

INSTITUTE OF MEDICINE

**CROSSING THE QUALITY CHASM: NEXT STEPS FOR HEALTH PROFESSIONS
EDUCATION**

**“MAJOR STAKEHOLDERS COMMENT ON KEY STRATEGIES AND ACTION
PLANS”**

JUNE 18, 2002

WASHINGTON, DC

DR. EDWARD HUNDERT: (Inaudible) creditors, heads of licensing agencies, deans of schools who, I suspect when you think about what your action was targeted at that you've committed to do, part of what you're trained to do is get these kinds of people to change their behavior to help a lot of other people change theirs.

And we felt that it would help inform the way in which the rollout will happen, if we had an opportunity to get a sense of how these important stakeholders react to the kinds of recommendations that are coming out of this summit.

What I'm going to do is invite each of them to just briefly go down the line here and introduce themselves and say what organization they represent or their background and then get them started. Why don't we start right here?

DR. ROSS BAKER. I'm Ross Baker. I'm an Associate Professor at the University of Toronto and I think I'm here because I'm the Chair Elect of the Association of University Programs in Health Administration, so I represent what some people feel is the dark side, I guess, or as we would say in the safety lingo, the blunt end of the environment. And it's an interesting, I think, addition to this focus gathering.

DR. ROBERT BERENSON: I don't know nothing about the dark side. I'm Bob Berenson and I'm currently at the Academy for Health Services Research and Health Policy but I think I'm here because I spent three years helping run the Medicare program and I think a lot of that -- that was the dark side I was referring to. And also think a lot about public policy issues and that's my background.

MS. JOEY RIDENOUR: And I'm Joey Ridenour, President of the National Council of State Boards of Nursing and I believe I'm here so regulation can figure how to do it better.

MR. CHARLES INLANDER: I'm Charles Inlander and I'm President of the People's Medical Society, a consumer health advocacy group. And I'm here obviously because it all affects us.

DR. DANIEL DUFFY: I'm Dan Duffy for the American Board of Internal Medicine and I never thought I'd grow up to be a regulator.

MR. DONALD WILLIAMS: I'm Don Williams. I'm the Executive Director of the Washington State Board of Pharmacy and I'm representing the National Association of Boards of Pharmacy. And pharmacists are attempting to get more involved in collaborative practice with physicians, nurses (inaudible).

DR. COLLEEN CONWAY-WELCH: I'm the late Colleen Conway-Welch and I'm the Dean of Nursing at Vanderbilt.

DR. HUNDERT: Great, thanks.

What we agreed to do -- and this is going to be fairly free form to give everyone a chance to react. But we thought we would start by asking each of the seven panelists to, both from the presentation that was just made from each of the groups but also from everything they've heard during the course of the summit, to comment on the single strategy that they think will have the biggest affect on reforming health professions education from their perspective, everything they've heard.

What do you think is most likely of the actions that are proposed to have the biggest affect on health professions education? We'll go right down the line. Colleen.

DR. CONWAY-WELCH: Something that we frankly didn't talk about too much but was -- I was surprised at when it did pop up was the interest on educational research and the support for doing research on educational methodologies and pedagogues, et cetera, in terms of how most effectively to deliver the content going forward.

The other point that was made was that if we have so many silos, but if we focus on the patients as the real receiver of all of our educational efforts and then back up from there and apply the appropriate teaching technologies that are evidence based, that we might have a chance for success.

DR. BAKER: I think the issue is to engage faculty in a way that will bring forward the energies and insights that they have. We've heard a lot about the need to create new organizations to have more conversation among existing institutions, existing regulators and I think all of that is important.

But we need to move down to the level of the people who are actually going to do the work and think about ways that we can start right now to engage people in doing this work.

I've had the opportunity over the last few years to be part of two very exciting initiatives, one of which is a summer symposium that Paul Batalden holds every year at Dartmouth. The second is a series of interdisciplinary collaborative activities that Linda Hedrick (sp) and Paul Miles and Linda Norman and a variety of other people in this room were engaged in as well, which really worked on the grassroots level to engage front line clinicians and faculty in making change happen, trying out teaching models.

And I think we need to start to do that with even small amounts of resources. At the same time, we talked about the big picture and getting additional resources and deciding what the full elements of the curriculum are.

DR. BERENSON: Well, I'm going to go the other direction. Instead of the grassroots, go to the interaction with the broader system. I'm with the person, who in the last session, mentioned that it's hard to do this kind of work when the signals in the system more broadly are not conducive to rewarding the results of what everybody would wish to be doing, and that has to do with the kinds of values that the Chasm Report identified in payment policy and liability and licensure and those kinds of things.

So to me, the greatest interest would be in leadership development, but leadership going beyond including those dealings who don't believe there's a problem.

And more specifically, I'm struck that there's sort of two ships passing in the night or I actually should say this activity is like little rowboat passing a major ship that's going a very different direction.

And we're seeing folks who are in leadership and perhaps would be supportive or lukewarm or whatever to this activity are the same folks who in national public policy are supporting the same silo payment systems, the lack of reimbursement for teens, payment for activities and not for results.

We could go down the line on the defects and so that the broader system sorrow would be very, think expansively about leadership and not, sort of, allow the true leaders who should be here to sort of have it both ways.

MS. CONWAY: I think one of the strategies that would be most important for us as regulators is continue to work together between longer disciplines to identify those competencies that, I think, were began under the last two days that may not be truly inclusive lineage competencies people need to develop over time, and continue to discuss how that will be played out if the education not only on in trade but on continued education.

What do you do with those people in the professions now that may not be competent in that area?

I think the other thing that struck me as far as strategies is to really understand that we cannot do this alone. I think I mentioned to you once that (inaudible) which there are 61 of us, were pretty compelled by the IOM Report that demonstrated true data, that there were too many loss of lives on a daily basis and an annual basis, not knowing what to do.

And I think this is the first time that I have felt that there's been some strategies that may help us move forward and not have the same outcomes.

MR. INLANDER: Well, I would say that the major accomplishment of the last two days from my perspective is the two words, patient centered. There's nothing new here that we've talked about in terms of knowing the quality of the system and how poor it's been.

We can go back into the literature and it's been documented for years and years and years how miserable overall the care has been, how there's basically been no quality focus on care and as meaning to skew out the system, this is going to. It's been published in books and so on and so forth.

Yesterday I was talking to Lyle Bootman. I said, you know, isn't it interesting. We're now talking about this after we've been writing about this for 30 years. And both of us agreed that the key is that it's now come into this building, it's now in the walls at a higher level, that finally together we've recognized -- recognized that this is a patient centered quality issue.

It's not just safety, it's quality. There's more to quality than safety. And we have to look at it from that perspective to move forward. I'm not worried too much about where the health professions and education are going to go because they're going to have to go this route or they're not going to survive.

It's the train that's on the track and it's going down the railroad and the fact that we're here are going to make it that way.

I think it's very important -- and the one thing I did want to speak about and it was raised yesterday in Don Berwick's presentation is, it's somewhat implied in many of the IOM reports and that is that the failure is a systems failure.

Well indeed, there is a systems failure. But we have to recognize that it's individuals who create and run and operate these systems. It's why everybody is so irked at the Cardinal Law. He knew what was going on and didn't do anything about it.

We have a system where you all know what's going on and you have to take personal responsibility and not just say oh, it's the way the system works. We create the systems.

And so if we, as individuals, I think -- and I think has been coming out, at least in the meets that I've been at, are focusing on the patient and focusing on what the goal of all this healthcare is about.

We know fine the right ways to do it as long as we keep our eye on what that goal is and we are concerned about the outcomes and we're concerned about where that patient ends up, because they're not just a gallbladder in room 304, that they are a human being who has a whole set of priorities.

If we do that, then many of those issues that seem to be system oriented will go away because we will be trying to do the right things and the right systems will be created.

And I'm very optimistic. I mean, as much as I talk about this other way, I'm very optimistic because the fact that we're here in this place -- and I mean physically in this building, that the IOM has taken this up in the last few years and that the level of people who are talking about this who, ten years ago, when I'd be on Oprah and Donahue, would be calling up those shows saying

don't let that show run. There was even a lawsuit attempted, not to let the show run when we published *Medicine on Trial*, which was ten years before (inaudible).

The AMA tried to stop it from being aired because they didn't want these issues exposed. The fact that we've acknowledged that they're there, that we're ready to go ahead and move it, that to me is the biggest accomplishment of what this meeting is and wherever we go from there, I think, will only be a positive move.

DR. DUFFY: The -- let me say the thing that I think has come out of this meeting. It's actually been three recommendations. And it is the convening and the IOM convening, because I preened with the gentleman to my left, that having this content in this room adds a great deal of credibility.

The IOM can do this and the convening of the stakeholders, particularly the regulators, regulators who certify those accredit training programs and those who license the individual health professionals.

Convening that group to develop a common language -- and the word common language occurred in two of the groups. That's going to do more than probably anything else on this disk.

I see all of the others as actually being derivative or the receptor sites towards that action.

But then what I've learned at this meeting personally is: although I thought I had a pretty broad view of collaboration and interdisciplinary work, it's mind boggling how our languages and our cultures and our ways of doing things actually impedes the goals that I had truly agreed the gentlemen to my left espouses.

MR. WILLIAMS: Over the last couple of days, a couple of things I've heard relate to incentives to have some affect on reforming education. I think we need to give people a reason to change and demonstrate that this is the direction that education has to move.

We talked about adding ESP -- EBE (?) questions to the licensing exams. I think that'll move faculty in that direction.

Also building it into the regulatory process including training inspectors and health facility surveyors to be looking for those things. There is a tendency to do what either gets paid for or what people are looking for in the way of inspections.

DR. HUNDERT: One of the things we discussed about the Reactor Panel is that after a single go round with everybody answering one question, what I'd really like to do is have a format where we're going to throw out a couple of questions and ask only a couple of people who'd really like to answer that question to chime in, and then, open this up to the audience.

A couple of those questions, though -- one is, there has been throughout the summit this issue of is it two ships or is it a little tugboat and giant barge and so forth.

But with respect to, you know, by focusing our attention on health professions education, you know, how much room do we have to maneuver that in the context of the need to reform health systems, financing reimbursement, all these other things.

And that was our charge and I think the group did a very, very good job sticking with it. I was wondering if we could turn it around and ask if any of you have thought about the most important actions that policy makers and regulators and accreditors and so forth, that that could be taken by you to foster an environment for the reform of health professions education?

MS. CONWAY: I personally feel that we need some very compelling data as we describe what it is that needs to be different. We talk about evidence base being data driven and I think that as we describe this need in regulation or accreditation or certification, to be different, we need to have the data that drives it also.

DR. BERENSON: I guess I'd go back to my days as a medical student and house officer. And part of what I learned was some -- was diagnostic material and I could imagine this group could do very well with all the activities projected to get me a little more attune to using informatics, not only more in tune but have that being sort of a measure of performance or being able to work in multi disciplinary teams, et cetera.

But also, a lot of what I did back then was seeing role models emulating what senior people were doing, the faculty were doing and that was directly related to the bigger system.

And if the system gives incentives to not participate in multi disciplinary teams, that's when I'm going to learn even if somebody comes to a classroom and shows me a video of the potential benefits.

So I think you have to function at both levels, sort of simultaneously. The one thing that I guess I'm troubled -- and so it is clear that policymakers, that the level of policymaking that I was involved with, such as major public payment policy, et cetera, could redesign things in significant ways to be more -- to promote what folks in this room are trying to do.

And indeed, I go to meetings that discuss Medicare payment policy and we have -- we use the same language. We say how come our payment policy is silo. We pay hospitals based on their historic cost and we pay doctors based on their resource cost and it is not patient centered at all.

I'm interested in getting, sort of, the best results for the patient and paying based on the needs of the patient and not the needs of the institution.

So we have those very same conversations and there are proposals to reform it. I guess the problem is in, what I guess I would say is there's ultimately sort of the (inaudible) pressure but not change anything that even more fundamentally there's a cost associated with changing it, a cost to society, a cost to the programs.

And so, I can -- Ken Shine yesterday mentioned that the professions have given up in the role they have in cost containment and are -- still have sort of an important role to play on quality improvement.

And I think that's sort of an artificial distinction. I think it's probably an accurate reflection of the way things are. I think at all times you have to frame or formulate the issues, recognizing what those external bodies are going to be concerned about, one of which is cost, and be realistic going in.

I would have had the overarching statement include cost effective care, have that be on your turf as one of the qualities that you're trying to invoke in students and not go through some external regulators give them the authority to sort of arbitrarily deal with cost.

And so, I mean, I said a number of different things. But in summary, I guess what I would say is that public policy at the broadest level actually has very many of the same perceptions but always have this constraint on them.

And so, I think activities here need to recognize that and be more, sort of, proactive at anticipating what the regulators, the policymakers are going to do with these good ideas.

If incentive comes across as we need more money to be patient incentive and doing informatics, et cetera, it will come right up against constraints. And so I think that has to be built into any proposals or any suggestions for making the greater systems support the educational functions that you all want to do.

DR. HUNDERT: Dan.

DR. DUFFY: I think what the regulators can do is actually adopt the overarching objective and develop measures that will actually measure that overarching objective and hold ourselves accountable to those measures.

There's a step in between there. That's the heavy hand. Then the step in between there is while we're doing that, actually implement the quality improvement paragon that they want to be learned and we want to use in healthcare systems.

But we can't implement that valid improvement unless we know what it is we're measuring. We have the overarching objective but we need to take each of those five points within the overarching -- or six now -- that's in the overarching objectives, develop measures that we can use to determine how well we're doing on achieving the objective, and hold ourselves accountable in accreditation, certification and licensure for those.

MR. INLANDER: Well, I would take a different dimension here. Going out to the actual practice of healthcare and the licensing and the regulating from a public policy standpoint, which I think if we fundamentally change will fundamentally work to help change the education process.

For example, I would advocate that all state licensing boards be 100 percent consumer members and have no professional members on it. We have no nuclear plant operators on the nuclear regulatory commission or their board. There are no head teachers on the state or superintendents on any state board of education as formal members; they're only at hock.

We have a board that is basically saying the medical licensing function in this country has been one to protect the medical profession and not to protect the consumer.

If you turn that around -- Ed Swanky (sp) can do all that for us from a system advocacy side -- but if we turn all that around and start to make it patient centered at the basis of what level of incompetence we're willing to accept or what level of competence we should be expecting, then we're going to see a major change, as we should see, in the way professions are treated.

The second thing I would recommend, and it's a broader thing, is facing the fact that we're in the year 2002 and it's time that we deregulate doctoring as we know it.

We still have laws that are so archaic that protect no one except certain professional bases. In Connecticut it is still illegal for a midwife to deliver in any hospital in the state between six pm and six am.

And, you know, these kinds of laws that were written hundreds of years ago, not even hundreds - 50, 60, 70, 80 years ago, were meant to protect certain professions, not to protect certain professions.

Now, I'm not knocking doctors. Nurses do the same thing. They don't want people lesser trained than certain levels to do certain things and so on and so forth. That's archaic in this era of technology and better training. We can be training people and have trained people all across the way of delivering care to do all kinds of things that don't require having a BA in nursing or an MD degree or being a PA or other things.

And we can be delivering three quarters of the drugs from drugstores through ATM machines more accurately and know that we get the little card bits out that says what the side affects are and the Smart Card will for the first time report back to my doctor that I finally filled my prescription, who today he has no idea if I fill my prescription.

We can incorporate all that. But that's going to take deregulating to re-regulate. We have regulations that were basically set up 100 years ago because of Flexner, which was to get all packaged medicine in place.

It's time for a new look at regulating and if we do that, we will be then able to focus back on where professional education has to go. We are still denying very, very fundamentally sound ways to educate people who don't need to have the same professional degrees that we have today who are delivering all kinds of care, from home care and caregivers and all different types of settings that didn't exist when these laws were written years ago.

And if we do that and focus in on where the care is being delivered, who's delivering it, with pharmacists for the most part pouring from large jars into small jars and it's a high school kid who asks, you do you need information about your Viagra. It's sort of ridiculous. Shouldn't it be the other way around?

Let the kid pour it from a large jar into a small jar. He's got better eyes than we do. And the pharmacist should be out in front giving out the information that they've been so well educated to give (inaudible).

DR. DUFFY: That's even a great position to be put into.

MR. WILLIAMS: As a pharmacist, well, allow me to suggest that that's certainly the direction the pharmacy is moving in is to make the pharmacist out there in front with the patient, providing that information and letting technicians do the counting, pouring, ad licking and sticking and things like that.

I think we can provide a valuable service to both the patient and to the practitioners who wrote the prescription. I'm not quite ready to deregulate all of the health profession, but there is a need to take a look at the whole system related to even how people get on medical boards, pharmacy boards and things like that.

That system of appointment by the governor or even worse, election by the regulated, is not working very well.

DR. HUNDERT: Let me ask if anyone would like to answer this, and then after this question, I want to open it up to everyone because I hear they have questions.

But of everything you've heard, which are the things that you think -- if anyone would like to take a stab at this -- are actual steps that you actually heard that you imagine are really going to happen in the next year, let's say, from this conference, just to be a little provocative here?

DR. CONWAY-WELCH: Yeah, I think, what I was amazed at was the number of regulatory and accrediting groups represented who really seem to achieve a certain, significant level of consensus that they would go back to their boards and whatever and that they would foster a meeting that would pull all of them together in one place and actually have them talk together.

That seems to be a no-brainer. But the -- there was a level of enthusiasm that I thought was really quite encouraging.

DR. HUNDERT: They'll do anything for a trip to New Orleans, those people. That was the LSU-Tulane Group, ok.

DR. CONWAY-WELCH: I did have one point. It's interesting to me since doctors and nurses are the largest group in the healthcare profession, that we have no existing forums to get the deans of nursing and the deans of medicine and the associate deans of academics in nursing and in medicine together in one room to talk.

There just is simply no mechanism to make that happen. And as we talk about ways that the IOM can help and as we talk about the need to establish common language, starting off with a very small step forward of hosting a meeting where deans of nursing and deans of medicine, preferably those of the same schools but that's not critical, could actually have a forum to come together and talk about this word salad as misunderstood initials and activities, I think would be very helpful.

DR. HUNDERT: So, it sounds like the recommendation to get all the accreditors together at LSU Tulane, at least one person thinks that one's going to happen. I'd love to hear other thoughts from all of you on things you've heard that you expect will really happen in the coming years.

MR. WILLIAMS: In our group, I had at least three comments related to adding questions to the licensing exam, both medicine and pharmacy and that's something that I'm certainly going to work on after I leave here.

DR. HUNDERT: Great. Dan.

DR. DUFFY: Yeah, I think that this meeting or something like it is likely to happen. There seems to be a good deal of commitment around this room to have that happen. I think it will be the IOM; I'm not sure about that.

The other thing is that I do think some of the boards, at least with medicine, are moving ahead with the implementation of the, several of the areas, particularly the patient care quality improvement, evidence based medicine are being added and we're learning something about that.

What we need to do is learn more of the other professionals in that arena and we're not doing that.

The last thing I think is going to happen and surprisingly fast is the informatics, that it may happen despite ourselves because the technology may be moving faster than our thinking about it.

DR. HUNDERT: Great.

DR. BERENSON: I think what might happen is actually putting together sort of the case for the value added to the five or six components of the overarching, whatever it's called.

I think we -- as we heard yesterday, there are a lot of people who don't know that things are broken, who would be skeptical at many levels in the system and I think that -- we talked about this a little bit our group -- in fairly creative ways. Not just reports, but videos simulations, being able to go through a patient encounter or a patient history and sort of contrast what happens under a system where that is not patient centered, that is not human oriented, that doesn't informatics, et cetera, and one that does and try to make that case because I think until that case is made in a fair and compelling way, we're not going to have the major ships in the water really turning around. And I think that could happen.

DR. BAKER: I think that a lot of the work on the content is already going on. One of the difficulties we face is that there are silos around the content, as well, and the informatics people talk to each other and the quality improvement patient safety people talk to each other and the team people talk to each other and the evidence based healthcare people talk to each other.

And we need to be drawing the links more strongly. And one of the things the IOM could help facilitate is to think about ways to make linkages between those communities, the scholars and practitioners to try and identify ways in which they can learn from each other.

DR. HUNDERT: I'd like to open this up to all summit participants to ask any questions or comment react to what you've heard so far. I certainly would make one reaction, which is there was a comment yesterday that perhaps many of the deans of medical schools are complacent and don't think anything is broken and so forth.

And I'd just say from my perspective of having been in that world for a few years, I've met almost no medical school deans who think the system is working. And, you know, when they get together all we've talked about is how broken it is.

So, you know, one question I have is how much reaction to that comment as -- I think that was a very helpful comment because it woke a lot of people up. But I don't know whether I would take that as a take home message that deans of medical schools don't think the system is broken.

I think they absolutely do. I think that's what they wake up every morning thinking about. But that's just my own -- .

DR. BERENSON: -- If I could just interrupt for a second, I think that proof of whatever is in the pudding. I forget what the phrase is.

And when there are specific arguments over whether, I mean, my ordering patient is Medicare, whether Medicare should change its payments to hospitals or the physicians to, I think, be more coincident with this vision.

If not the deans, their representatives on the national associations are not in support and so I'm looking for that to happen.

DR. HUNDERT: Right. I was talking about health professions education, sorry. On a lot of these other things I agree. Yes.

MS. JUDITH LEWIS: My name is Judy Lewis and I am with the National Academies of Practice and I'd like to just think about what the last speaker said about reimbursement driving the system.

And I think as we start to reformulate the system with the patient as incentive, rather than as the healthcare provider as incentive and look at reimbursements based on value to the patient, not

necessarily the level of the provider that's providing the service that that's going to be a fundamental change.

And if we get to the point where we start to realize that the true captain of the ship or quarterback or whatever, this is really the patient and go from there, that that's going to be a fundamental change that's going to drive education and practice and informatics and all of these other things.

DR. HUNDERT: I do have to just share with you that up at the podium here after the comments that were made about the captain of the ship business, Don Berwick, after he finished his remarks, was relating a story he had heard of someone saying the physician is in the airline analogy is really the mechanic who makes sure that the aircraft, all the pistons are working and everything like that.

And that's a slightly again, different metaphor like calling in the plays from the patient to the quarterback or whatever. Yeah.

MR. FORREST CALICO: I would be interested in adding one piece to the mix, if I may. I really believe that values drive behavior and it's changed by and large at its root.

We've talked about patient centeredness as opposed to provider centric functions as we have now. We've talked about inter disciplinary training as opposed to silos.

And by the way, Ed if I may, I think there's one other way to look at this, you know, and that is that it depends on the play, if we're going to use a sports analogy.

Sometimes the pharmacist is the best quarterback. Sometimes the rehabilitation therapist is the best quarterback. Sometimes the nurse is the best quarterback.

So, it depends on the play that we're engaged in as to who ought to be the quarterback and who passes the ball in a given, as a disciplinary team, so just another slant on the sports analogy.

But to get back to the values theme, you know, this young lady sort of began to address that issue, I think. I believe that another intensely powerful driver for change would be our value of serving the under served. We really haven't talked about that here.

You know, we've talked about some very important issues but I would just like to throw out to the panel and see if there's any comment on that, that if, you know, our system -- let's, you know, our educational system really reflects our provider system, I believe.

And I really think we're designed to buy and large serve the insured and that in an era when the gap is widening between the haves and the have-nots, as we're all concerned about, we need to consider that particular level or lever in our health professions education system of revitalizing our commitment institutionally to serve the under served.

DR. HUNDERT: Could you identify yourself for the -- .

MR. CALICO: -- I'm sorry.

DR. HUNDERT: Okay.

MR. CALICO: I'm Forrest Calico with the federal Office of Rural Health Policy. Thank you.

DR. HUNDERT: Any reactions to either of the first two comments from our reactor panel?

MR. INLANDER: Well I agree with you on the under served and I think the under served are a growing, growing group of people for many, many reasons.

Obviously, we have the economically under served, we have inner city under served, we have rural under served, we have gender under served, we have disease management under served.

I think we are beginning to see probably more under served by the system, truly, than we are seeing served in an adequate way. And absolutely, there is institutional racism and there's all kinds of issues here.

But there's also institutional ageism that basically are letting the elderly get a lot of care, but not a lot of good care and getting a lot of care that they don't need, simply because they can get reimbursed, somebody can be reimbursed for that at the same time.

You see it all the time. It's quite obvious. The elderly themselves complain about it to deaf ears from the system, from their legislators and so on and so forth.

We seem to have this conflict that we keep throwing things out at people that's going to be enough without looking at what it is we're throwing out. And in that process, we're not serving people very adequately.

And piggybacking on that, and I think that some of the points that have been made in terms of the reimbursement issue -- you know, it's hard to tell, and being an old liberal, you know, it's hard for a person like me to say there's plenty of dough in the system, and there is.

We're throwing money away like it's going out of style on a lot of crapola and we know it. I mean, the system is, you guys, it's been in the study. It showed yesterday that it's been out there for years and years and years.

We're doing unnecessary surgery, unnecessary testing. And believe me, it's not liability that does it. I mean, when the c-section rate is going down they were raising their -- I mean, the liability rates were going up. So it's not -- it has also to do about medical malpractice insurance companies investments and the way they're regulated.

There's not much less and that's something else. The fact is, we're not spending money in the right places, we're not directing the money the right way.

That can be changed. That can be focused in the right places. And believe me, the practitioners will go to where people aren't if the money happens to go where the patient is, which is I think what the point was before in all this thing.

So, I agree with you. There's clearly the under served. But we can't just focus in on this group of under served because then the bubble pushes out over here on the other place as it always has and we've got to really look at the fundamental system that I think as the comment before was, that the money should follow, be attached to the patient, not attached to the system and if the money is attached to the patient then the care will come to where they are. They have a pot of money to deal with.

DR. BERENSON: Yeah, just to make it a little more concrete, to follow up on the question. I think it is needed in the type of faculty development and in educational programs, sort of to deal with the epic, the culture of the professions.

And I -- it was referenced yesterday so I went back and looked at it, which is the work called Medical Professionalism in the New Millennium of Physician Charter put together by the ODIM (sp) Foundation and European Federation of Internal Medicine.

It is fabulous and I really do think there needs to be a sort of an agreement amongst health professionals about what's the epic of professionalism. And they start with root fundamental principals, principal of primus of the patient welfare, principal of patient autonomy. I first looked at said well, oh there's that doctor autonomy and then I reread and say oh no, it's patient autonomy.

And principal of social injustice and then the set of professional responsibilities, which I think are wonderfully developed. And see, the sense I have is that -- and I know physicians that are in other health professionals that currently practicing physicians probably would not subscribe to many of these principals.

And I think that probably needs to be imbedded in educational programs as an explicit discussion of a new professional effort, that goes towards the nature of the question, which has to do with social justice, etc.

DR. HUNDERT: Why don't we go around, start here and carry on?

DR. DON DETMER: Don Detmer, Cambridge and University of Virginia. I just want to make two comments.

One, a clarification on the -- as a member of the Committee of the Harrison (?) Chasm Report. The concept of resource constraints and cost concern and such, as Bob mentioned, I think, is clearly in the committee's thinking and report pick up in efficacy, efficiency, timeliness and safety.

And the issue is that obviously you can't be efficient. Efficiency really does have to do with how you use resources wisely and so forth. Maybe it isn't as crisp as perhaps it could be but it clearly is absolutely a piece of the thinking of the committee as it did that.

I think the other comment I wanted to make though, that I think it's not maybe gotten quite as much attention here as it's going to need is the issue of passing the ball versus passing the buck.

There is this issue that sort of -- we are talking about accountability but accountability is -- can be a little slippery because you also need to have people feeling responsible and somebody being responsible and how the legal system plays into this. It's not an irrelevant issue.

There is a new group at the IOM that is pulling together, health law experts, to start looking at this inner play because there is a legal agenda in this move forward clearly that is there and it's a complex one, but it obviously also needs to be thought through and played out. Thanks.

DR. HUNDERT: We're going to take these four and then ask people to react to any of the four. Yeah, if you could identify yourself.

UNIDENTIFIED MAN: (Inaudible) from the Department of Veterans Affairs.

I was just (inaudible) report that came out two and a half years ago and one of the things I remember from the report, if I remember correctly, is that in five years the number of deaths from that gross event should be reduced by 50 percent and it's one of the recommendations.

I don't know who exactly was supposed to do that but that was the recommendation that came out of there. And so it's half way there, and so, time wise. So, I was wondering what the panel things as far as how long the trajectory to make that 50 percent reduction in five years now that we're half way there.

And if not, then what would you recommend to do in the next two and half years to make it a little closer, essentially in the area of education since that's what this is about?

DR. HUNDERT: All right. And one more and then, we'll (inaudible).

UNIDENTIFIED WOMAN: I guess I wanted to hear a little bit more probably reaction to that comment, which could lead into my comment.

DR. HUNDERT: Okay, reaction to the last two comments.

MR. INLANDER: You're not going to make the goal, point blank. First of all, I think the goal -- I think that the number itself was understated. It's not 48,000 to 90,000. It's probably closer to 300,000. Let's take sepsis as an example itself.

200,000 people in the United States die of sepsis in the hospital out of the 700 cases gotten. A lot of that is preventable. We have a lot of other notes of chromyl infections which aren't really counted in those numbers, half of which are preventable according to the CDC.

I would suggest that in the climate that we're in right now in terms of hospitals telling us they're understaffed or under funded or going out of business or whatever else, that we're going to -- that if we really studied hard these numbers are going to go up rather than going down because I -- and I think Leapfrog's first survey of where hospitals are is that we're not getting very far yet in this and it's going to take more than five years.

Further, I think that if you look at the trade press, look at the medical trade press and read what they feel about these standards, particularly the Leapfrog standards. It's wait and see, let's see if they do anything about this.

So, I don't -- I'm not very optimistic that those things are going to be implemented, at least I feel -- mainly because I don't think they are being institutionalized and I don't think we've had -- hopefully something like what we're talking about here can begin to institutionalize safety standards and other things.

But, I don't think we have a system out there right now that institutionalizes them. States aren't adopting it in terms of review. JCAH (?) is still looking to decide how it's going to do those kinds of things, I mean, and that's just the way life is.

So, I'd be very surprised, number one, if they've even gotten down at all. I suggest they might have gone up. And I'd be very surprised, if at any time in the near future, we even start to see the trend going down.

DR. HUNDERT: Other reactions, particularly to the last point that was made, which is the implications of all this for health professions education?

MR. WILLIAMS: I think we need to include the IOM reports in our educational process so that the students become aware of what the issue is so that they might be able to take some kind of action on their own because I think a lot of these things are going to happen person by person.

It may be the slow way of doing it but that's the way we convert people is one person at a time.

DR. DUFFY: Two, I really don't have any prediction on whether we're going to make it or not. I kind of doubt it.

The thing that's most troublesome is that the reports have suggested that these errors are systems errors and the thing that we don't have yet is an approach to the systems that comes through our medical education process of all of the competencies that have come out in the medical education arena, the systems based practice and practice based learning and improvement are the two that seem to be the most confusing to our professional education establishment.

So, I think we're a long way from correcting those errors.

UNIDENTIFIED WOMAN: And one of the areas I think that we are pointed to is the fact that close to a decade ago we looked at the reduction in the number of physicians in particular that we

had and planned on moving forward with that as it related to capping residency-training programs.

The IOM study, especially when we talk about under served populations, whether those populations are under served because of the economic and insurance base or whether they're under served because of their gender and definitely because of their color or their race or ethnicity.

So I guess as we move forward, one of the recommendations of the IOM study on unequal treatment was that we quicken in a hurry increase the number of physicians, in particular of color, and other health professionals in general as it relates to addressing the issue of unequal treatment as we move forward in the realm of quality.

And so I am very anxious in that as we move forward and as you have reacted to what has been going on, that we continually address this issue. It is important for us to address the issue of individual patients, but I think as it was pointed out in the IOM study, especially around patients of color that the inclusion of oppression around communities of color also be included in how we move forward in the delivery of quality healthcare because that's going to be critical because we're not all on even keels right now.

So, I am prayerful that when the meeting takes place in Tulane that we will sure up that the diversity of America is represented in that meeting, while everyone is enjoying that very diverse and cultural convening.

MR. INLANDER: May I ask a question? I have a question. I guess I'm interested in this because you made the statement just now, and I am very interested in your plus on this, that if we did more training of physicians than I would say other professionals of color, there was -- were you presuming that those folks are going to go back and treat those communities that are now under served, because the studies show that that doesn't happen?

And I'm wondering if there is other incentives that have to be put into place. The intensity is the providers go where the money is and they don't go whether they're -- regardless of color or economic base, they go to where the highest dollars are.

And so, are there some ideas attached to what you're talking about that will bring the care back to those communities that you're saying are under served from physicians of color and other folks that may do it.

UNIDENTIFIED WOMAN: I, you know, I'm -- the research coming from the IOM study pointed in the opposite direction. Given the fact that African American physicians, and because of our data source we don't have data -- the best data that we have now basically lumps all people of color into the realm of African Americans.

And the study has been that African American physicians, be it system or individual, actually patients feel that the quality of care that they receive from them is best, that they are looked at

parents whether -- with their patients whether those patients are referred to specialty care or not for a longer period of time.

And also many of those African American physicians that I'm talking about, how they are engaged in medicine through the pipeline, through high school, through college, through medical school has a lot to do with where they practice.

So, I'm checking some of the data that has come from the congressionally requested study and presenting that back—that, in fact, by increasing those numbers.

African American physicians right now post affirmative action make up 3.9 percent of the physicians that practice in the United States, yet African American people are 80 percent more likely to have diabetes, 40 percent more likely to have cancer and 30 percent more likely to have a cardiovascular disease.

So, if we increase by 500 percent African American worker students, we could never ever address the issue. So, we'd have to move along the lines in not only the pipeline but also physicians and assistants that exist right now.

So, yes. But as you know, the numbers of students of color that are entering professional schools are decreasing exponentially. And so we're going in the wrong direction. And I hope that we will be included in that discussion.

DR. HUNDERT: It's interesting to me, I'd just like to note that in some of these discussions about health professions education, when you're trying to think of some targeted outcome, especially around some value issue, people always look to the African pool and to the question of well, who's coming in in the first place.

And I remember yesterday in our Informatics Group, one of the central things was well, shouldn't we be requiring people to already be at a different level before they start nursing school, medical school, whatever, than we used to putting the financial illness onto the undergraduate school to do this rather than us doing it and so forth.

And, you know, I do think that of the different interventions that could be made in the health professions and certainly medical education, trying to find ways to ensure that the physician population mirrors the national population is an extremely important goal, only part of which is driven and it's important by the fact that there's every reason, I think, to believe that more under served will be served.

But, it's only one of several reasons why we have to do a better job with that.

One last question from the audience, then I'm going to ask one more question for everybody. Yeah.

UNIDENTIFIED MAN: Just a comment, people ask us pharmacy accreditation -- we've been through kind of a case study over the last 25 years taking ourselves from a product orientation to a very patient focused orientation.

We focused hard on education. The change has been slow. And the change has been slow, I mean, we have good progress. We have 30 states that have collaborative practice legislation right now that allows this kind of thing.

But it's the policy change that would make change that I think the IOM wants in terms of the timeframe that it wants because the educational change is a generational change. It's not a quick hit change.

And I think the way you pay people and whether they're threatening their parking space would probably have a lot more influence on change than how quickly we educate people who, in their time to get at our level, may be able to impact some things along the way.

DR. HUNDERT: Great.

Comments on the timeframe of these different changes?

MS. RIDENOUR: I think it always takes longer than you hope and I think this is time to begin to now and I think that I certainly feel that I've been much more encouraged about actual changes and to not just rearranging our chasm like that, so to speak.

And I think that we all came away with some strategies. And I guess one question that I would have is, if we truly all go back and say we want to do something similar, what are the resources at the IOM that we could tap into to say there are speakers that could come in and provide some of the emphasis that has been started.

And so, that's kind of a coming back to you with a question, but -- .

DR. HUNDERT: Right. Yeah, one of the next steps is that the committee that organized the summit is having another follow up meeting in September. And, you know, there have been a huge number of concrete suggestions that can be implemented out of this summit.

One of them, for example, is if we were to develop a kind of speaker's bureau where if, for whatever organization, whether it's a consumer group, a professional group, a student group, whatever, and wanted to have somebody to come in and talk about what are the implications of the quality chasm initiatives that's for health professions education, that you could find somebody who could come and meet with your organization leadership, with your group, whatever.

And I think my hope is that we're going to be tracking a lot of these very specific changes and trying to think about how to resource, and whether the IOM would themselves or they would try to find other funders, and so forth.

One of the most provocative though suggestions that I heard in the panel of seven was the one that came at the end, which was this statement that maybe we should have a health professions education national report card; very, to me, provocative and challenging approach.

And I was wondering if anyone here on the Reactor Panel had in their mind, if such a report card were to be developed, what would be one thing you would want to see on it as a measure that you think would be a measure of the quality of health professions education in this country in light of this conference? And just a few people who would like to -- yeah.

DR. DUFFY: I think the most important measure would be a measure of patient centeredness of the institution in which the health professions were being trained. I don't know exactly what that measure would look like, but a robust measure of the putting the patient first, organizing all of the care around individual patients rather than around any other unit or mechanisms measuring.

DR. HUNDERT: Colleen.

DR. CONWAY-WELCH: To take it a step further, it's interesting that we're focusing so much now on the patient as the driver and the patient as the center of the system and will cause change to happen.

Wouldn't it be interesting if we also thought that the student was the center of the educational system? And perhaps, if the focus moved to the patient and the student, that that might reinforce this whole idea that they are both highly valued.

And the students then may start asking some of the tougher questions because they themselves feel that they have been valued in the process and can transfer some of those learnings over to the patient, perhaps we could accelerate the change.

DR. HUNDERT: That says something patient centeredness, something about student centeredness too.

DR. BAKER: I think we really don't know what measures would work and I think we should put it out to the programs now and say well what things have you changed to increase the use of information technology, to make your program more patient centered, to think about quality improvement and patient safety, what are the changes that you've made and what evidence do you have that it's had an impact, both on education and on quality of care and put the onus on schools to come back to us and say what are they measuring, let's rate the temperature a little bit on that.

DR. CONWAY-WELCH: Well, and as for what they'd like to measure but don't have the tools for.

DR. HUNDERT: Any other thoughts about -- yeah.

DR. BERENSON: Just as a, I mean, I also agree with this sort of measures of patient centeredness, I'd even get more concrete and come back and measure whether every patient in a

teaching situation is able to communicate in his or her language or preference and have that be just part of the routine care as a very concrete way of demonstrating the primacy of patient centeredness.

I also wanted to just sort of -- maybe this is a little tongue and cheek -- but around sort of the timeliness this is going to change. I'm old enough now to remember when HMOs were a communist plot rather than a capitalist -- I didn't make that up. I heard that from others so I figured.

I go back and ways and the entire health system has changed and has changed five times. The one thing that it strikes me that hasn't changed much is medical education in my whole time period when everything else in healthcare has changed.

So, I am -- I'm from Missouri, I guess, and a little skeptical. I fully applaud what's going on here but I'm a little skeptical.

MS. RIDENOUR: I would like to see on the report card something around lessons learned. What is the institution able to really talk about when something goes wrong so it doesn't go wrong again?

I mean, I know it's imbedded around competency. If you can talk about what went wrong, you should be able to identify what it is that people need to understand or develop as far as their skill sets.

DR. HUNDERT: To me, there's a very interesting parallel process in a comment like that where the institution as an institution isn't engaging this practice based improvement in systems thinking, then it's unlikely that each of the individuals in it is.

And there's this reflectivity of the values was alluded to. And my favorite quotation comes from Mark Twain who once said, "To be good is noble; to teach others to be good is nobler and less trouble."

But what I want to do in turning it over, if you could stay up here for the wrap up, what I was going to do in turning it over to Mary to wrap us up is just thank everyone again for all of your participation in the summit.

From my own perspective, I think that what came out at the very end here, when you really say, if you were going to grade all this, what would you grade.

And it comes back to this individual relationship centered thing, which is patient care and education. And the parallels there are sort of obvious to everyone.

People talk about philosophies of health professions education. I think my own really is informed by an interest that my wife and I have in comparative religions. We spend a lot of time traveling around trying to learn about different world religions.

And when we were trying to learn about Hinduism on one of our trips to India we had this remarkable teacher who told us that there was a philosophy because Hindus believe in reincarnation, that of course, there's this idea that in fact through most of history likelihood that you could die while your daughter was still of child bearing age -- and my wife and I have three daughters.

So there's this philosophy of how you should raise your daughters which goes something like this -- you should raise your daughter as if you might be raising your own mother because you be -- so, you know, true that there is -- it's a rather mind blowing thing to think about. But (inaudible).

So it's that you could in theory be reincarnated. It's true that there is no branch of Hinduism where this could ever happen but just as a possibility, you should raise your daughter as if you might be raising your own mother as a philosophy.

And what does this have to do with anything? Well I think in health professions education there is this philosophy that I think we need to convey that comes out of the last statements, which says you should train your doctors, your nurses as if you might be training your own clinician. You should train your own nursing students as if they might turn out to be your nurse, train your medical students as if they might turn out to be your doctor.

And extremely, given the relative ages of most of the people in this room -- this is, see I don't actually know about reincarnation, but I do know that these are the people who are going to be at the peak of their careers shortly when we need them the most.

So, I think the take home message that you have to take health professions education very personally.

So with that, I'll turn it over to Mary.

MS. MARY WAKEFIELD: Thank you very much, Ed.

And I know enough of you in this room to know that I'd give my life -- put my life at risk to stand up here for longer than 60 seconds, so let me just make a couple of quick comments.

First of all, in terms of next steps for this specific effort -- as you know already, the Institute of Medicine Committee will reconvene again in September and at that time we're going to be reviewing a draft report from this Health Professions Education Summit.

At that time the committee will also be considering, suggesting recommendations for the report that the committee members think are important to incorporate into that report, important in terms of moving health professions education reform forward.

To the extent that as we review the materials that you have generated over the last two days, to the extent that we see, and I know we will, some very compelling cases for recommendations to capitalize on your key areas presented and discussed here, then the committee may well choose to bring up and highlight some additional suggested recommendations.

That report is slated to be available by the end of this calendar year, so it's around that time that you can start to look for it.

I also want to say, just to sort of summarize our intent and approach here, that this effort, this Health Professions Education Summit, was really designed recognizing that in order to achieve a very significant change in health professions education, that that change was fundamental to closing the gap, closing that chasm between the quality of healthcare that is delivered today and the quality of healthcare that we collectively know should be available to the public.

We know -- at least I think I can speak for the members of the IOM Committee -- that changes in health professions education for reforming education is essential to crossing that chasm.

It's not optional. We can't go part way. That bridge isn't going to take us there unless health professions education is reformed in very significant far reaching ways.

And to that end, that's why many of you or basically all of you were brought here to participate in helping to inform thinking about how we might reform health professions education.

And I have to say that, Bob Berenson, we on the committee share your concern about the magnitude of this effort. This is not easy. We've put a lot of effort into this and it is absolutely our hope that we will be able to move this health professions education reform agenda forward.

And I have to say we are a little bit optimistic about doing that this time around. We're optimistic for a few reasons and I want to share them with you because I think to some extent they distinguish this effort from previous, very notable efforts, some efforts of which many of you in this audience were actors and other previous reform efforts to which some of you were students of.

This effort, we think, is a little bit different though for a few reasons. First of all, we think it's different because the IOM took a different approach. It allowed the involvement of a wide, far-reaching very diverse group of individuals represented in this room today and here yesterday to engage in trying to discover and push solutions to addressing some of the challenges that we've been talking about.

So, rather than a small cluster of individuals, 20 around a table, we really opened this up to bring some of what we think are the most knowledgeable experts in this field who have a stake in this together from very different walks and avenues, different places, different locations in terms of where they do their work.

So, we think that you collectively brought together bring a different dimension, a different set of views and action steps that can be put in play effectively.

We think that's true because while we're ultimately going to be producing a report, that report does not stand on its own. That report, we think, is accompanied by the action steps that each of you have one way or another committed to doing over the last couple of days.

So we're operationalizing this effort differently than we have to other reform efforts historically. We're casting a different web. This web, if you will, covers and connects very diverse stakeholders at multiple levels who are able to engage in very different actions, locally, regionally and nationally.

So, we'll look forward to more leadership from federal agencies. We'll look forward to more leadership from the Institute of Medicine. But you know what? We're looking forward to more leadership from each of us in this room and the individuals who we can engage within our own associations, committed to moving health professions education reform and viewing it as absolutely critical to crossing that quality chasm.

So, we're optimistic for that reason. We're also optimistic because the environment in which we're operating with health professions education today is a bit different than it's been historically.

That is we've got, as all of us in this room know, increasing and sustained awareness of compromises in the quality of healthcare delivered in the United States and Canada today.

So, that interest on the part of many stakeholders beyond those in this room really continue to shine a light and give lift to efforts to improve quality and efforts to improve quality of healthcare, I don't think, can move forward very far without also addressing and making changes in the training and educational efforts of the individuals who will be working in those healthcare systems.

So, an additional attention being placed on quality in health provides us with a window of opportunity.

The environment's also changed because we've got changes in demographics. What people need to serve their demands and their healthcare needs are different.

Our demographics are changing and the associated healthcare needs of the company, both changing demographic, also calls for changes in what and how we're educating our healthcare professionals.

And finally, associated with that -- let's see, I thought I had a fun point. Well, you get the drift, you get the drift.

And thank you for bailing me out. And as we -- the drift is, as we continue our efforts through the rest of this year on this Institute of Medicine Committee, we're really going to be looking forward to hearing and learning about the launching of various actions that you've thought about in the last couple of days and that hopefully you'll be catalyzed to think more about over the course of the next few months.

Finally, I'll just leave you with a variation on someone's comment that for me puts it all fairly succinctly and that is that when we think about crossing the quality chasm, reforming health

professions education is the bridge that absolutely has to be built to allow that crossing to happen.

Thanks so much for being here with us to help set the footings for that bridge today. Thank you and thank you.

END

© Federal Network, Inc.

www.fednet.net

202-393-7300