

**Making the Health Care System Safer Through
Implementation and Innovation:
Behind the Scenes: How the News Media Covers New
Developments in Patient Safety and Health IT**

June 8, 2005

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CAROLYN CLANCY, MD: Welcome to Behind the Scenes: How the News Media Covers New Developments in Patient Safety and Health IT.

As all of you know, and you have certainly been hearing from us regularly, AHRQ is committed to supporting research that has a real world impact on clinical practice and healthcare quality. I think you have heard that from almost all speakers today, starting from Nancy Johnson, who talked about the gap between our knowledge and understanding and our capacity to translate that into delivery.

We have all seen the power of the media in delivering important information on health care in the health care systems of the public. And as surveys have shown, the media is a very important source of information for health care professionals as well, and I don't mean the New England Journal or the Lancet, I mean the mainstream media. But I think we are all left with lots of interesting questions so we are thrilled to have this panel today.

First, how do you choose what stories to cover, especially those related to patient safety and HIT? What do we need to know as researchers with stories, about how they work, what kind of information reporters need for a good story? What do they think about patient safety and health IT? How do they think it will play out as media stories in the foreseeable

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future?

So with that as a back-drop, let me say that we are pleased to have four very distinguished panelists join us today to discuss these issues, each representing a unique perspective on the news; a daily newspaper, a national wire service, broadcast media, and the health trade press. After they each give brief remarks - remember, I told you before this would be interactive -- after they give us some remarks about how they approach patient safety and HIT, we will have an opportunity to ask them questions, and we should be ready to answer their questions. So the point here is to have a very lively discussion.

You will find bios for each of the panelists in your conference materials, so I am just going to emphasize some highlights. David brown is a physician who has been a science writer at the Washington Post since 1991. He is from Framingham where I went to high school, so I do need to mention that. He received his medical degree from the Medical College of Pennsylvania and continues to supervise medical students at a general internal medicine clinic in Baltimore one day a week.

John Hamilton has served as a correspondent for NPR science desk since 1998. His current beat, as they say, includes neuroscience, health risks behavior and bioterrorism. Before joining NPR in 1998, Hamilton was a media fellow at the

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Henry J. Kaiser family foundation studying health policy issues.

Scott Weier is the editor of iHealthBeat, a daily publication sponsored by the California Healthcare Foundation. In addition, Scott also writes regularly for Health Currents, California Helpline, the Daily Briefing, and a news feed produced by the Robert Wood Johnson Foundation.

And then Lauran Neergaard is a medical writer for the Associated Press in Washington, DC. She covers public health issues and medical research. In addition, Lauran also writes a weekly consumer health column called Health Beat. So with that, we will start with David Brown.

DAVID BROWN: Thanks, Carolyn. It's nice to be here. The area that you are experts in, health technology and patient safety, are, in fact, a rich vein of possible news stories for us, for people like me, for a couple of reasons. The two biggest ones probably being that they are, they offer stories about the interaction between technology and excellence, and technology and thinking, which are two things that are interesting phenomenon, interactions that one sees all across contemporary life, not just in the sphere of medicine.

Nevertheless, There are several aspects to patient safety stories that I think make them difficult stories to sell, and I just want to mention a few of those. And in

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particular, three elements that the press values and I say this not in defense of these values in particular, though I am not necessarily against them, but I guess it's the reality, one being that generally the press prefers things that go wrong and mistakes that are made, rather than things that go right and mistakes that are averted. This is the man bites dog being a story, but the dog bites man not being the story. We also like human drama, and we like stories that have some sort of emotional valiance somewhere where some sort of feeling comes into play. And this was illustrated in my experience a couple years ago when I did a story a story about the computerized physician order entry system at Brigham Williams. And I - the editor that was editing the story was very interested - I followed an intern around for a couple of days and watched her interact with the system - and he was really hoping for some kind of moment in the story in which she wakes up in the middle of the night in a cold sweat worrying about some error that she was going to possibly make. And there wasn't such a moment. And that made it a somewhat more difficult story to sell.

I actually had a huge amount in there about how the system works and the source of information that it provides the clinicians and some of that remained, but his -I remember him saying at one point while he was editing it, "Well, you know, the system itself isn't all that interesting." And I begged to

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differ but he wanted human drama, you know, near misses, things like that. So that makes the story somewhat more difficult.

The stories are basically stories about dogs that don't bark, things that might happen and don't happen and while there has been at least one great story written about a dog that doesn't bark, and having that be the most important fact in the story, there aren't a lot of stories written like that and they are somewhat hard to get into the newspaper, so good luck.

JOHN HAMILTON: I second everything that David said about the difficulty of presenting these kinds of stories in the media. (inaudible - adjusting microphone)

I was going to say that I second everything that David said about the difficulty of getting this type of story into the mainstream media, like many of the reporters that are on a health and science desk, I have written plenty of stories about studies of medical errors, systems that are better than other systems for preventing errors or detecting errors and I have to say that there has only been one story about medical errors I ever did that got much of a response in terms of people writing letters and people actually saying that they remembered hearing it.

This was several years ago, at the time when medical errors was something that we were all reporting on because of the work of Lucien Letham [misspelled?] and those folks at

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Harvard. And I did a story - I was trying to show people what it was like to make a medical error. This is a bit like what David was talking about, how do you get the specific of when something goes wrong? And this is something that, of course, most of us never see while it happens.

So I kept calling around asking if there was someplace where you could see this happen in real time and somebody finally put me in touch with a group of anesthesiologists up in Boston who run a patient simulator lab that is specifically designed to make doctors - interns makes errors. And I spent four hours up there with a producer recording what happened. And they have patients who look very life like and they subject them to everything that could possibly induce an error.

So a patient comes in who had been in a motorcycle accident and he is distracting you by yelling, and he has had a lot of alcohol intake and then the lights go out and the power goes off. These are the kinds of things - and they keep turning up the pressure and they keep giving you symptoms that are hard to figure out and they wait until the doctors screw up and then they talk about it afterwards.

And it was - the experience was we told several stories on the radio, and I think we used three stories to show three different scenarios where cascades of events led to medical errors. And it showed, I think, in a way that no other story I

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have done how human errors are and how error are part of cascades of events, not usually an isolated incident. And interestingly enough, it was the only story that I got a whole lot of letters. The people that were in it liked it, a lot of listeners wrote in to say that they found it fascinating and a lot of people said that they had never understood what a medical error was until they heard some of them actually being made.

So I'm not sure if that's helpful in terms of how you get a story on the air, but it's worth thinking about as you are trying to think about the research you do, how do you make it real in some way, how do you make it dramatic in some way. And let me just say one other thing about the future of safety, patient errors, and sort of medical errors and information technology news, I think it's going to continue to be very tough to get a lot of attention. Every now and then you will have - the President will mention something or there will be a White House commission where you will have a lot of attention on the issues that somebody will say that however many thousand people are dying a year of medical errors. But once you have said that, and it's been reported, it has a tendency to go away.

And I think that the other thing you have got going against you is that in this country we think of safety in a

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very individual way. What most of you who are researchers do work on has to do with aggregate risk and errors made over a population and people don't think about risk that way. They think about what happens to them and the same people who will, you know, call me up and say, Why aren't you reporting the risks of my cell phone causing brain cancer, will be talking on that same cell phone as they drive at 80 miles an hour around the Beltway. And to them, the brain cancer risk is the great risk and the driving is not. And you have a huge challenge to get around that. I will stop there.

LAUREN NEERGAARD: I want to echo what you have already heard and just bring up a few other issues and one of the big issues affecting you is that, in fact, in the news business we like things to be new, we don't like to repeat the fact that there is a problem, which is different from science. And so how many times can we say, There is a problem, in the course of trying to focus attention on patient safety and health IT issues?

So we are always looking for something new to report and that's where your research comes in, but that has an inherent problem too because a lot of this research is in its infancy, and when I am considering a story, one of the things that I want is data because I don't want to mislead my readers into thinking that something is a bigger deal than it really

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is. And so when somebody comes to me to say, I have the software system that is going to solve the patient safety issue, which unfortunately they do at an incredibly frequent rate. I think I have probably heard from 80 percent of the hundred or so software vendors. My first question is, I want to see the data. It's the same question that I ask when the pharmaceutical companies call and say that they have the newest and greatest cure-all, you know, there has to be data that makes this applicable to my readers.

And there is a lot of research that's going on behind the scenes now that is not yet to the point where it's real applicable to the general newspaper reader in this country. And so one of the things that I also look for is national utility, there are some very interesting demonstration projects and pilot programs that are going on that give remarkable insight into the attract ability of different patient safety problems. They may not be appropriate for a national readership yet, or they might provide me a nice peg to, again address the issue and say, There is all this research going on. It depends on whether it's something we have reported before. And that can be very frustrating I think to researchers who are very proud, justifiably, of their work, but you know, We wrote about your competition the other week.

That said, the AP provides you a little different type

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of venue than some newspapers. You may run into national reporters like myself who look for national pegs for stories but we also have bureaus in every state. And so something that may not be a national story for me, might be a wonderful story for whatever state you are in. And we also have different types of reporters that you may run into. I happen to specialize in medicine, but IT is certainly a business story and with some of these demonstration projects that Medicare is putting on with some of the research that AHRQ is funding, you may run into generally assignment reporters and this would be an entirely new field for them, first time perhaps that they have ever written a story like this and they will need the full grounding and, Well, this is the issue about patient safety. And then this is how our work fits into it.

Some of the most effective stories in terms of how readers react are the ones where they are going to see something tangible. That's why readers actually like to read about projects on electronic medical records. If they get the sense that, Oh, this is going to be something that I might be actually able to use in X amount of time, but also behind the scene stories that will ultimately effect them, even if they don't see it happening.

I find very important to the drug safety side of things is something that I have been very interested in and bar coding

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of drugs in hospitals, for instance, I found to be a really important story even though the consumer was not actually going to look at it, it wasn't anything they had to do, but it was very important for them to know that this one little piece of the patient safety puzzle was going to be addressed in this way and was it going to be enough and, you know, was it actually going to work. Here's what data we have.

But when the FDA actually came out with the requirements for bar coding, drugs dispensed in hospitals, that provided a nice peg to look at, Well, how do you actually do this from a manufacturing standpoint, from a medical standpoint, in a way that won't slow down care, that won't create errors instead of preventing them? And it's something that I think the average person could understand, Oh, this is an opening into thinking about patient safety and what questions I might - should ask my physician if I am going into the hospital, and what questions ask about drug safety when I am not in the hospital.

And so that's why that was a very useful story, I think, for readers because it provided a concrete example of something happening but let them think about the broader issues that everybody faces whenever we get sick.

SCOTT WEIER: As a member of the trade press I am proud to say it's much easier to get news in our publications related

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to what you all do. Our audience is primarily people who closely follow healthcare IT news. It's included, but not limited to policy makers providers, insurers, technology vendors and researchers. And one of the chief objectives of iHealthBeat is to provide one-stop shopping for all news related health care and information technology.

To that end, our editorial staff conducts daily news searches of more than one hundred media outlets, including those represented on this panel, other newspapers, trade journals, television broadcasts, radio news shows. We then summarize the stories and provide links to them when available so you can actually look at them yourself.

Now, we also, of course, write original content in the form of staff and guest columns. And I think it's worth noting that we run a regular feature and audio interview with Dr. David Brailer, who you will be hearing from shortly.

There were a few subjects I was asked to address specifically, I was requested to discuss our news selection process and what I think you all should know about working with the news media. Given that, I hope you have such a tight focus I think it's pretty easy for us to sift through health care stories after all, if there is not a clear-cut health care IT angle, we are not going to cover it.

That said, we do have finite space and we also have to

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make difficult editorial decisions. Because we want our news to be fresh, we are always going to prioritize stories that bring something new to the table, whether that becomes said in invasions in the field or new evidence uncovered by researchers. Of course, the reality of our jobs in the news is always unpredictable. I wish I could tell you about a clear-cut formula for insuring that your story is going to get covered, but there is always a chance something bigger is going to come along. I try to plan my editorial calendar to take this into account. Although I plan some stories far in advance, I try to maintain enough room and flexibility in the budgeting process, but there is always some space for unexpected stories that come up last minute.

This lack of predictability is both what I love and kind of resent about my job because often those stories don't come up and we are left to kind of try to find some stuff to find last minute which is when I often rely on you all to give me a lead, and sometimes I'll call you with just hours of lead time to get back to me. So when you can that's great.

And before I wrap up, I just want to say that I have been really excited by a lot of the news generated this week both with the Hence Conference and also here. I think that you are going to be reading a lot more in the trade press about that activities of the newly formed American Health Information

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Finity. And I know that iHealthBeat is eager to provide coverage that will assist organizations submit the proposals that Levitz outlined Monday and again this morning and we are also eager to cover the AHRQ grants that Dr. Clancy announced this morning.

Thanks for having me here, I appreciate it.

CAROLYN CLANCY, MD: So now is your chance, questions you always wanted to ask, here they are, you can ask questions.

While you are gathering your thoughts, I have a question and this might be best aimed at you Scott, or you may have the most direct experience. I spoke at a conference sponsored by the California Health Care Foundation last November and I went to look something up there I don't remember what it was and I noticed that there were a couple of bloggers attached. Are blogs affecting your work at all?

SCOTT WEIER: You know, we don't actually have blogs attached to our site, but we have been considering it. It's a question of how to moderate that and there is a lot of control that you need to exert, and often in the trade press we have limited resources to actually make sure that people are posting things that are appropriate and relevant. \

So I think that certainly blogs are having an overall impact on health care, it's not quite infiltrating our publications specifically yet but I know the foundation is

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looking at ways to incorporate that onto their web site.

MALE SPEAKER: Again, I appreciate all of your prospecting in that regards. Perhaps I would like the panel to address the question that we constantly grapple with: In a position - by the way, I really have had learned as well as the medical administrator, have learned to appreciate how much the press has to really advocate the quality safety and now HIT. I think that's a very important role for the press to be in. The question is: From a national perspective, I think you are all doing a phenomenal job probably in some ways overwhelming information as being surrounding and appreciate your comment about that. How does that trickle down to perhaps some of the local or statewide - state agencies or state affiliates of your respective organizations and how you all begin to coordinate that?

I think that I would like to hear your all's perspective on that because I think a lot of the AHRQ mentees as well as various community efforts that are actually quite newsworthy, sometimes that gets lost and health care as a profession we are not big people to sort of boast about we do that is actually kind of good.

LAURAN NEERGAARD: Why don't I take a stab at that. There isn't a lot of coordination as you might guess. If you,

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for instance, were to call me and you had something that was going on at a local level that I thought would be an interesting local story, I would refer you to an AP bureau that would be appropriate for you to pitch that. Now, that does not guarantee that they would share the similar interests because there aren't that many health reporters around and what interests a health reporter is not necessarily going to interest a general assignment reporter. General assignment reporters can be scared of health coverage. I mean, it's complicated, it's hard to get doctors to talk, it's hard to get computer people to talk. So we are meshing two difficult to communicate industries. But it is helpful if you start talking about a project with a health reporter.

JOHN HAMILTON: I can add one or two things to that. First of all, I can assure you that NPR's level of organization is much, much worse than any of the wire services. In part, that's because we are often perceived as a network like a television network. But in fact, the so called member stations are in no way beholden to NPR. They choose to buy NPR programs somewhere are indications - so if you hear All Things Considered, it's because a local station decided to purchase that from us. It does not mean that we have any control over what they do.

That said, you talked about the process of if things

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worked their way down, and I am going to turn it around and say things trickle up at NPR. So often the way things would happen, if a story did make it on NPR national, what would happen was you might go to a station reporter some place, and a number of our members stations have very big news organizations of their own if you are in Boston or New York or Philadelphia or Los Angeles, San Francisco. And if it's a story, especially if you pitch it as a story where it's a local example of something that is happening nationally, This is a hospital that has an information system that has reduced errors by fifty percent, and what's more, it's something that the VHA is planning to implement in all of their hospitals, it's something that somehow has a national scope even though it's a local story, there is a much better chance that the reporter is going to not only do the local story, but then turn around and call us up and say, Hey, are you interested in this for All Things Considered or morning edition? And the reporters out there who work for the member stations love to get pieces on or even if they are not going to do the piece, they like to pass along ideas to us. So that's often a very good way to get attention for whatever is going on in your community.

DAVID BROWN: And at a big newspaper like the Post, there is sort of analogous situations to what John and Luran just talked about. I am on the national staff, the metro staff

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has a health reporter who tends to cover or does cover local health industry and regulation, and also to some extent some science and research, if I do a story about some big idea, I am obviously going to want to find an example where it's happening. But if - I am not the only person who is interested in going to a hospital and watching mistakes not happen. Snd so that I would just urge you to think - realize that there is a metro staff, there are reporters in bureaus all around the country, California, the southeast, Chicago, and there are people - they don't do as many science stories obviously, but they are possible recipients of your pitches.

MIKE WAGNER: Mike Wagner, Clever Clinic Health System. I think that the press does a tremendous service for us of us by reporting some of the terrible things that have happened at Dana Harbor, and at Duke and other places. I am sorry those things happened, but I think there is some recognition that these things do happen from your stories. \

My question is: How do you balance a story like that? It would be so easy to present the salacious public interest parts of those stories, but so many of the stories I read did have a balance, trying to tell some of the positive things that came out of those terrible events.

SCOTT WEIER: As a trade publication, we definitely, first and foremost, go to the hospitals to talk to the people

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there and see what they are trying to do to rectify the situation. And also that it kind of capture it from the less informed so that other organizations don't fall into that trap. I mean it's partially, you look at it as a learning process and I think that I'm kind of seeing everybody engaged in that. You need to make sure that you are actually teaching some lessons to people, rather than just kind of reporting on all the horrible stuff that's happening all the time.

LAURAN NEERGAARD: For those of us who report for the general readership is - something that I am always looking for is what can my readers do to try and make sure that that doesn't happen to them. And so much is out of your control as a patient, but stories about what lessons have been learned, stories about different projects that are being implemented to improve safety, those are all the kind of things that people want to read about and therefore that helps you provide the balance. And I think that our readers really demand it, our editors really demand it. It doesn't do any good just to write the bad thing and maybe you write the bad thing one day but then you follow it up with, And this is what else is being solved. That's natural news progression, it's the second day now, what's happening, part of the story. Things like the VA system, things like some of the work that's being done by FDA

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to bar code, all of those things are sort of naturally second day angles, whenever you have a disaster that you have to report. And we look at it from the viewpoints of news that a consumer can use.

JOHN HAMILTON: At NPR, we almost always have a discussion when we are considering covering one of those stories about whether the - it's usually a very dramatic anecdote, somebody did an operation on the wrong side of the brain, or removed the wrong limb or gave radiation in a dose that it shouldn't have been given. But we always have a discussion before we do those stories about what it represents in a larger statistical context. Is this something that - we try to make clear to the people who make the decisions about what to put on the shows that something like a medication error is something that affects an awful lot more people than somebody having the wrong limb removed.

This is, there are some errors are much more common than others. And another thing we try very hard to do is to give a larger context to every story about things that go wrong and often these stories have a whole other side. I mentioned a couple of times that having the patient of the wrong limb, at least one of the stories that got a lot of attention was, in fact, a patient who was diabetic and was going to have both legs amputated anyway, and that didn't come out until well

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after. And if you read the first day story was, Surgeon cuts off wrong leg. And you are left with the impression that somebody has lost something terrible, how could they possibly have removed a perfectly healthy leg? And when you looked beneath the story as some media organizations did, you found out that the context was much more complicated, and we really do try to do that.

DAVID BROWN: It seems to me that there is two issues of balance. There is this disaster that occurred at a distinguished institution. How about the ninety percent of patients who were treated successfully and disasters didn't occur? I think that stories don't, they don't mention that either in a big way or frequently in passing because there just isn't the, that's either understood or that's not the news. You don't write about all of the dogs that bite postmen that day.

The other balance issue is trying to get some sense on sort of perhaps the egregiousness of the error, or how it happened so that it's not just, Something is botched. This term botched appears in all together too many news stories in my opinion because it's an assumption that if a mistake is being made, you have some clumsy, stupid, half drunk person making it. And lots of errors are an accumulation of small misunderstandings, or they are things that are near misses that

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hit.

And there was an example in the news several years ago in which an anesthesia resident - a young woman, a teenager actually, who was getting, I believe some sort of a facial procedure, might have been a dental procedure, had died suddenly, a sudden death, a cardiac arrest. And it turns out that the anesthesia resident had pushed an antibiotic, and I think it was clindamycin, but I'm not sure, but pushed a - IV pushed a drug that you are not supposed to. And there is, in fact, in the PDR, in the label, something that says, Give this over five-minutes, do not IV push. Though it doesn't say, Because there are reports of sudden death.

I was - this was - there was a lawsuit against this person and an attempt to basically take the license away from this resident, and I was curious to know, I had never heard of this adverse or this risk of this drug, I looked it up in Goodman and Gilman, which is a major text of pharmacology, it wasn't listed in that, I actually had the pharmacy at the University of Maryland Hospital do a literature search and, How common does this happen? They found two case reports, one from the French literature, one that was reported before the birth of this anesthesia resident, and that was pretty much the cases that could be easily found on sudden death from IV push of whatever this antibiotic was.

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The stories didn't really explain that. At least in my opinion they didn't explain it adequately. It's true the resident did something that he shouldn't have done, he pushed a drug that it says in bold face type, Don't push. But how many chairmen of anesthesia, if you ask them, Here's ten drugs, which one of these is associated with sudden death if you give it an IV push? I would be actually curious which one of them would pick clindamycin out of the list.

So I think stories about mistakes do need more to suggest that you get at the egregiousness because they're obviously cutting off the wrong leg. There is not, that's not, it's hard to see how that's something that is anything other than an egregious mistake, but there is other things that have horrible outcomes that are more understandable.

FEMALE SPEAKER: Jack, I have a question about, just an opinion, from your perspective as reporters who have been in this business for awhile, one of the topics that we keep discussing with AHRQ and other entities is, the whole idea of who controls the data, the health care data, and one of the ideas that's coming out is that the patient should control the data rather than the health care provider or the payor. And I was just wondering if you had any sense at all from your experiences as health care reporters for some of the patients that you have talked with might feel about that kind of a

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model.

SCOTT WEIER: Again, I feel like I come at this from the provider angle more, so I think that we are kind of naturally biased to some degree, but I think that the value in getting patients enthusiastic about having some control of their own data is that they care about the data. And they actually then find out whether or not it's being digitized. All of a sudden, there is knowledge there, and that kind of helps build momentum for all sorts of efforts to make sure that there actually is some data being transcribed and conveyed to both patients and providers and the cross providers. And I think that kind of - I don't think it should necessarily be one way or the other, I don't think the control should rest on either side, but I do think that having both parties involved is really important to the overall movement.

JOHN HAMILTON: I guess I would just add that it sometimes is hard for people in health care to think about data the way patients do. Sometimes it's a little bit easier if you think about all the credit information kept on you and if somebody was saying, Well, we really don't want you to know what that is, or to mess with it, or to worry about where we send it, how old you feel, especially if you have just been denied a home loan based on something that you didn't have any knowledge of. And I think I try to think about health care

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data the same way, and certainly every time we do a story about privacy and data, we hear, we get a lot of feedback from people who have very strong feelings about wanting to know what information is out there and then have control of it. And I think if you are going to succeed in any of your efforts, you are going to have to work with that.

CAROLYN CLANCY, MD: Harry?

HARRY SALK: Harry Salk [misspelled?] of Boston. You have already addressed this question implicitly and maybe you have nothing more to add, but I just have to ask anyway for your assistance because a lot of us have, at least I have difficulty making things sufficiently concise for the media story and I am reminded when talking to a local well-known TV physician reporter from the Boston area, I was - Art Grant actually, and he listened to it for a while and said, Well, Harry, that's great for inside baseball, but - and the idea being that it was very - I hadn't quite made the story in a concise and attractive enough way.

Now, you have talked about a lot of things that make stories attractive to the public, but it still remains always a challenge to get the right stuff presented. Do you have any other ways that you wish we would do this to make it more easy for you to digest?

DAVID BROWN: Well, it's sort of - it's painful to hear

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a question like that because it suggests that if you just couch the information in the right way, we would do the story. And the fact is that there is a tsunami of good story ideas that washes over each of us everyday, and basically, if it's not something you have to do, like Clinton getting heart surgery or something like that, it's almost a semi random activity of what you grab onto, you know, among the universe of interesting stories - and that's a bit of an exaggeration, but what gets reported is an expression of reporter's interest, who is on vacation, whether other stuff is going on. I happen to be working on these two sort of big stories this week, so all kinds of good stories are not being done by me, they may be being done by other people on the staff, but sometimes they aren't done at all and we run wire stories or we don't run them at all. So it's, just realize that it's an amazingly irrational system, and don't take it personally, and you are not doing anything wrong.

LAURAN NEERGAARD: I would add to that, that I don't expect you to come up with what the story is necessarily, that's my job. And your job is to tell me what's going on and I have to figure out whether it's something that I think is interesting enough to me, amidst all of the other things that David described to you, that I can sell to my editors in the current context of what I know is going on that day, not just

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on my beat but in the world at large. And maybe it just clicks because one of the things that I do is look for trends and when I get enough of a sense that there is a movement going on or a trend towards something, that's a perfect time for me to write. And so maybe today is not the day but you might hear from me next month. But in terms of, Gee, you didn't present it to me in a way that I can put it straight on the air; that's my job.

CAROLYN CLANCY, MD: I guess I am reminded of an academic colleague who had his first article in the New England Journal. This is about fifteen years ago now, this was about which women benefit from chemotherapy for breast cancer. So you could almost guess that there was going to be a lot of press interest and sure enough, CNN was going to come and take it, and just incredibly excited and that was the day we went to war in the Persian Gulf so that was the end of the breast cancer story. Next?

FEMALE SPEAKER: My question goes back to sort of the HIT area and that is that certainly confidentiality and privacy are important topics and hot topics. We clearly always hear about the big breaches in privacy. The question is: How can we work with the media and work with you to sort of flip that around, to sort of gain public trust that as we move toward sharing information and doing more data exchange, that the public feels that the information can be shared securely as

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opposed to always taking it from - again, what's new is when there are major breaches and obviously that has a large emotional impact that goes with it.

So any suggestions or advice for flipping that around for gaining public support on this?

JOHN HAMILTON: I have been struck by how few - we get pitch stories all the time, it's a constant extreme of stuff but I have been surprised at how few are offering to show the success in protecting patient data. I get a huge number of stories from groups that are telling me how difficult it is for this group or that group to meet privacy requirements that it's slowing things down, it's difficult, it's a delay. I don't think I can - I am trying to think of an example of somebody saying, You know, we implemented a system here where I think we can assure everybody that uses this that their stuff is going to be safe and secure and we would like to tell other people about it because we think it works. I just don't hear that very much.

MALE SPEAKER: I would like to throw a challenge out to you all to help us think together how we can create a culture of safety. It seems that's there is a gap between one of the things I think the first five years has done for Boston hospitals and patient safety movement has accomplished, has at least begun to I think permeate the hospitals and the people

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working in them with this new understanding of learning
premiers of blame free approach to adverse events as way of
approaching them. And obviously, these are not the sort of
national reflexes, both for the press and the general public,
but somehow I think we are all pretty clear from the research
we have done and the lessons we had from other industries that
this is one of the most powerful tools for advancing patient
safety is creating this environment where we can actually learn
from these bad things that happen and create the conditions to
allow that learning to happen.

Again, and I am not sure exactly what I am asking from
the press, but I think we are going to have to work together to
both educate the press and the public that we have to have a
different approach, I mean the accountability function of the
press is very important,, okay. I wish you held a lot more
things in terms of things that are happening in this country to
scrutiny and accountability but there is yet a higher level of
education, a job that needs to be done that doesn't involve
suspending that role in the media, but it does involve a
responsibility and a necessary education.

So what I have heard is very good balance, in fact, I
have been very impressed with what I have heard, the lengths to
which you are going to kind of give the story a sense of
balance. It's not just some horrible, hideous thing that you

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are trying to put things in context on a story by story basis, but I'm wondering if this larger education and lesson in shift in culture and understanding is happening, and what it's going to take, and what the role the press is going to be to help take us there.

DAVID BROWN: I would like to address that. It's a really hard story to cover. Changes in culture are just in generally difficult to cover and --

MALE SPEAKER: I am not asking you to cover the change in culture safety, I am asking you, how can we work together to really move the public's understanding, the lame shame game is really not going to advance it, so I think the first thing would be for the press to understand this, which again I think is not the common sense first reaction, but it's a profound lesson that we have learned together in this patient safety movement

DAVID BROWN: Well, I think the way - first of all, we don't - I assume any of us - view as our role as promoting this, but there is interesting news in change of culture. But I am saying it's a very hard topic to cover for some, both because of abstractness and because it's very difficult to do, to go someplace and watch it happen and describe its pieces and its process and not just the idea of it.

Just as an example I, a couple years ago, proposed to

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the VA system I wanted to do a story about certain root cause analysis, the idea of taking some adverse event or near adverse event and the formal analysis of how it happened and what might be changed to prevent it from happening, just as kind of a case study. And they said I couldn't do that, which was perfectly fine. One of their key pieces of their culture blamelessness is that, you know, reporters are not going to sit in on these meetings. So that it's a - it makes it very hard to write about it vividly and with the kind of human characters that really make a story come alive.

LAURAN NEERGAARD: I would echo that in just to remind you that our role is to report news, it is not to advocate. And if in the course of reporting news we have the context involved that does provide important education, that's the role of putting context in our stories that educate our readers and that's something that we all try to do. But there is a line between educating and promoting that we can't cross, and it's nice if what you write has profound societal change and does good for somebody. But that's not our role, that's your role.

And that is, however, one of the reasons that we always ask the questions that we ask of you of, Put this as a context for me, what's actually happening, what are the changes? But as David said, it helps us when we are allowed to access to actually see some of these things, and with the privacy rules

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that are out there now, I know it's difficult, but any way that you can allow us to see some of the changes that are happening as the course of this patient safety research, that informs our stories to a degree that just quoting someone never does.

FEMALE SPEAKER: What is the one piece of information that you would want all of us to walk away with?

JOHN HAMILTON: Let me give that a try. In the context of, How do you get attention for what it is you want to talk about, I gather that's on a lot of peoples minds, how do you get the media, mainstream media to pay attention to your story or your issue. I think if there is one thing I would say is know what's going on in the news world. More and more news organizations, even when they are not strictly reporting the news, are doing things very much related to the news.

So you will notice when half the media is down covering the Terry Schiavo circus, the other half is busy interviewing every ethicist in the country. If ever there was a time to give your views about that subject, that is the golden moment, look for those moments when you know that there is a big title report on medical errors coming out, or if you know that the President is going to mention information technology in an important speech, you want to be ahead of the curve telling news organizations, Here is something related to that that you might want to report.

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SCOTT WEIER: I just want to echo that because I think for us, sometimes we blink and it's a new day just because of the way we treat the world, we are always looking for the newest stuff. We're always waiting to see what happens and it's helpful if you can be opportunistic with how you present information to us, and sometimes strategic and holding off on your information and sending it at a time when there is other stuff going on that relates to it so we can tie it to a bigger story. That's a great way to get your stories in our publication. It's just to kind of have the context be naturally relevant to what's going on in the news right now.

LAURAN NEERGAARD: I would urge for all the folks in the room who actually work with patients, when there is bad news, when there is a disaster, don't just have the immediate reflex of closing the door on us. Talking to us is important at that point, if ever there was a time that it's important to talk to us, about candidly about what you know went wrong and what's going to be done to fix it

DAVID BROWN: I would say that you all need to realize that it's detail not generality that gives journalism its power, and when a question comes up about creating the - or reporting on the change of culture, culture of safety, that's obviously a really important idea, and it really helps us and, in fact, it's essential to be able to illustrate that in some

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way. And to have some person, some event, some quantifiable number of outcomes, something that illustrates that in a concrete way, and because saying that, Boy, people used to just do everything they could to cover up their mistakes and now they are not doing it any more, and that's the story, we want out, it isn't enough to get it, even if it's true, it's not enough to turn it into a news story.

TOM LEWIS [misspelled?]: Tom Lewis from Primary Care Coalition in Maryland. There are a number of news stories in the last week or ten days that I found quite interesting as a set, and I wonder how you think of them, both as health reporters and as people with a more global news view. The first is Secretary Levitz, I think was very moving and effective presentation, on the power of integrated health information to lead to better quality care for more people at lower cost. And a couple with that on Monday, in a lead article in the Post was another three point line lead and the Americans health care data or personal financial data was compromised somewhere between Citicorp and Experian, one of the large data brokers of personal financial data. Then you couple that with medical marijuana, the Supreme Court decision, a decision that went against Planned Parenthood forcing them in Indiana to release medical records for young women under 14, and I wonder how you - is this something that you would look at individually in

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stories, is it something in an editorial page function, an op-ed kind of thing? Because to me these individual - and then today actually to involve another panel member in national public radio talked about a committee within the Senate that wants to give additional powers to the FBI for administrative subpoenas for all kinds of personal data including health records.

So I look at that and I say, Gee, I am lucky enough to have a really boring health record so there is nothing in there that would affect me personally even if I published it for the panel. But what about the people who might be using surreptitiously, medical marijuana for their cancer treatment and other kinds of activities, and sort of where do you - where does this fall in a press or personal note or a news reporting requirement? Because to me, some of those activities undercut one of the primary missions that we are all about here.

LAURAN NEERGAARD: Well, if you have to draw all of those things together, it probably belongs on the editorial page. But the fact that you draw them together, I think it's indicative of what our readers are concerned about. Privacy of your medical records is an important thing to people. And yet, as John pointed out, we don't hear a lot about that when we are pitched stories. It's always that we are going to have the electronic this or the electronic that and it's going to solve

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all of these problems. And yet, I think that we are going to have to have a look at - a strong look at privacy before any of this flies with the public. And that's something that - I actually get phone calls from readers whenever I write about health IT, Well, did you ask about privacy? Did you see that, you know, the credit desk? So the readers are thinking about it and obviously when I get phone calls like that it makes me ask more questions like that. And so that's, in the research realm, it's a question if you call me with your, This software is going to solve this problem, it's a question I am going to ask you.

DR. CAROLYN CLANCY: I think we have time for one more question and I am going to go over here

MALE SPEAKER: As clinicians become more computer literate, some are turning to the web and starting up web blogs or blogs addressing various medical topics including health care IT, myself included as a contributor to a web blog. How does the press view the web blogs in ordinary politics? I think there is a view of competition between the press and web blogs. Is the press, in terms of its medical reporting, looking at the increasing number of medical web blogs, perhaps using them for a source of leads, and how does the press view an increasing number of individual clinicians and groups of clinicians themselves becoming publishers?

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SCOTT WEIER: I think that I view it as a really good source of information for myself, but I think to kind of keep in context that it's somebody from a very specific perspective writing that information. And I really hope that readers who log on and read that stuff know that it's coming from a physician with a certain vantage point. And I hope that people continue to be savvy enough with their media consumption that they are able to keep that in mind. And I would like to think that journalists will continue to be professional and will continue to try to get in a variety of perspectives of the stories they run. So I would like to think that people would kind of balance the equation and read in an informed way.

DAVID BROWN: Just from my personal perspective, I don't have time to read web blogs, I don't have time to read half of my e-mail, I pick up my mail once a week, it's this huge tub of thing that I throw ninety percent of it out unopened, so I could spend all day sort of reading the media then it would be time to go home. But I would - but I am sure there is great stuff out there and I am sure that there is real connections being made that we're missing and all sorts of other people are missing and it may be capturing a very small audience.

And to both answer you and the man who obviously is doing a lot of integrating of news events that that I haven't

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done and lots of other people, perhaps lots of other people perhaps haven't done, I would urge you to think about contributing, offering the stuff up as op-ed page pieces. The Post has a Sunday opinion section as most newspapers do, the Outlook section, they are always looking for new voices. This whole alternative reality that I am sort of unaware of except that it exists, and you can offer some of your insights from that reality into ours without having us cover it. You can write it yourself.

LAURAN NEERGAARD: There are a handful of the blogs out there that every so often I take a gander at, but like David, there is just not enough time in the day. We are all overwhelmed with all the different forms of media now, but in some way the blogs are just a natural extension of the chat rooms for various patient groups that have extended for so long, and in that form, they can actually offer us story ideas. If something is all of the a sudden generating a lot of interest, that might be something that I would want to pursue. like I would pursue any story though, by checking it out, not by assuming that it's true because I read it on a blog.

But I would also echo that if there is something that you see on a blog or that you as a blogger are really getting into, maybe it is a story that, don't assume we are going to read on your blog, but that you can call us.

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JOHN HAMILTON: I love the blogs, I read the blogs, I read blogs all the time. The only one or the only ones that I read everyday are the ones that report scurrilous rumors about my own organization. But I find - I would love to read others I don't have time - but I do find I frequently now will if I am researching something. If you are going through any of google or any of the other searches, you often turn up blogs now and I happen to find myself reading them in places like are reporting on the goings on at Los Alamos laboratory and so on, some very interesting blogs.

That said, I don't see it as competition and I know that people raise that a lot, Media is concerned about blogs as competition. I guess I have never really thought about it that way. They are somewhere between a source as if somebody I would call up and them about that and a rumor mill, an anonymous place to blame other people. It's a little bit hard to know how to use the blogs. I find I am most interested in the blogs where people identify themselves and I have, in fact, put some of those people in put blogs from people who are in various special interest groups and so on. People who identify themselves, often I'll call them up and talk to them about whatever it is they had on their mind. So we are not in doubt they are reading the blogs everyday, but if we are researching something, we may well find what you said in a blog.

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CAROLYN CLANCY, MD: I am very - first of all, this has been a fascinating discussion and I am very sensitive to the fact that people whose stock in trade is asking questions and kind of being in control of the conversational flow, it is not always necessarily instantly comfortable to be on the receiving end, so I'd ask you to please join me in thanking this terrific panel.

[Applause]

[END RECORDING]