Mark Chassin, M.D., President, The Joint Commission

Mark Chassin: It really is a pleasure for me to be here with you this morning, and I thought that what I would do is talk a little bit about the current state of health care with the high reliability framework in mind; a little bit about how we are starting to think about bringing high reliability to health care, although there are certainly lots of doubters that look at rates of adverse events in other industries and say health care is different, it will never get there; but then talk about some of the very specific and concrete problems that we believe underlie the big obstacles to getting health care to a much safer level of performance.

So just to fill you in on The Joint Commission and who we are, the American College of Surgeons started a program of actually requiring hospitals to meet some minimum standards of quality early in the 20th century. Now we are The Joint Commission. We accredit or certify almost 19,000 organizations across the spectrum of health care delivery. We are private, we are not related to government, not-for-profit in all of our activities, and we are voluntary. We’re most known for our hospital program, but as you can see, we accredit more home care organizations than hospitals, and we accredit or certify, a term of art that I won’t get into unless anybody is interested, programs at every level, at every part of the delivery system in behavioral health, from those wilderness outposts where troubled adolescents are sent to reacclimate to the real world to the most complicated academic medical center hospitals.

Our core strengths are about understanding what is achievable in the real world with respect to quality and safety and setting up-to-date standards about how to do that that change from year to year as the science changes and as our understanding of quality and safety changes, to continuously update those standards, and to figure out how you actually visit an organization and observe what’s going on to understand whether those standards are actually being complied with or not. So every one of our programs involves on-site visits to the organizations that are all now, for the last six years or so, longer than that, unannounced, so a hospital will get a notice on their secure extranet site that they maintain with us a half hour before our survey team shows up saying that we’re here. And that’s
what we do. We have a lot of other programs, but that's our core strength, and I'll talk a little bit more about some of the new things that we’re doing that branch out from that.

So I think it's fair to say if we were to ask about safety and quality in health care that it’s characterized by a couple of problems. One is that routine safety processes fail routinely, and when you measure carefully things like hand hygiene or the way we administer medications or even the way we identify patients before doing something to them, with them, for them, communication as patients are moving through different stages of the care process, if you actually measure these processes carefully, you find failure rates of not just a few percent, but 30, 40, 50, 60, 70 percent — seven-oh, 70 percent. We recently, with one of our new projects, looked at the risks of a particular kind of adverse event, which I will address here, and found those kinds of error rates.

Now, in addition to routine processes failing routinely, we also see uncommon adverse events, but all of which are preventable. So we still have a problem with patients undergoing surgical procedures that were intended for others or surgical procedures on the wrong part of their body. Now, those of you inside health care know that this is possible, and those of you that are outside health care are probably saying, “What? How is that even conceivable, let alone possible?” Well, the data suggest — I said this is uncommon, but we have a big country, and we have tens of millions of surgical procedures, so the best data that we have suggest that this happens about 40 times every week in the United States. Those data are extrapolated from states that have mandatory reporting, and we can go into the numbers if you want.

We have fires in our operating rooms that burn patients that are entirely preventable. We have infant abductions still from our nurseries in hospitals, and we leave foreign objects in patients following surgical procedures. I actually looked at the latest numbers from a similar data source, and the frequency of that problem also seems to be around 35 to 40 times per week in the United States.

Now, The Joint Commission, you saw in a previous slide, also accredits almost 450 hospitals in about 45 countries, have done a lot of international work, and I know that a number of you have as well. And I can tell you from the standpoint of health care that the problems that I’ve outlined here and the many others that we could continue to talk about are global phenomena. There’s no developed health care system in the world that has got this right. They all have the same problems.

I’m now in my fourth year at The Joint Commission, and as we thought about what our proper role was in this environment of questionable quality and enormous variation on top of that, so the average of many of these problems is pretty mediocre, but the variation is even scarier. One of the things that we wanted to do was to say to ourselves, “Well, OK, we have a pretty good idea, because we’re in it every day, of the current state. What are we aiming to achieve? What is the future state that we are hoping to get to?”

And we actually went through this exercise with our board, and did this a couple of years ago, and created a vision statement for The Joint Commission that is very succinct. It says, “All people always experience the safest, highest quality, best-value health care across all settings.” So this is a vision statement for health care that we thought was
appropriate as an aiming point, a target, a North Star, if you will, where we would like to end up so that we could all retire and not have to have any quality activities in health care anymore, because it would be the way everybody works and produce this kind of result every day. And it's been actually an extraordinarily powerful exercise and helpful to us as we organize our programs, which we can also talk about more if you like.

Before going on in more detail to talk about some of the programs, I wanted to reflect a little bit on this, on this vision, because this to me is a translation of high reliability into health care, and it says in a few words what high reliability would look like. We would have very high performance that was consistent, with little variation, maintained over long periods of time. And we have a few isolated examples of that in health care, deaths due to anesthesia during surgery have gotten to that level over the last 25 years or so, and we could talk about some of those lessons. That is a pretty isolated case.

We have excellence in specific service areas in particular organizations, but we have no health care organization, whether it's a hospital, an ambulatory care practice, it doesn't matter what kind it is, that has established the kind of consistent excellence that commercial aviation or nuclear power has, so there is no such thing as a high reliability organization in health care.

We have some models that have produced really excellent results, and I'll share one of them with you. It has to do with a program actually The Joint Commission started a decade ago when there were no measures that were standardized for quality in hospitals. The Joint Commission started that program, the government picked it up a few years later. And these are a couple examples of medications that are life-prolonging when they are given to heart attack patients. Aspirin and beta-blockers are the two listed here. And when this program started, it was not uncommon to see hospitals at 50 percent, 60 percent, 70 percent, with lots of variation from month to month, year to year. In 2009, the averages for these life-prolonging treatments were 98 percent of the thousands of hospitals that report to us, and what's even more remarkable is the consistency. So the percentage of hospitals over 90 percent was also remarkably high.

Now, it is true that there are millions of patients that suffer heart attacks, and even one percentage point decrease from providing these treatments is a substantial opportunity to improve, but there are no other metrics in health care on a national basis that show this level of performance and this level of consistency over many thousands of organizations. So this is an exception to the rule, which is routine processes failing routinely and having lots of variability.

Now, as we looked at and have looked at The Joint Commission over the last couple of years at high reliability and how to get from where we are now to this state that's expressed in that previous slide, it seems to us that the high reliability research has defined and characterized in very interesting ways how high reliability organizations maintain this excellence in safety over long periods of time. As I've said, no health care organization functions like that, so we can't send a delegation to XYZ hospital or clinic and see how it works and then bring it back.
And, actually, that's one of the big obstacles that characterizes health care in which health care really is different from many other industries, and that is that competition among our health care organizations is not going to drive excellence. It doesn't really matter. When I was at Mount Sinai for 12 years in New York City, it really didn't matter how good Mayo was or UCLA or the University of Chicago; we didn't compete with them. There isn't going to be the phenomenon of the Honda Accord or the Toyota Camry coming to the United States and shaking up health care the way it's done in electronics and aviation and in automotive industry. That's not the way health care is delivered. It is local, and even when there are good data on quality, they are often ignored, because patients and families don't by and large look at data on quality when they select their doctors or hospitals, and neither, frankly, do doctors when they refer patients to specialists or hospitals. So we don't have that. Even though that would be helpful for many organizations, we don't have that option in health care because we're all pretty mediocre.

Frankly, there is little guidance, at least as I've been able to discover, in the high reliability science and in the case studies. There's very little guidance on how you get from what I briefly characterized as our pretty mediocre state with quality, with respect to quality and safety. How do you get from low reliability to high reliability? So we have considered that problem and asked the question, how do we create blueprints, roadmaps, assistive devices that allow health care organizations to build toward high reliability? What would it take?

And as we've thought about that, we've characterized the problem as sort of high reliability up there in that wonderful fluffy cloud in the upper right, and health care down here somewhere in less than highly reliable, and we can talk about how far down that is and what is that distance, but just from the standpoint of where we are now.

And as we've characterized this, both from our assimilation of the high reliability science and our deep knowledge and understanding about health care, it seems to us that there are three critical ingredients. And I know you've talked about some of these, and I'll talk about each one as it applies to health care.

The first is leadership. Without leadership at the health care organization level committing to zero quality failures across all of the critical quality processes that affect patients, you can't get too much progress. And that requires leadership from organizations like The Joint Commission, from governmental organizations like Medicare, private organizations. There's lots of leadership here. From the health care organization's standpoint, it is the governing body, the medical staff, the management, the nursing leaders, all of those together are what The Joint Commission has been referring to for many years now as the the leadership of the organization. There has to be a commitment to high reliability.

The second problem that we need and don't have yet is a fully imbedded safety culture, and I will talk a little bit about how far away we are from that in health care in a moment.

But there's a third element, and the third element is that we don't do a very good job with fixing our processes even when we try. So the third element to this, the third pillar of getting to high reliability, is what we're calling RPI or robust process improvement, and I'll talk more about that in a moment as well. What we mean by that is a bunch of tools that
have come out of industry that are starting to be applied in health care — Lean Six Sigma, formal approaches to change management, all of which are necessary if we’re going to be able to fix these routine processes that fail routinely and understand where our risks are for events like wrong-site surgery and retained foreign objects and fix them by diminishing the risks.

This is borrowed, stolen, adapted from Jim Reason’s characterization of safety culture, and I’ll talk about each of these three elements. It pulls together the improvement and safety culture components.

We don’t have a very trusting environment in most health care organizations, so when I tell the story from the USS Carl Vinson of the seaman who lost the tool, shut down the training exercise that that aircraft carrier was engaged in, and I ask health care organizations — okay, that’s a nice story, you’ve heard that, but now switch gears and think about the part of your hospital where surgical instruments are cleaned and decontaminated and then packaged and then sterilized. Think about that at the busiest time of the day when you’re between cases, you’re processing all those instruments, and think about the recently hired tech in that department, who observes that a part of that cleaning process isn’t being done properly, knows it because she was just trained and she knows that there are a couple of steps missing here, and my question for the folks in the room is how certain are you that that tech would do the right thing and report it immediately to her supervisor who would then do the right thing and recall all those instruments that had gone through that imperfect process so that patients would be protected? How many of you are certain that would happen in your organization?

In a room of 300 or 400 people, three hands go up, four hands, never more than 2 percent. That is the distance that health care has to go from where it is now at the bottom corner to get to high reliability with respect to safety culture, and there are all kinds of reasons for that. I’ll talk a bit more about that in a moment, but the problem of safety culture and of the trust component of safety culture is in my mind the biggest obstacle that health care faces.

If you don’t have trust, you don’t get reports, you don’t get reports of the small things that you can fix easily before they do harm. In health care, we are most often in the situation of looking retrospectively after a terrible adverse event hurt a patient, trying to figure out why it happened, because we didn’t get the early warning signals. But if you get the early warning signals, then you have to, as an organization, use effective tools to fix the problem and report that fix back to the people who reported it to you so that you convince them that in fact they did the right thing, which reinforces trust. And those of you in those kinds of industries take this for granted, but let me tell you, in health care, that is a rare, rare organization. That’s why we need the robust process improvement tools.

Now, we wrote this up in an article, this framework and way of thinking about high reliability in health care that I think you all received a link to, that was published as the lead article in an issue of Health Affairs that was devoted solely to quality a few weeks ago, and it got — it’s been getting a very good reception.

We, The Joint Commission, organized an audio conference for chief executive officers, chief medical officers and chief nursing officers the week after this was published. We had
over 650 people sign up, over 400 attended, and more than 500 have downloaded the audio version of this conference, so perhaps we’re starting to get some interest in actually making this happen in health care.

Now, with respect to trust, let me spend a couple more minutes on this to give you an idea of how difficult this mountain is. One of the things The Joint Commission does is look at adverse events. We have something called the sentinel event program. We created the idea that adverse events ought to be reported, studied, and looked at in health care going back to the ‘90s, and we have a unit that has helped organizations look at more than 7,000 of these over the years, and then we write about common problems that we see when we’ve looked at different kinds of adverse events. Sentinel Event Alert communicates these common findings. One was called, “Behaviors that Undermine a Culture of Safety.” We have required for a number of years now that leadership in health care organizations establish a safety culture, and we saw that there were lots of incidents that were at least in part attributable to the failure of caregivers to report unsafe situations when they knew they existed, and we dug under that to try to understand why they don’t report.

One of the big reasons they don’t report is the culture of intimidation. And if you want to look in more detail, I would urge you to look at the Institute for Safe Medication Practices Workplace Intimidation Survey, published a few years ago. They asked caregivers, largely nurses and pharmacists, what kinds of behaviors did they encounter in the workplace that to them seemed intimidating. And there’s a wide range, all the way from just simple impatience to actual physical abuse.

Well, if you ask the question, what are the most common of these behaviors, it won’t surprise you probably to know that the most common are the everyday annoyance kind of behaviors, impatience with questions, the passive refusal to answer a question, return a phone call, return a page, a condescending tone. “That’s the stupidest question I’ve heard yet today, and it’s only 7:00 in the morning. I’m sure that this has set a low bar. Give the drug the way I ordered it.”

The nurses and pharmacists who answered that survey, a quarter of them said they had personally experienced those kinds of behaviors from physicians ten times or more in the past year, and about half that number said they had encountered the same behaviors from non-physicians at the same frequency.

So the media, as they talked about this, misrepresented the issue as disruptive physicians, and the problem of, you know, the caricature of the surgeon having a tantrum and throwing instruments in the operating room, and that certainly happens, but the high-frequency intimidating behaviors, or the ones that I’ve told you about, and it is both physicians and others who engage in them, and these are the common everyday behaviors that erode trust and stifle the kind of reporting that we have to have if we are going to get even close to a truly safe culture.

Now, The Joint Commission, as part of the safety culture requirements, encourages, requires indeed, organizations to create a code of behavior that clearly identifies what is acceptable, what is unacceptable, and to apply those criteria across the entire spectrum of the employee population, and we have a long, long way to go before that actually happens. So the trust component of the safety culture is a critical part of the problem for health care.
The other part of the problem is the recognition of what a close call or a precursor event — what a close call actually means. The vast majority of health care organizations, if they hear about close calls at all — I mean, obviously a punitive organization won’t even hear about a close call, but the vast majority of health care organizations are in what I guess Westrom has called a bureaucratic culture where you have a strong temptation to celebrate a close call, right, because nobody got hurt, and somebody was heroic enough to stop that error trajectory, and so you don’t have to learn anything from that. That means your systems are working, your defenses are strong, and we can proceed because nobody got hurt in that one.

Educating health care frontline workers, about what a close call is is extraordinarily challenging, it turns out, because they engage in workarounds every day, and that's probably 50 percent of what they do, is actually prevent — do these saves and good catches, and they believe that that's part of their routine work, not an indication that there are weak defenses and latent conditions and unsafe situations that need a lot of attention. So even if you try to extract those close calls, it takes a lot of work in education and training in order to get health care workers sensitive to this whole idea that close calls are worth their weight in gold, because they’re free lessons.

So robust process improvement simply, and many of you know this, is a combination of these tools, and I won’t go into a lot of detail. We at The Joint Commission are in the middle of a very aggressive program to adopt all of the aspects of robust process improvement. They obviously help us fix our business processes and do a better job for our customers, but we are also walking the walk, because we are expecting our customers throughout the delivery system to use these tools. We are also adopting every component of safety culture, and we are measuring the extent to which we are successful in getting to a safe culture and in establishing RPI. We report those measures to our board as part of our strategic planning process, and we are holding ourselves to very high standards with respect to how aggressively and how effectively we are adopting all the principles of safety culture. And we’re almost there.

This is a big part of how we are organizing ourselves to do our own business, partly, as I said, because it’s good for our business, but also because we want to learn what our customers will have to go through as they go through this process.

Now, let me take the last couple of minutes and talk about some new initiatives The Joint Commission has put in place, because we have to deal with organizations that are across an incredibly wide spectrum with respect to all of the components of high reliability, from the ones that are completely clueless and have no idea what high reliability means or even that quality is a good thing to be identified as the highest priority, all the way to the ones at the leading edge who have already committed to the goal of high reliability and are struggling to get there. We created a part of The Joint Commission just a couple years ago called the Center for Transforming Health care, as a separate 501(c)(3), to do an activity The Joint Commission has never done before, which is to create interventions ourselves to help solve these safety and quality problems.
This is actually a very direct response to our customers in recent years, who have said to us, “Stop telling us only about what the problems are and start helping us fix them.” We are raising outside funding support so that we can deliver the products of this work and not have to charge our customers to recoup the R&D. We have a number of major donors that have stepped up to the plate, not nearly enough, so if you have recommendations, please see me at the break. And we’ve started a lot of projects.

We have gathered a group of 19 organizations that we have vetted and have chosen, because they have mastered the tools of RPI, even if they haven’t committed to high reliability, they know how to do Lean Six Sigma and change management. And we asked them as a starting point, of all the safety and quality problems out there, which ones are the most important for you to solve for your own organization? As we put these hospitals and systems together in teams to solve these problems, working with our center and our RPI experts, we want them to be working on problems that are important to them. The problem that got the most number one votes among this group of organizations, does anybody want to guess? Hand hygiene, yes.

Now, this is sort of — in one way, it’s sort of a poster child for a problem that we should have solved a long time ago. This is not a knowledge problem. We know from data like these, this is monthly death rates in one hospital department from infection, and a hand-washing program was put in place there. Death rates plummeted immediately. This has been shown over and over again. Unfortunately, these data are from the 1840s. They are actually Dr. Semmelweis’s original data showing that it’s a really good idea to wash your hands. So it’s obvious to doctors and nurses, it’s obvious to the public, it’s obvious to hospitals, and it’s been obvious for over 160 years. Why is this so difficult?

Well, here’s one of the reasons. When you actually use these systematic problem-solving tools to understand why this routine process fails routinely, what you find is a lot of different causes, and these are just five out of about twenty of the most common ones. I’m not going to spend a lot of time on the detail here unless you’re interested, but the key point here is that every one of the causes requires a different strategy to get rid of. It doesn’t matter if you’ve got all of the alcohol hand-rub dispensers in the right places, if nobody — problem 5 — is going to feel safe in saying, “Doc, you can’t go in that room until you wash your hands,” you’re not going to get to where we need to be. Each one of these requires a different strategy, and the kicker here is that when you look across organizations, the pattern of causes varies. Each of these letters at the top is one of the eight hospitals in our Center project that started down this road. These are the top ten causes, and X means it was statistically proven, related to variability at that hospital.

And what you see here is evidence that the standard way we approach improvement in health care, which is somebody comes to a room like this, tells a great story about how they got rid of infection in ABC department, that becomes a what, health care people? Best practice, right? And we, hospital ABCD takes that best practice from Memorial Hospital and we do it the same way they did. And those of you in health care know when you do that, sometimes you get good results, but more often you get “eh” results, and you start questioning why did I go to all that effort? This is one of the reasons. If your causes of the failure of the same process are different from the place that generated an effective best practice, you won’t get the same result.
This is just to show that a number of these places, like Hopkins, Memorial Hermann and Cedars, thought they were operating at very high levels, and they were happy to participate with us in showing the rest of the world how it was done, but when they actually measured rigorously, they found they were at 48 percent compliance with hand hygiene. They got up to 81 percent, sustained over ten months without technology. And we will talk, if you like, about the role of technology. That was the improvement that they were able to generate using these tools.

We have a number of Center projects. I talked about hand hygiene. I’ll show you how we’re disseminating. We just concluded a wrong site surgery project that is now going to be disseminated. Hand-off communication, surgical site infection, preventable hospitalization are the other topics of projects we’ve launched, and we’re continuing to test our capacity by getting as many of these projects out as possible.

Now, here’s our challenge at The Joint Commission. We have this learning from these projects generated with this systematic approach to problem solving, but we have 95-plus percent of organizations that have no capacity to do this kind of work on their own and maybe not even much motivation to do much more than they’re doing now, how do we get this learning to the rest of the delivery system?

Well, fortunately, The Joint Commission has a requirement that every organization have an effective hand hygiene program, and have effective ways to prevent wrong site surgery and all those other problems, so our organizations listen when we say we have a solution. We are hardwired to every one of our 19,000 accredited organizations, and we’ve created this tool called the Targeted Solutions Tool, which is plugged in through our secure extranet connection with all of our accredited organizations. They can access it at no added cost. It doesn’t require any special training in Lean or Six Sigma. It doesn’t require any jargon, learning, or anything more than just routine process improvement understanding. And it is completely voluntary and completely confidential. We don’t immediately send the data over to accreditation. This is a pull strategy, but if our surveyors on-site see that there’s a problem with hand hygiene, they refer that organization, if they haven’t already gotten to it, to the TST.

And what happens at the end of this process, with very simple guides to how do you measure accurately, how do you figure out what your causes are of hand hygiene failure, then pick the interventions proven in this work that we’ve done with the Center hospitals and another couple dozen pilot hospitals, pick the intervention that solves the cause that you have and the intervention that looks like it will work for you, all of which have been proven. And this is the platform that we will be using to deliver the results of these Center projects to all of our hospitals and other organizations.

In the first seven months, we’ve had more than 40,000 unique visitors to this website, growing at about 1,600 new unique visitors per week, almost 1,700 projects started in almost 1,000 health care organizations, most are hospitals, about 40 to 50 new projects week. This is a learning database. This is not just a one-way pushing out of information. The organizations collect data and enter it into the database, and we have more than 135,000 observations of hand hygiene compliance. A number of projects have gotten
through the baseline data collection period, and the average baseline performance was 47 percent, so a lot of opportunity to improve.

And when they improve, we expect to see results like this, which is from one of our Center hospitals that did this throughout their entire organization. And what you see on the lower right, is when they got to a real 90 to 95 percent compliance with hand hygiene, their rate of health care-associated infection with multiple drug-resistant organisms plummeted by almost two-thirds.

So we are committed to driving the health care system toward high reliability or consistent excellence with the vision I've described. We believe that leadership commitment, safety culture and robust process improvement are the ways that characterize the pathway. All of our programs and activities are organized around delivering various kinds of assistance, motivation and encouragement, if not — since we are not a public regulator, we don't get to close places down, but the idea is that we are prepared to recognize where our customers are on this very wide spectrum of commitment and journey toward high reliability and to help them, wherever they are, make the next steps.

And the real trickiness here is that high reliability practices that characterize the way many of your organizations work, cannot be just dumped on a health care organization that is in the beginning of its journey. They will just be crushed under the weight of those unfamiliar practices, so we have to bring them along in incremental steps as rapidly as we can, but in incremental steps. And that is our learning, and I look forward to discussing this further with you and learning more from you. Thank you very much.

**Question:**
What is your experience with implementing mindfulness?

**Mark Chassin:**
In most organizations, not all, there are a few that have gotten a trust component of a safety culture implemented consistently enough that frontline staff are beginning to understand what that means, but the vast majority are not there. The vast majority have trouble reporting obvious errors and obvious unsafe situations, and that's a problem, because we are very often still in the shoot-the-messenger mode in health care organizations. And if you're in that mode, as you know, if you report something that's unsafe that involves other people, you will be ostracized and cut off from your friends and likely berated by your supervisor, so being mindful about small things is a really difficult state of mind to achieve.

**Mark Chassin:** [42:40] The next question talks about two studies that were published, one on the WHO Surgical Checklist, which claimed to have an association with a very large reduction, a 45 percent reduction in surgical mortality in association with its implementation. The other, a study that actually, I think, looked at team training at the VA, at the Veterans Administration Hospitals, also with a reduction in surgical mortality.
The second one is more believable than the first one. The first one is not believable for a number of different reasons. The Surgical Checklist is a series of steps that's designed to prepare a surgical team for what might happen during the surgery, including making sure you've got the right patient, so it incorporates our principles of universal protocol.

The problem in general with checklists, and we have checklists all over the place in health care, and, in fact, there's an interesting little bit on CNN, which I think is still there from a few days ago, that describes how a surgeon in the University of Washington operated on a child on the wrong eye, despite having a giant checklist posted on the wall of the operating room outlining all the steps that were supposed to be taken in order to prevent exactly that occurrence.

So what we find when we go back through these kinds of adverse-event investigations is that often there is a checklist with the principles of the steps that are required, and typically it's on a clipboard somewhere or posted on the wall, and somebody is charged with checking off boxes on the checklist, but those checklist boxes have nothing to do with the reality of the workflow in that place. So a checklist is wonderful as a reminder of a well-functioning process, but what we have tended to skip over in health care is how to create the well-functioning process, the reason I emphasized robust process improvement, and instead slap a checklist on a poorly performing process which doesn't work very well to produce safety, in my view.

Now, the team training is a different story, and I think we have a long way to go to understand how that is best positioned to improve in health care. The operating room is a particularly unique environment. I think there is a place for team training. I don't think we understand exactly what it is yet.

Mark Chassin:

The question was, what's the patient's role in improving safety and quality? Shouldn't patients be vigilant if not vigilante-like in helping improve safety?

Isn't that a penetrating comment on how poorly we function in health care if we have to rely on patients to improve safety? And why on earth would we burden patients who are ill, who are frightened, who are coming to health care organizations to receive care and treatment, with the additional responsibility of trying to make sure we're doing our jobs?

On the other hand, as a patient myself and as an advisor of many patients, both family members and others, I think that's exactly what patients need to do. There are many problems with this, for example, the marking of a surgical site is actually not done very well by patients, and that's a problem. If the hospital is doing it well, then patients can actually get in the way and mess it up. But that aside, yes, patients I think can play an important role and they do in selected instances, but we need to get to a place where we don't have to rely on patients.