoades, the international people systems guru who helped craft the “values DNA” of 2 of the most successful US airlines says “great organizations are off the wall”...she means that the values statements virtually leap off of their walls and are lived everyday by everyone on the board at the top to the people at the bottom. As a board member of large multiple public companies and an advisor to start ups, she sees greatness through values at work everyday (Oral Communication, April 8, 2009).

We introduced the term “values genetics model” in a prior article to explain how values are expressed by the collective behaviors of a corporate body and by individual people. Using this “values genetics model” approach, we can consider the

intrinsic core values of human beings as their values or genes that are expressed through behaviors, like traits. That is nature. The environment where they work and deliver care is how nurture factors can come into play. The core values of an organization can be considered its genetic code or corporate genotype expressed through the collective behavior of its people or phenotype.

The translator or mediator between values and behavior is “choice.” Choices that we make are expressed through our behavior. In some cases, we choose to behave one way or another; however, this is not a simple issue of conscious preference. We, as individuals and as organizations, make conscious and unconscious choices everyday. We are blind to many of the unconscious choices that are embedded in the systems of which we are a part.<sup>8</sup>

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### *The Board Maintains the Values DNA*

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Certain instincts, such as self-preservation and survival instincts, can trump conscious choices. It is the duty of the board of directors to assure that, in Rhoades words, the values leap off of the wall and are embodied in the behaviors of all who serve in the institution—even those physicians who do not work for it. The National Quality Forum Safe Practices for Better Healthcare, 2009 Update provides a clear blueprint for boards and the CEO. It provides a guide to ensure values and behaviors are in synch, risk identification and mitigation is undertaken and reported, and provides a clear outline of actions that governance and administrative leaders can take.<sup>9</sup> An intangible, issue critical to healing and optimal performance in organizations, is trust.

### **A VIOLATION OF TRUST**

Regardless of the nature or cause of an unanticipated adverse event, the University of Illinois chief risk officer, Dr Tim McDonald, says that disclosure by caregivers establishes a direct relationship with patients and families. Furthermore, he uses the expression “stop the bleeding and start the healing, so that we can quell the hemorrhage of trust that occurs between patient families and their caregivers” (Oral Communication, April 9, 2009).

An approach to disclosure and care of caregivers involved in unanticipated adverse events is again delineated in the National Quality Forum Safe Practices for Disclosure and Care of the Caregiver, of which Dr McDonald was a contributor, along with many other safety leaders such as Rick Boothman, the Chief Risk Officer of the University of Michigan, known for a “principled approach” to malpractice.

Only time will tell whether the Braxton Rel case has a malpractice dimension. However, the surviving family feels like they have been involved in a hit-and-run accident. They feel left and abandoned...bleeding out the life blood of their spirit as the health care system careens down the road knowing that they have betrayed a sacred trust.

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### *A Hit-and-Run Accident*

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Sue Sheridan, an internationally renowned patient safety advocate, originally coined the concept in a national speech and

in the literature when she described her own experience after an event that led to her husband's death and a separate event that permanently disabled her child: “It is so hard to articulate the profound sense of betrayal and abandonment that my family felt. I can only describe it as a hit-and-run health care accident. My family was abandoned at the side of the road, injured and traumatized by a well meaning motorist who fled because of legal and personal fears. We were left to seek out help on our own with our own resources. No one looked back. They pretended as if nothing had happened, including those eyewitnesses on the side of the road.<sup>10</sup> A hit-and-run, in our world, is considered criminal. Why is it OK in medicine?”

The message to board members is much more than “doom and gloom.” There are great banks run by great leaders. Of the more than 8400 banks in America, only a minority got involved in the most risky ventures. Unfortunately, they were some of the biggest. There are also terrific success stories of great hospital boards who are setting a new bar and involving patients throughout their organizations. One needs to look no further than the Institute for Healthcare Improvement led by Dr Don Berwick, the North Star of the quality movement. Collaborative efforts at Institute for Healthcare Improvement led by Jim Conway through their Boards on Board initiative<sup>11</sup> are a place to see the best, become the best, and deliver the best to our communities. There are many state- and association-based programs leading fabulous work such as the American Hospital Association, yet many mainstream board members are not participating.

Many non-clinical trustees feel that they do not know enough about health care to contribute more than financial advice. We can all learn a lesson from people like Dennis Quaid and Steve Rel, Braxton's father.

April 7, 2009 was an interesting day for safety. In Chicago, Ill, Dennis Quaid gave his first speech on patient safety to inspire health information technology providers and caregivers. He shared lessons learned from the near death experience of his twins. His speech to a relatively technical audience was acknowledged with a standing ovation from audience of 7000. Quaid, already a celebrity, sought to take the time reliving his own painful experience to protect others, knowing that he could build awareness and that the suffering of his family could help other families.

That same day, more than 1300 miles away at a statewide meeting of pediatricians, a patient safety presentation was made. So compelling was the Braxton Rel case that the presenter suggested it was a “defining moment” and an opportunity for those physicians to step up and lead. The clinical elements and cause of death were not discussed; however, when these clinicians heard the story about the lack of outreach by the care providers in their community, they were shocked. Braxton's father came to that meeting and at its conclusion, these physicians were given the opportunity to express the compassion and empathy that was missing in this case. A number physically embraced this suffering man with the love and support that any of us would crave if we lost a child, truly a healing moment that brought civility back into focus. Oddly, the day before, a front page article in the local newspaper profiled Braxton as a true role model, a team player, and a leader. Those who subsequently reflected on this short life, discussed how he reached out to help special needs kids and always had a smile for others who needed that human connection. The article talked about him in the context of sportsmanship.

As this is being written, Braxton's father is preparing to become a patient safety advocate. The only way that he and his family can heal is to make sure to turn the pain and loss into

something positive. That is to help prevent pain and despair of other families. There are many other heroes in this world like Steve Rel, Braxton's Dad. People like Sorrel King, Nancy Conrad, Jennifer Dingman, Dan Ford, Becky Martins, Mary Foley, Arlene Salamandra, Patti O'Regan, Sue Sheridan, and Julie Thao, who willingly relive their experiences in speeches and in the literature, help develop standards such as the National Quality Forum Safe Practices, give of their time and money to help others, and reach out to help the next one or family who falls.<sup>12,13</sup> Why do they do this?—because they believe in the common good. They want to turn a bad event in their lives into something good in the future. In so doing, they believe that they are honoring their loved ones who have been harmed. Rarely do they get the “air time” from boards, unless an accident occurs in a hospital. Why?

Hospital board members should ask themselves... why must we rely on people like Dennis Quaid, Steve Rel, and other advocates to focus our attention on the risks for which we are accountable. Do they really need to teach us about the “right stuff”? Does Braxton Rel's short life need to teach us about sportsmanship and kindness?

Aviation, banking, and the pharmaceutical industries have far more regulatory oversight than hospitals. The next chapter of regulatory intervention for hospitals is yet to be written. Is it wise for boards to “wait and see”?

Board members should learn from banking leaders who ignored risk and their responsibilities out of selfishness. Moral relativism and situational ethics are not going to cut it in the new world of transparency. The bankers' governance issues are no different from ours in health care—this is about leadership, accountability, and values. It does not take a “master of the universe” to understand the Golden Rule.

Accountability comes with transparency. As our hospitals careen down the road to a more transparent future, it is wise to remember that board members' names are on the registration regardless of who is at the wheel. The media and their communities are more and more likely to make them famous, especially if they leave damaged families in their wake.

In closing, Julie Morath, cited above, gives the board members 1 question to be continually asked when they hear of adverse events:

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## Could This Happen Here...Are We Sure?

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June 8, 2009

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Sincerely,

Charles R. Denham, M.D.  
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