

John Nance Keynote Presentation Transcript

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Department of Health
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Begin Transcript

Dr. Pattison: . . . the Medical Quality Assurance Commission and I'd like to give you a special welcome today to our annual workshop. And we have a number of guests with us today and some are still to arrive. And we're going to be doing some formal introductions at lunch.

Obviously a couple of housekeeping details before we start. Uh, the restrooms are just outside here in the hallway. If you have a cell phone would you please put it, um, into silent mode?

Lunch will be served, um, in the room right next to us and we'll come back in here and eat, and that will be at noon. And there is an evaluation that you still have in your packet, and there are extra ones out on the table. And we ask that you please give us feedback. It really is important as we plan our next workshop.

Before we begin I would like to acknowledge our workshop committee who is led by our own attorney Teresa Landreau who has done an incredible job along with Maryella Jansen, Terry Elders, uh, Dr. Green, and Dr. Johnson. And Julie Kitten, Julie puts everything together and makes everything work and I don't think the Commission could function without Julie so Julie thank you for all your work in organizing this.

So I think we have an exciting and rich program slated for you today and our title is "Using National Researchers Data to Enhance the Commission's Approach to Patient Safety." So let's move on into our program.

I am very honored to introduce our first speaker Mr. John Nance. Mr. Nance is an attorney, pilot, author, an aviation analyst for the ABC World News and Good Morning America. He is also a founding board member of the National Pa-Patient Safety Foundation and has been an

energetic part of the medical community for the last 20 years. We know him best as the author of “Why Hospitals Should Fly,” named the 2009 book of the year by the American College of Healthcare Executives. ???? which refers to the protagonist in the book, as hard-nosed realists, people who work on the front lines of medicine, where egos are big, tradition is strong, change is difficult and mistakes are a mess. Issues that we deal with every day in our work at the Commission. “Why Hospitals Should Fly” is actually his 19th book. His latest thriller “Orbit” is in development as a major motion picture from Fox 2000. Finally, and delightfully, he is a really good speaker. He somehow manages to be relevant as he is energizing and inspiring. Please give a warm welcome to Mr. John Nance.

John Nance: It is quite an honor to have an opportunity to come and speak to you, uh, today on many different levels. Uh, one, I’m a fellow Washingtonian, and so I have a great interest in this state. I actually have to admit I’m a transplanted Texan. Um, anybody in here originally from Texas? Know a Texan? Yeah, one in the back. So you know there’s no such thing as an ex-pat Texan so we have dual citizenship. But I’ve been up here for almost 40 years and what you all are doing is very near and dear to my heart particularly because of all the involvement ???? being settled in the past 20 years. As a matter of fact I say it’s more than just important, you’re in a pivotal moment and many of the things that I want to speak to you about this morning, uh, are reflective of, not just my opinion although there’s a lot of that in there too, but it has to do with the question of where you are as a Commission and where I would like to encourage you to go in terms of changing the methodology, uh, to reflect a different, a different perspective on patient safety and the effect that you all, you all have not only in terms of licensure but also in terms of education. First, quickly, a story. Now you know I come from aviation so some of these are aviation stories but they all have a very direct point to what we’re trying to talk about. Number one, uh, about 15 years ago a 747 400, this is the most modern version of the 400, uh, before

these new guys come on line, the ones that Boeing has up at Boeing Field right now. 747-400 United Airlines taxis out at, uh, San Francisco International Airport. There are four pilots aboard, one captain, one first officer and a relief captain and first officer. These are highly experienced people. It's the usual San Francisco fog. About 50 feet above the runway and everything is pea soup up to about 2,000 feet maybe. Uh, they are going to Hong Kong so this airplane is loaded so much that when you look out the wings are actually drooping down a little bit. They get the take-off clearance. They push the power up. Big four engines, uh, giant Pratt & Whitney's producing about 55,000 pounds of thrust a piece. They get up to rotate speed, uh, where you lift the nose, lift off, actually when you rotate the airplane up, uh, the cockpit goes immediately into the fog, they lift off the ground and number four engine, the outboard on the right side starts doing a thing we call compressive stalling and this is a giant engine. A compressive stall is kind of a disruption in the air flow but it's bang, bang, bang and it shakes everything terribly. Now the two, four guys in the cockpit, highly trained, highly qualified, nobody's on everything, nobody's doing anything wrong but they are being rattled around so badly that they practically are forgetting everything that they know. They lift off, they get the gear up, and as they're trying to struggle with this, the relief co-pilot yells because he knows that there is a thing called the San Bruno Hill out there and it's about 30 degrees off the center line of the runway and he realizes that they have started drifting off in their course and they are aiming straight for the San Bruno Hill, And he screams "Pull up, pull up pull up, you're going to hit the hill!" The fellow who's flying it who is in the right seat, the captain, is so boggled he didn't take over, the first officer, uh, the co-pilot who did the liftoff, he yanks on the yoke, pulls the airplane up. They miss the antennas on the top of the hill by 50 feet, five zero feet. FAA didn't see this. They saw the track. They thought they were higher than that because of the lag time of the instrumentation. At that point the relief captain sees that now that they are so nose up that the air

speed is falling off and he screams “Push, push, push, you’re going to stall.” And right before the ??? comes on to notify them that they are about to stall the airplane, they push it forward and manage to gain control. Finally they shut down number four, bring the airplane around, land it, and with wobbly legs shut everything down. And this is where things have changed. Because this is the 90’s and before that, 20 years before, no one would have ever known about this. Because the FAA didn’t know they almost hit the hill, all they saw was the track. All they knew is that there was an emergency. And these four men took a look at each other and trusted something that had happened between United Airlines and the FAA, a disclosure situation, uh, as a matter of fact Tom ??? is going to talk to you about the proto-elements of something that we are going to move into, I think, very aggressively here in health care, hopefully, that is similar. That has to have trust. These guys initially, as airline pilots, didn’t trust that. As a matter of fact our trust for the FAA is historically very low. But the FAA had said if you self-disclose something as an airline, and you as crew members, said United, self disclose something to us, we are not going to take the stance that we’re going to that the chance that we are going to take your profession away or we’re going to consider that you’re a bad boy and you shouldn’t have been flying that airplane, that whatever you did was wrong and licensure is involved and all of the typical ways that we used to look at it in aviation, the same way that we still do in the military to a certain extent. They had said “You know what? We are running an airline here and we hire professionals. And if we hire professionals and the professionals fail, we’ve got a problem that is as systemic as well as it’s individual and we’ve got to first find out what the heck happened and then, as long as somebody did not fail to come up to a minimum standard, we have to turn to ourselves and say how did we facilitate this failure? How did we as an organization either let this happen or not intervene?” So these four fellows instead of walking out of that cockpit with a code of omerta and saying nothing, went straight to the chief pilot and the chief pilot did exactly

what they said to United that they were going to do. He said OK, fine, we're going to form a committee how we're going to self-disclose to the FAA, we're going to make sure that you guys don't get hurt but we need you in point to figure out what happened. How did you almost stall the airplane? How did you get off course? How did this all this happen? Why didn't you shut that engine down immediately? Six months later we found out that every pilot in 747 service on the planet had been mis-trained. Because of what happened to these guys. Because we got that information we found that what we had been putting them through, with the compressive stall simulated in the box, where most of our training occurs, it did not shake the airplane anywhere near, or the simulator, anywhere near reality. And so we trained them to be able to handle something with a level of ??? that was literally one order of magnitude below reality. Their eyeballs were being shaken back and forth so badly in that cockpit that they couldn't see or think. And this was one of the things that we have now gone back and started re-training. We're all safer flying on 747's as a result. Why do I bring this up? Because what do we want to accomplish in a human system when we have a problem? It's not just a matter of systemic versus individual. As a matter of fact there's a citation that you'll find that, uh, that the staff, I gave this to them late and so they did a yeoman's job in putting this together last night, but there's a paper by Bob ???? and Peter ???? and I highly recommend you at least look at the summary of because it talks about the fuzzy line between individual accountability and systemic accountability. You know, we see too much travelling around the country these days, Kathleen, my wife, and myself and, uh, and consulting. We see too many people say ok everything is systemic now, there is no individual accountability. Oh yes, there is individual accountability. We can't back off from that whether it is a doctor, or it's a nurse, or it's a pharmacist, whether it's a pilot. But that individual accountability does not serve us well if it obscures the systemic aspects and this is one of the things that is so important as you move into a broader array of

understanding of the effects of not just licensure but the effects of investigation and, and compare what you all do with for instance what the National Transportation Safety Board does. It really does, in a simplistic way, coming down, come down to the question “Do we collect scalps or do we improve practice?” Let me tell you where we’ve been, a little retrospective in, in medicine, not that you all don’t know this, not that I’m not preaching to the choir. But the reality is, we have a thing called medical apartheid and I mean that to be a little bit disconcerting. Uh, certainly it is not a racial term, even though it was used that way with South Africa, but apartheid means separate, apart and one is over the other. We have docs over here, we have everybody else over here and for physicians in the room, and I know they’re a lot of you, this is not a slam in any way, form or fashion. You didn’t design this. We designed this as a people. We’ve designed this not only in the US, we put you up on a pedestal and that is exactly where you belong as leaders. But the problem is that that pedestal has led to a massive disfunctionality and this is one of the reasons that we have so much doctor/nurse communication problems. We have so many people failing to speak up in a situation where they see something wrong and fellow practitioners too. But certainly those who are not doctors speaking up to a doctor you know this is a difficulty. Farmers market, Ben Franklin’s hospital model. Everywhere I go around the country I see CEO’s who say “Oh, yeah, we’ve gotten past that now. We really managing for a patient centered hospital.” But you scratch them deeply enough and you find that no, they’re not. They still, in the DNA of the American hospital, they’re doing it exactly like Ben created the first one in Philadelphia in 1761 which basically was a farmer’s market for the purpose of serving the doctors and there was a trickle-down theory that if they did that well that the patients would be OK. This is still the basic way that we approach it even though we say we aren’t. One of the massive changes that has to occur if we are going to move into what I call a “patient-centric” system not “patient centered.” Because patient centered is too often a wink, wink,

nudge, nudge yeah we're patient centered but what we're really centered on is keeping the money flowing, keeping the doors open, and keeping our docs happy. And you know 20 years ago all CEOs in this country of hospitals were saying that, well as a matter of fact this is what the American College of Health Care Executives was saying, "If we keep our doctors happy, everything else works." Well we certainly want our doctors happy, we want them secure, we want them in a position that they're not going to be in for some time with all these changes. But we also cannot use that old model anymore because everything was built on a cottage industry and there's another paper in here that I think is pivotal that came out last year in the New England Journal of Medicine. It's a who's who in the authorship. It's a cottage industry of post industrial care. And what it really does is illuminate the reality that we still are possessed to a great extent even with doctors who come into an employment situation too often with this cottage industry attitude. Uh, my friend and colleague who's at the Jefferson Medical School in, uh, Philadelphia, Dr. David May, uh, who is about to author a book I think it's just come out now called "Demand Better." Uh, David has, has been basically wrestling with this for a long time and he, he coined the phrase "autonomous scientist" to describe how everyone at Jefferson is trained still, how everyone across the United States is trained. Remember that old cartoon of Pogo many years ago? Most of you are close enough to my age, you'll remember Pogo. I have to be careful with that. Talking to a really young audience these days, they don't know what I'm talking about. It says "We have met the enemy and we are they." But we have met the enemy and yeah we are they but so are the medical schools. We've got the same medical schools. That's not the point of everything I'm talking about this morning but it's a very important point 'cause otherwise we're going to be doing remedial education for a long time to come and until we get this thing, until we get people who are turned out of medical school with the ability to understand that one of their prime duties is to create a human team of absolute transparent

communication whenever and wherever they practice. We don't do that today. As a matter of fact I have med students come up to me, I get the third year students at Jefferson every year and they come up to me all the time and say "Why didn't we know about this? Why didn't they say something about this in the first, second or third year?" They're at their three and half year point, they've got six months to go, they're going to have MD after their name, it's the first exposure they ever had to their responsibility to build teams. Autonomous scientist, and every doc in this room, every one of you, and again this is anything but a slam. It's actually a very honorable statement but you're trained like all the ones we just turned out in May and June. You're trained for a previous century and it wasn't the 20th. Seriously, you know what I'm talking about. You're trained to be that individual who got to somebody's cabin at 2:00 am in the morning on the prairie. Uh, you got there on a horse or behind a horse. The only thing you've got is that little black bag, what's in your heart, what's in your head. There are no helicopters to come pluck your patient away. There are no, uh, desk references, there are no telephones, there's nothing, there's just you standing between that patient and oblivion. We still trained the same way. But it is absurd when you consider the massive infrastructure and capability we have. George Halverson, head of Kaiser Permanente down in California I think said it best in a book about two years ago called "Healthcare Reform Now." Forget the second half of the book. It was George's attempt to solve everything. The first half, however, was brilliant. Best statement of the business case for patient safety I've ever seen. But he coined the term that we do not have a health care system in the United States. We have a great non-system, of wonderful people, wonderful heart, great heart, great intent, incredible science. We have put it together as a system. And even before we get to the massive disfunctionality of our financial model of fees for service, which essentially the federal government has said is dead on arrival and we're going to have to change it and we know that it is not serving the interest of keeping the

population healthy. But even before we get to that he's dead right in terms of looking at the cottage industry mentality, the autonomous scientist mentality, and the fact that it has been this way for time immemorial. We have massive change coming. We can't resist it. The overall case I want to make with you today is that the upheaval, the revolution nationally needs leadership in many different ways. And licensure and governing organizations like this are absolutely critical and you can help Washington lead the nation by changing some of the methodology. I know that the public is putting tremendous pressure on you. I know we've got functional, (sigh) how, how do I say this without . . . I mean I am media too. I put on my ABC hat. But we do have some people who are, shall we say, less than possessed with the alacrity necessary to examine and print what is done in this body to be as nice as I can about it. When they start counting scalps whether it's a, pressure from, uh, from one of Nader's groups or whether it's the Seattle Times, or whether it's my own friends at KOMO. When they start counting scalps and they say your effectiveness is measured by how many doctors you sanction and how many doctors you, you throw out, uh, we are so misguided, so grossly misguided on that. But how do you resist that pressure? Because you're in a political position to a certain extent. And this is what I really want to get across to you. My view, this is Nance, but my view is this body has to become a teacher, a professor, as a body and, and to do something that has really not felt comfortable before and won't feel comfortable to you, but basically to turn to the public and say "Let us tell you why we do what we do like we do. And why not everybody is going to be put up on a scaffolding and hung. Let us tell you why that's the wrong way. You all remember the situation at Virginia Mason a few years ago when Dr. Robinson made the mistake with his group and ended up, um, killing, uh, basically a woman. I forget her name. You, you all probably do remember the name. But, um, I said (which one?) McClinton, that's right. And, uh, Derrick Kaplan (sp?), by the way, was another founding board member of the NPSF and, uh,

a good friend of mine, and uh, right here in Olympia by the way that, uh, that, uh, he and I and a bunch of other people started making the changes for Virginia Mason. But here, after all that work, ???? method, all the alacrities that have brought to patient safety they end up with these horrible consequences and the media went berserk. You remember this. Other hospitals called up and said “Gary, I’m glad it wasn’t us.” And the Seattle Times especially pounced up and down. I wrote an editorial about a week and a half later that said now look, this is, this is myopia. Because what we want to encourage is exactly what Virginia Mason did. They came out immediately and did all the right things. They fully disclosed. They held the hands of the family. They said, “You get a lawyer, we want you to be well represented. We’re going to tell you everything that we find out happened. We’re going to do our best to make it never happen again. And they get trounced for this? The reason is because our population does not understand the relationship between that kind of activity and what they’re encouraging if you just go out and take scalps. And, and of course one thing that I said I would say in that editorial, and I was a lone voice by the way, and, and even then I got shot at a couple of times. “Well, no they just need to get rid of the people who did this.” No it was the system. They were very good doctors. And, and many of you know this case very intimately well. Very good doctors, a very good group of people. They made a mistake. The mistake really goes back into the origins of using those unlabeled little cups. And, uh the rest of the story gets complex and very clinical but by the same token if, if, if we want to solve something systemically, getting rid of one person, or sanctioning one person isn’t going to do it. I know you know this. I don’t need to be a, a, talking to you in a way that I assume that you don’t understand these principles but the fact is that our body politic does not understand these principals and they are going to need a lot of help because we’ve got to change a lot of the way we do business, not just in this body, but in terms of turning to the public and saying no, shooting somebody is not the way we handle a complex

adaptive system. Let me tell you about the NTSP for a minute. First of all, I probably shouldn't put this up; this is "armed mentorship". That's my term. Uh, that's where you guys are, this is what the FAA is wanting to be. You're armed! You've got the capability of removing a license; you've got the capability of sanctioning. But a mentor is what is the most important element of what you can bring to bear on this. And I know that's in the charter, that's what the legislature has said uh, that uh, with educational aspects and so on that you've got the capability and the charge to do. I think there are some things that need to be, need to be added. But, I think that that's, whether you use that term or not, that's the right way to look at it, as a mentor. FAA, Federal Aviation Administration. If 800 independents and their headquarters in Washington every caught on fire, most of them would die, because they couldn't get out of the building in time. They, they dither around; they don't make decisions very rapidly. But, in the field, in general aviation, some of you in this room are pilots, you know this, the FAA has become an incredible mentor. They have reached out to the population of pilots, private pilots and said, let's talk about icing conditions; let's talk about these things that can get you in trouble; let's talk about running out of fuel; let's give you some seminars, let's help you. In other words, they have become a mentor as well as an enforcement authority. Now at the higher levels because with airlines, airlines are supposed to do that for themselves, the FAA becomes an approving authority. And yet there is still mentorship there when it works right. When it doesn't work right is when the body politic puts so much pressure on FAA that we end up with a secretary of transportation like Ray LaHood and I'm sorry I don't have a whole lot of respect for Mr. LaHood's actions lately. Uhm, we had the sleeping controllers, you all remember that. Here's a classic case. You remember the one in Washington DC, two flights landed around midnight and the controller was dead asleep. Now this controller was the only guy in the tower camp??? And on top of that he was a supervisor with a twenty year perfect record. And immediately the

secretary of transportation comes out and essentially says fire him, fire anybody, nobody is going to sleep on my watch. Well gee, Mr. Secretary, uhm, were these carbon based units, or where they mechanical or silicon based, because if they're carbon based, unfortunately, sleep is a part of the profile, maybe we need to look at the on duty time, maybe we need to look at the policies in the FAA for how they handle the shift work. Maybe we need to look at whether this guy, regardless of intent, set himself up in a way that was ??? or maybe he was just human. And the fact, I won't bore with all the details, he was doing the best he could, he had tried to replace another guy, he tried to get the shift thing changed to where he didn't wind up with an overnight at the end of a five day profile. No one would listen to him. He was doing his best and he became human and he fell asleep. And for that we've got a Secretary of Transportation who wants to just fire him. That's gonna solve the problem. It's never going to solve the problem. Systemically, it's, you know, it may feel good. And you all know this. It's not going to get us where we need to go. Um, let me tell you a story that many of you have heard. If you've read my book it's in there. I've probably told this story about fourteen hundred times. I've even had the, the uh, folks who, um, ??? KLM Dutch Airline who, whose current leadership come up and validate what I was saying. I'm going to give you a very abbreviated version. Many of you have heard of this incident. It was March 27th, 1977. This is what changed aviation, by the way. This is what slapped us collectively in the face in a way that we could not ignore the need to understand human beings to a much greater extent than we had. We had to understand causation on a human basis. We had to understand just like United later on figured out if we don't approach this on the basis of "We've got to find out, oh what happened" and all factual analysis, before we can get to the point of asking did anybody fail to come up to the level necessary. Secondly we, we absolutely have to consider that in a human system there's never going to be one cause. There's always a multiplicity and most of those are gonna be systemic. So before we

get to the point of discipline, we have to understand what went on and see if we can influence. This is a 747-200 coming in from Amsterdam to the Canary Islands with about 290 people on board. It was a charter flight flown by the chief pilot, by the Director of Safety, by the Vice President of Operations all rolled into one. A man named Jacob van Zandt, a family man, 36 years on the job, wonderful guy, everybody loved him at KLM, and, uh, he was just, he was just a typical, wonderful Dutchman. Ah, he got in the airplane that day because he needed currency, and he displaced another captain, he was going to fly this trip down to the Canaries, he was going to fly it back. Unfortunately they closed the main airport as he was coming in and he ends up the 11th airplane after 10 others have landed, diverted to another island, and an airport that isn't ready for an instant air force. On top of that there are blowing clouds that were getting worse, it's almost like fog. He sits there for 3 ½ hours with everybody else, getting more and more concerned because he's about to run out of crew duty time. Bear with me a minute, I know this has no bearing on medicine, but???? human beings. But we've learned in aviation that if we work a pilot more than 24 hours, uh, just like that one paper confirmed, you know, that we're the equivalent of a drunk. We've learned that we begin to see runways where we haven't yet built airports. And this is not a good idea. So we have massive limitations and he was the progenitor of the limitations. He was the cop on the beat. He was the one who said "You must keep within these." Now he can't violate that and he's about to run out of time so when they finally get everybody loaded and they open this other island up again, he's the first out of the box and it's now almost pea soup fog, these clouds blowing across this upper 3,000 foot high runway. He's told to go to the runway, taxi all the way to the end because it's too heavy, this 747 to, uh, use the taxiways. He gets all the way to the end, turns the airplane around, looks at his watch, he's only got a couple of minutes left. If he doesn't get off the ground, he isn't going to make it over to Las Palmas in time to pick up his outbound charter group and get folks off the airplane and so

he's anxious to go. Many different elements on this. But, but, not the least of which was the pressure on this captain. And the pressure was not just that of "I am the captain I want to go," it was all the considerations of inconveniencing the passengers, of paying \$35,000 for rooms if he had to shut the operation down at Las Palmas 'cause, he would run out of crew duty time and he would have to put his guys to bed for 10 hours or 12 hours. All these things were rolling around his head. He gets to the end of the runway, starts pushing the power up and the first officer, highly experienced, highly trained 32-year veteran in this cockpit of three pilots in the older 747's looks at him immediately knowing that he has forgotten they don't have the clearance to take off and says "Wait a minute, we don't have the clearance." Much to his credit because this guy could fire him. And Jacob, in the inimitable fashion of all those of us who have ever been in a position of command authority, said those magic words "I knew that." Why do we do that? Pulls the power back and says "get the clearance." The first officer, the co-pilot is all over it. He calls for the clearance. Now he's talking, he's a Dutchman speaking Aviation English, a stylized version of our language; he's talking to a guy in the tower who is a Spaniard who speaks aviation English very poorly. So there's kind of a, no pun intended here, a Tower of Babel here, and he asks for the clearance. The tower operator reads him one of two clearances. They don't want to have the clearance, go to the other island, it's called an ATC clearance, and they also don't have the take-off clearance. So he just read the ATC clearance first and because we have learned what happens as human beings, because our memories are not as good, our listening is not as good as we think. Twelve and a half percent of the time, minimum, we get it wrong. We do a read-back. We've learned that through bloody experience, so the first officer is now doing the read-back as he is reading this one of two clearances back, he looks to his left and Captain Van Zandt's hand is coming forward again on the throttle. He thinks he's got everything ready to go and now this guy is in one of those excruciating positions we have seen doctors, nurses, everybody in.

Probably everybody in this room has at one time or another corrected a senior leader. You live to tell about it. You really want to try it again in 45 seconds and see what happens? That's the dilemma of the first officer. So he's trying to figure out how not to embarrass his captain again, 'cause I can't tell you how embarrassing it would be for a line captain let alone the chief pilot gonna take off without a clearance and have to be corrected. So he comes up with something very clever. He decides to clear himself to take off and let the tower be the goat that says "Uh, basically, KLM you, you can't do that." So at the end of his transmission, at the end of his read-back of this clearance he says, "And we are at take-off." And then he lets go of the button. Now the problem is that there is no phrase in Aviation English that says "We are at take-off." There is a phrase that says "We are in take-off position." Now what do we do as human beings? What does every doc out there do? You hear something you are expecting to hear under a high pressure situation and you fill in the blanks. That's what he meant. So the tower makes that assumption. The tower operator hits his button, and he says "OK" and then he pauses for three seconds and he says there's something not quite right with this transmission. And he says "Stand by and I will call you." Unfortunately there's another pilot out there some place who doesn't understand KLM's non-standard statement. And so after the word "OK" they hit their button and somebody says is asking a question and when you have two radios on the same channel they block each other out with a thing we call a ???? and a high squeal. And so the only thing heard by the guys in the KLM cockpit is "OK" and then a squeal. ???? says Jacob, "Good to go." And now the first officer has challenged it in a way that was as depressurized as possible, expecting the tower to say "Negative KLM, hold your position," the tower said OK and blessed it. So now the first officer has nothing to do but help support his captain on the decision to take off. They've only got 700 yards of visibility. They can barely see the first stripe. Power comes up and they start rumbling into the fog. Ten knots. Twenty knots. Thirty knots. There's

a second officer too, a flight engineer. We don't have them on the newer airplanes. This is a guy or gal who sits side saddle???? two hots, too colds and makes your ears pop. And this individual is sitting back a little ways, sort of like the circulator in an OR. Has a better view of things. Kind of like that new person in the office who's wondering "Why do we do it this way?" And they're told to sit down and shut up and maybe in six months they can actually have an opinion rather than debriefing them which is what we should do for any new blood that comes in the door. NASA has learned that the hard way, twice. Fifty, forty knots whatever, the second officer leans forward because he just heard a transmission in his headset that worries him. And he says "Is he not clear then that Pan Am? He's talking about a, a, a, transmission or something about the runway and another Pan Am airplane that was, uh, not another there was another 747 out there in the parking area. And the captain turns around and says "What?" I mean he's trying to keep this airplane on the center line and if he white lines it faster and faster. The first officer is worried about getting the power. They're concentrating on a very critical takeoff. They and don't need to be interrupted. The first officer turns around and says "What?" as irritated in his voice as the captain. Now the second officer realizes what he's done. We've all been there. He has questioned the judgment of a senior leader. A guy who could fire him like that. And now he just wants to get out to 50 knots, 60 knots and so he mumbles something about???? Pan Am. The whole timbre of his voice changes. What he's really saying is "This was the dumb thing I said guys, please forgive me. I'm going to sit back here and shut up in abject embarrassment. You'll hear no more out of me." Seventy knots, 80 knots. And sure enough we hear no more from him. Ninety, 100, 110, 112 knots they blow out of the edge of a cloud 'cause remember I said there were clouds blowing across the runway if not???? fog. So there's a bubble of visibility about 3,000 feet in diameter and halfway down at about 1,500 hundred feet ahead on the runway is another 747. Pan Am had missed the turnoff in the fog; they were taxiing on the runway as

well. They were cocked halfway around blocking the entirety of the runway, Jacob was too fast to stop, too fast to swerve, too slow to fly because he needs 30 more knots to lift off and he's got nowhere to go. He grabs the yoke, utters an oath, jams it into his chest, raises the nose, drags the tail for 50 yards. He's going to try to leapfrog this 747 over the back of the other 74, knowing that he's going to run out of air speed if he crashed on the other side or at least damage the airplane severely. 'Cause he's got nothing else to do. For a moment it looks like it's going to work. The nose gear passes safely over the back of Pan Am, that huge Pan Am logo we all remember comes by on the left, but the body gear and the wing gear were hanging too low and they go into and through obliterate the coach cabin and most of the occupants of Pan Am. And KLM now robbed of 40 knots, is ballistic, not aerodynamic, it comes back to the airfield, it begins to crumble and break up and all that fuel, that extra fuel they put on ignites and a fire ball into the fog and disappears. It'll be 30 minutes before the tower realizes they lost two airplanes. They thought KLM got away. Pan Am meanwhile, the wings fall down, fire breaks out, it's, it's a rather hideous scene that was snapped on a couple of pictures by a few of the survivors who came off the, off the jet. And within 45 seconds we have lost 583 people. We have not had a Tenerife, that's where this was, in medicine. We are not likely to have a Tenerife in medicine. We're not likely to have the ability to turn to the public and to our hospitals, and to some recalcitrant boards here and there and basically say guys, we gotta get this under control. That's what??? does in medicine. We've gotta have a lot more help. And part of the help we have to have really, is the, is the mentorship that I was talking about. The incorporation of physicians is needed but not the tolerance of the cottage industry. We have massive and problematic financial pressures, significant systemic pressures on all our doctors. We have incontrovertible research that any disruptive behavior. You're going to hear more, uh, on this from???? a little bit later. Uh, is a direct threat to, um, to every aspect of patient safety. We have the tradition of what I

call MD omerta. Now traditionally the concept of omerta was against a, uh, public authority. A little bastardized use of the word but the idea is we don't squeal on another doctor. And, and there are penalties for doing that that are not only internal but they're external, you can get sued for that. The inadequacy of care review and I think it is very inadequate and you've got one heck of a difficult job. And as a lawyer I understand the very serious due process requirements. But let's take again, let's take a ???? You've got a really good doc who leaves a sponge in a patient and that's essentially the case. Now there was a whole team around him, very much like the fellow who at Duke University tearfully walked up to the cameras and said "This heart/lung transplant, this little girl died because I failed, I am the sole responsible member." This was, uh, Dr. Jagers (sp?) after that terrible situation about five years ago where they mis-typed the blood and they had to repeat the heart/lung transplant. I wanted to scream at the TV when I saw that. No, no, you're not, you may be responsible in some aspect, you were the leader but there was a team situation here. We've got a lot of different causal factors. I've done this many times, roll out of the bed at 2:00 am in the morning when ABC calls and something has happened I've got to get on the air and fill about 30 seconds starting out with the basics. There is never just one cause to an aviation accident. There's never just one cause to a medical problem. But the public wants immediate answers and they want heads. And you know there's a systemic aspect. So let's go back to the doctor with the sponge. They're calling in the Seattle Times for somebody to take the fall. And you're the Commission that can make it happen. And yet you know that this is not only a good guy with a long, good history, but there's, it's, it's a systemic aspect. What do you do? I would say to you that if you'd make it a little more endemic to ask the question "What are we trying to accomplish?" What are we trying to accomplish? Not just the charge from the legislature. But, what are we trying to accomplish? It becomes very clear. You're not just trying to prevent that guy from ever leaving a sponge again you're trying to prevent anyone from

ever having a sponge left inside, anywhere again. And that is the departure point from which you've got to turn around basically to the public and say "Not so fast Charlie. Not so fast. That's not the way we promote the medical safety that you depend on." That's not systemic and we have to understand the systemic causes, we have to make sure that this is not done in the future by anybody, not just this doctor. If, at the end of the day, he or she didn't rise to the level expected OK fine, then, then something needs to be done. But not until then. The NTSB, the National Transportation Safety Board, I'm amazed that I, I now know literally all the board members and three of them are personal friends, there are five of them on that board. NTSB over the years has been given a great degree of independence and they have pioneered a methodology that I, I should say is more of a philosophy, and the philosophy is that they don't want to understand, or know, or think about any form of discipline, any form of, of, uh, bling (?). All they want to find out is everything that can possibly be discovered about the causal chain and everything that led up to it. And then, and only then, when they lay all these things out, despite the fact that Congress gave them the authority, no, they gave them the charge to find the probable cause in every accident which is too close to our legal cause, the probable cause in every accident but there is never just one probable cause and the NTSB over time they said there may be 20 or 30 and we're not going to rule them all out and we're not going to categorize them and say which is more important, which is less important because if we don't solve every one of them it's going to show up in another causal chain somewhere at some time. And they have done this in a way that required them to turn to the public and say "Wait a minute, we know you want a bad actor, we know you want to find somebody to blame, and somebody responsible but do you want to be able to get on an airliner with the assurance down to point zero, zero, zero, zero, zero, zero, one percent that you're going to get there alive and in good shape? Not as well fed of course anymore, we don't do that very well. Not as well treated either but if you do, then

let us do our work. Don't tell us you want scalps." I, I think the thing that made them successful was that they fought back. They went to the cameras, they went to the public and said "No, let me explain to you why this is not appropriate for us to come around and find just one probable cause and jump on that airline, that pilot or just walk away and say "pilot error" which we used to do. Um, we have met the enemy and it is the way we have always done things. I think that's the most dangerous phrase we have in medicine - "this is the way we've always done it." We have a most dangerous phrase in aviation and the pilots in the room know this, it's called quote "watch this" end quote. You don't ever want to hear you're your pilot say that. "Here Fred, hold my coffee. Watch this." It, uh, um, I think there are three pedestals of patient safety and, uh, I think I have a cheesy picture of three pedestals up here. The first one is basically, uh, patient-centric care. And I define this completely differently. Patient-centered? We all hear that and, and everything is patient centered. It's almost redundant. But patient-centric I define this way: it's where everything is subordinate to the best interests of the patient. Everything! Including money. And we aren't there yet. As a matter of fact we don't practice anywhere close to this around the country. Patient-centric means that every process including the mentorship of the physicians in the United States, including the mentorship of the nursing community. And that's another thing, by the way, if I, I could wave a magic wand, if I was sitting the Governor's office, one of the things I'd do is say you guys in nursing and facilities all need to be working together. You need to be working together on a systemic basis where you see where you see that a doc who is involved in something systemic, instead of letting him go and then feeling helpless you need to be able to combine that and be able to say to the hospital "Hey, we'll give you a ???? but only if you change this thing. But look how you set this guy up. And nursing, think of the tremendous dichotomy here. You all know the story very well I'm sure. Of the nurse who just hung herself after a baby died at, at Children's. Now not only am I angry as hell at the leaders of

Children's who abandoned everything they said they believed in terms of supporting their staff, supporting their people and understanding systemic causation, when the balloon went up they scurried for cover just like Cedars Sinai did they with the situation with the heparin and the, uh, the Dennis Quaid twins. I was down there dealing with them about two years before and they said they understood this and of course when the balloon went up they scurried for cover. "We're going to find the person responsible and we're gonna hold him accountable." So this nurse got no help at all. It was clearly systemic. Not only that, she ends up with her license revoked. Now, I'm not spanking the Nursing Commission for revoking her license but what I'm saying is some place between the perception of the public that you all aren't doing enough and the reality of nursing that if you do anything you're gonna get shot, there is a middle ground that has to do with mentorship and has to do with understanding the humans involved. Because first, last, and always, this is a human enterprise and it is the most important, I consider it the prime public utility in the United States and you just can't just govern it with a black and white look at this. Again, I'm preaching to the choir. You all know this. You wouldn't be having this meeting; you wouldn't have asked me here if you weren't well aware of this. The problem is we think we got some of this stuff under control. Let me get on with the uh pedestals for a second. The second one, by the way, is minimization of variables and best practices and this is where you can have a tremendous influence on the facilities as well if we can combine those operations because, or a least get a cooperation across the board because in so many instances minimization of variables and best practices has to do with coming away from that cottage industry and saying that "yes, we only understand that 18 to 20% can be nailed down, but those need to be sacrosanct", there is no excuse for any hospital out here to have undiluted KCL??? on the unit. That's absurd. Again there are still some that do. I don't if there are any in Washington, but we still have some across the country. Number one hit list of the

joint commission for twenty years. We, we still have hospitals that are not practicing with ventilator associated pneumonia monitors, even though we know it can reduce the VAPS to zero and we've got plenty of evidence in this, the same thing for central line infections and for ??? catheter associated urinary tract infections. We know more and more every week, but we don't have the ability to put it into play when we still have this independence of thought that's been drummed into all our autonomous scientists and we don't have any of the pressure that needs to be there after something happens to say "Why didn't you follow, why, why did you say that in your operating room doc, you weren't going to have a timeout, that you didn't believe it that? When the hospital said this is the way we are going to do it. Why did you push back on that?" Before we get to the point of holding them legally liable, we really need to hold them liable in terms of the licensure and this comes down to one of the most important elements and that's the third one here. Teamwork!! Collegial interactive teams is the phrase that I use and basically collegial means that everybody on the team has respect for everybody else and interactive means that there are no barriers in communication, no one will hesitate to speak up for nanosecond if they see, here, feel or even intuit that something is wrong. For that we need leadership. To get the leadership we have to train. I would like in a ideal world to see you setting up training courses that before anybody gets licensed as a doctor in Washington, including our guys and gals coming out of our own schools, they have to, they have to go through some courses on communication and they are not ???. Courses that show us that they can communicate, that they can create a team, not only that they won't be disruptive, but that they understand the requirement to get somebody to speak up, means that it has to be a respectful playing field. It has to be something that we say statutorily we expect of you but we need to demonstrate that and we need to have recurrent training as well. In aviation we learn this. I may be the best 747 pilot in the world. I'm not, I haven't flown in years, I really love flying that ship. But I need to

retrain every year; not only that, if I'm flying for an airline every six months as a captain, somebody needs to ride with me and make sure I'm not developing bad habits. This business of putting a doctor in a particular place and saying we certified you twenty years ago so undoubtedly you are still up to speed is really kind of an insult to the intelligence of everybody involved including the doctor because we do need the mentorship of this continuous form of, uh, you don't want to really use check riding I suppose, let's say proficiency checks, proficiency rides. And that is that under the educational aspect of what this board can do, well within the purview of what you can handle. There's another major thing, too, and, and this is a little bit off this particular part of it. But I don't think we can any longer, and you are the epicenter of this by the way, I don't think we can any longer, in this state or anywhere, tolerate a situation where a doctor for any reason including personal concern about the possibility of being sued, see something happen and fail to speak up. See something happening that is really serious. Maybe not as serious as the anesthesiologist who said "Uh, uh, the patients OK, I'm going to go pick up my mom at the airport. I'll be back in about 20 minutes." Then we end up with a brain damaged patient. I mean, that's criminal but what, and, and in that case people spoke up. But so many other things you see it, you've done it, you've been involved in seeing the investigations. There were people in that room, in that OR, in that ED, in that environment, who knew there was an incompetent doctor and they didn't say anything. They didn't say anything out of fear. Fear of being retaliated against by their fellows, which is one of the worst things you can have regardless of your profession. Even as a 5-year-old, being excluded from your group. Secondly fear of, uh, of, uh, of legal process. Fear of being sued. That's not a passive fear; we've got to change that legislatively. We've got to make it impossible for somebody to retaliate for an act of having honestly said "I'm worried about this particular practitioner." And that's a tricky thing to do but it needs to be done. But I think it basically; I would call it accessory before, during and after the

fact. I'm a lawyer. You have somebody who stood in an OR and watched something going on that was clearly ???? They should be meted out the same punishment. The same punishment. The same licensure punishment that you mete out to the individual who did it. And you may need a little statutory help to define that. Uh, I forget the RCW that would need to be defined but it's a very, very small change. But I, I, I don't think we're ever going to get past this doctrine of omerta until we do something like that. Until we say to everybody "By the way, if you saw something and you did not speak up, your license is on the line too." And that's why I would get just as tough as you could possibly be because that is going to have a very, very positive element in saying to people "The days of omerta are over." The problem is we don't think these things are as bad as they are. If you hooked most people up to a lie detector and you said "Do you have things well under control?" It would kind of be like Homer here. (Unintelligible background voices.) We think we have it under control but we don't really. Let me run you through real quickly. I say this to so many of the doctors and the audiences that I deal with across the country. But how we fail as humans? We fail by perception, assumptions and communication. Perception, there are a thousand examples practically in every direction. You've got the one that is still so bothersome to me is the crew that crashed on takeoff in Dallas, Texas in 1988 because three pilots looked up and said 15, 15, green in the flap position and there was zero, and there was no green light. They weren't drunk, they weren't distracted, they weren't doing anything wrong, but they were human. That was their mistake – they were human. And Delta? You remember Delta. They gave us the phrase "I don't know where I'm going to go when I die, but I do know I change in Atlanta." Delta fired these guys. They fired them and when we asked Delta why they said "Well, to send a message to the other pilots of Delta that if they ever make a mistake like that too, a human, inadvertent mistake that no one intended to make, we're going to fire them too." Oh that's brilliant. But you see when you get down to the essence of discipline

and how it interfaces with motivation, if we discipline somebody for being human we are really missing the point. On top of that, systemically as I say, we're just going for that one thing. We removed that individual and you're right, that individual will never do that again. But that doesn't mean it isn't going to happen again. We fail also by assumption. We make thousands of assumptions every day. We'd never get out of our house if didn't. But unfortunately we need to be teaching and, and this is another area of mentorship that can help tremendously. Things that you all could put in place, help put in place. If an assumption regarding clinical care, if wrong, could hurt somebody, do you really have the right to make that assumption? Is that something the patient and the patient's family has to assume themselves as a, as a liability of, of getting medical care? Because I don't think they're going to be able to explain that as a practitioner to a family at the other end of a terrible ????. We had the right to assume that we knew what was in that cup that was unlabeled. We had the right to assume and you've heard this all the time, "Well I assumed she was going to do her job. I assumed that was a good handoff. I assumed that was a .01. Our perceptions are bad; our assumptions are bad because we're human. And our communication, that's the worst of all. Uh, in communication the reality is that we think we're better than we are. I've got some friends who say that I also ought to put up a forgetfulness and this is a good example of that. (Unintelligible background noise.) I actually showed that at NASA's Kennedy Space Center so that's NASA approved. But, uh, the reality is that we, we don't do a good job of, uh, of communicating and we think we do. Twelve and half percent of the time, I mentioned that earlier, I can support 13.8% in literature; people who speak the same language don't know what they're saying to each other. We get it wrong. And we don't believe that and yet we load 'em up with distractions. Uh, we got a nurse for instance at a ??? machine with five people talking to her. We've got a doctor who's got something going wrong in the OR and someone else is talking to him and we got a radio on. Our distraction level,

we can go up to 40%. And here's another example of this one. (Unintelligible background noise.) That's an old Super Bowl commercial and you've got to get past the suspension of disbelief (?) that the poor doofus couldn't figure it out but when you do and you diagram that sentence we do this to each other all the time as humans. And we don't, on a professional basis, want to believe it. That, that the quote is that when somebody gets home tonight, somebody should be wearing. That is a perfectly mirror image phrase, it could go in either direction. If you don't mind I'm going to hold this a little, we got started a little bit late, 'til about ten after and we'll, we'll hit the brakes. Uh, but there are two other things, little clips I want to show you. One is interesting???? a couple of cartoon characters But I want to demonstrate this. Everyone in this room, I would almost guarantee, had this conversation at one time or another. Now any of us can go on this web site???? and create your own cartoon. A couple of British doctors sent this to me. I thought when I first started playing it that this isn't going to be useful and I'm just wasting my time and, and when I got up off the floor and stopped laughing, um, I realized that this conversation that we've had in so many different industries but especially in medicine. Now if there are, us, any orthopedic surgeons in the room this is not to pick on you but down in the corner there is an orthopod and the, uh, individual on the right he is an anesthesiologist and this fellow is trying to book a case (?). (Unintelligible background noise.) I just thought you might enjoy that. Is there anyone here who hasn't had that conversation? So all we're dealing with, and we know this so well, participatory, from the position on your Board here, uh, in every possible way, this is a human system. We spend 150 years trying to dehumanize all our human systems in Western society and we are only now becoming aware that that is a counterproductive methodology. We have, every one of our doctors out there, in great need of hand holding. Sometimes when they get disruptive and you well know it, we've got one third who of them who are mentally impaired, one third who are on something, and another third who are so stressed

that they can't handle it, that's pretty much the la, the latest research. And we need a lot more than, than just the sort of thing that the public wants to put pressure on you to do. Again, you know this and I, I really encourage you to resist it vociferously by putting the face in front of the camera at times and saying "Look, you don't understand. We, we, have as our goal not only what the legislator asked, the legislature asked us to do – to keep Washingtonians safe, but to do so in a way that keeps the practitioners safe as well." And this means we've got to understand the underlying cause. And just lopping off heads is only going to create a situation where people don't trust us in medicine. It drives information underground. It furthers the same problems, so you've got to trust us. The same thing the NTSB did very successfully with an entirety of the country over time. Dealing with the humanity of not only the physicians but the nurses as well as the facilities is very important and I really would encourage you to put those bridges into place. That where everyone, whether they're a pharmacist, a nurse, uh a doctor, are treated the same way. And are treated with the same level of alacrity and the same level of understanding because right now it is very much a dichotomy and this is one of the reasons that you end up with the uh, uh the folks, people like Public Citizen going berserk and just focusing on one thing and not understanding it, because they are just looking at how effective it is, based on how many scalps they are and like I said that is 100% counterproductive. We have to explain this to the public, and we have to explain it on an ongoing basis that transparency is so terribly important. How will you know when you've succeeded? Well we travel, all over the country, Kathleen and I, in dealing with hospitals and medical systems, doctors, nurses. And one of the things that we ask constantly is can anybody take of your mother if they came in to your hospital? Can anybody take care of your spouse? If, if, if somebody you loved in this life came on to the hospital today, to this hospital and onto your unit, could any Doctor, any Nurse take care of them? Universally, the answer is no. When the answer is yes, we're there. I think that's one of

the major criteria. I am out of time. Thank you so much for letting me come and talk to you very directly today.

Dr. Pattison: Thank you so much Mr. Nance, you've been uhm, inspiring, energizing and entertaining. So we are challenged, thank you. I hope you'll be back some time, maybe in a year or two to see how we've changed things. So with that we will now take about a fifteen minute break and then we will reconvene.