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EDITORIAL

Arthur C. Bachmeyer Memorial Lecture 2010

Each year, the American College of Healthcare Executives (ACHE) sponsors the Arthur C. Bachmeyer Memorial Address. This lecture is underwritten by the Alumni Association of the Graduate Program in Health Administration and Policy at the University of Chicago and serves as a tribute to Arthur C. Bachmeyer, MD, founder and former director of the program and a charter fellow in the ACHE. I had the privilege of delivering the 61st Annual Bachmeyer Address in Chicago this spring during the ACHE Annual Leadership Conference.

Following is an abridged version of my lunchtime comments to more than 1,500 assembled healthcare leaders from across the nation.

Good afternoon. Thank you for the privilege of addressing you here today. I am humbled to deliver the first Bachmeyer Memorial Address of a new decade. Although the previous decade could be described as one of despair, downsizing, disappointment, deceit, disillusionment, derivatives, debt and default, I refuse to be downtrodden!

As a student at the Wharton School of Business at the University of Pennsylvania, I learned from Professor William Kissisk that a good luncheon address could be readily divided into three sections. One should first point with pride at specific accomplishments, view with serious alarm developments in the environment, and finally, end with hope for the future. As a result, my presentation today will point with pride, view with alarm and end with hope.

In 2002, I underwent a spinal fusion for a high grade spondylolisthesis, which was effectively shearing my left sciatic nerve. I am pointing with pride at the high level of technology that enabled me to undergo such a procedure that allows me to remain essentially pain-free. I point with pride at the skill of Dr. Todd Albert, the chair of orthopedic surgery at Thomas Jefferson University Hospital.

I also point with pride at my family, including my physician wife, my fraternal twin daughters and my son. My daughters are the products of a special invitro-like procedure called gamete intra-fallopian tube transfer or GIFTT, so I am grateful for the access to such amazing life-giving technology.

I also point with pride at my role in the November 2006 publication of the Pennsylvania Healthcare Cost Containment Council Report entitled, *Hospital Acquired Infections in Pennsylvania.* This report, the first of its kind in the world, collated and disseminated data that made hospitals in Pennsylvania accountable to the pubic regarding their associated HAI infection rate. Publication of this report led to front page stories in *USA Today* and *Modern Healthcare.* I am proud of the role our team played in promoting the concept that *sunshine is the best disinfectant.* While the report showed widespread unexplained clinical variation, within one year of publication of this report, HAI in Pennsylvania decreased by nearly 8½%. I am proud of the commitment we made to public accountability and to the improvements in quality and safety that have resulted.
Finally, I'm proud of the fact that major leaders in academic medicine have written in the *Journal of the American Medical Association*[1] that when all is said and done, academic medicine has a single mission – to improve the health of the population. This is a watershed event that outlines the importance of the commitment we must share to improve population health.

I view with alarm a number of recent developments in our environment. The recent passage of health insurance reform ignores three of the four pillars of health reform, namely: the inability to demonstrate value for the dollars spent, the lack of care coordination, and little mention of our need to promote wellness and prevention. While it is laudable that we have extended coverage to those currently uninsured, ignoring the aforementioned pillars will create many unforeseen challenges.

I continue to view with alarm the growing burden of unexplained clinical variation in our day-to-day practice. While most clinicians do not recognize that a minority of our decisions at the bedside are based on solid evidence, the people who pay the bills clearly are cognizant of this fact. The evidence is overwhelming that autonomous decision-making without a solid evidentiary basis leads to waste and a propensity for medical error. Furthermore, nearly a decade of published work points to the fact that there is uneven adherence to the evidence when it does exist, and that the American healthcare system gets it right just about 55% of the time. This uneven adherence to the evidence is not indicative of poor doctoring but is, in part, a reflection of widespread system failure.

This widespread system failure is also chronicled in *To Err is Human,* the famous Institute of Medicine (IOM) Report published in 1999. This report made it socially acceptable to discuss the epidemic of medical error in our country. A May 2009 report in *Consumers Union* gives our healthcare industry a failing grade with regard to reducing medication error, stating that "to err is human, but to delay is deadly." We must get beyond the conversation focused on simple things such as hand washing and penmanship and tackle the more difficult issues of systems failures that lead to error. Healthcare will never be error-free, but we must strive for care that is harm-free.

While I applaud the influx of federal monetary support for comparative effectiveness research (CER), the study of what really works in medicine, I note with alarm that there is an explicit statutory limitation on the output of such research as the stimulus bill prohibits CER from being tied to any form of reimbursement. In short, even when we find out what does work, we will not be able to explicitly pay for it! Also, the IOM has published a list of the top 100 fertile areas for CER work. These include things like the appropriate therapy for atrial fibrillation, advances in hearing technology, and the study of fall prevention in the elderly. These are the bread and butter building blocks of primary care and it is noteworthy that the IOM enumerates these seemingly basic issues.

I also point with alarm at the growing anachronistic structure of the modern voluntary hospital medical staff. Medical staff leadership can be described by three tongue-in-cheek tenets, including, 1) "you missed three meetings, now you're president-elect of the medical staff," 2) like the Marx brothers of old, "whatever it is, I'm against it," and 3) a vote of 200

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to 1 constitutes a "tie" in most medical staffs. There is a persistent and false view that medical executive committees, meeting one evening per month, can manage the growing quality and safety agenda.

Boards of trustees at most voluntary community hospitals remain bamboozled regarding their role in quality and safety. Recent evidence suggests that only about one-half of all not-for-profit hospitals have a board committee devoted exclusively to this key fiduciary responsibility. And finally, I point with alarm at a recent National institute for Occupational Safety and Health Survey that notes "healthcare workers are actually experiencing increased numbers of occupational injuries and illnesses over the past decade; …by contrast, two of the most hazardous industries – agriculture and construction – are safer today than they were a decade ago."[2]

Despite all this, I am hopeful for the future. American medical education, led by such organizations as the Institute for Healthcare Improvement, seems willing to embrace the quality and safety agenda. I am very hopeful that great medical schools like Jefferson Medical College will continue to expand their commitment to curricular reform and include such things as health policy electives, joint MD/MPH degrees, and a special focus on training medical students in improving patient safety. I view all of this as an effort to appropriately redefine professionalism.

I am heartened by the development of a new disruptive technology, namely, non-human clinical simulation. I point with pride at the creation of the Simulation Center at Thomas Jefferson University where all new house officers are required to demonstrate their technical competencies prior to their rotations in the hospital. I am encouraged by the Association of American Medical Colleges (AAMC) demonstrating their commitment to the quality and safety curriculum by dedicating an entire issue of *Academic Medicine* (December 2009) to this important topic. We are making progress in moving this cultural boulder uphill.

Let me leave you with two closing thoughts.

High quality health care must cost less. The only way to reduce cost is to reduce waste. If we use the right drug, on the right patient, for the right indication, at the right dose, we will achieve a good outcome at a lower cost. This patient will leave the hospital sooner, will be happier, and will tell ten potential patients about the positive experience they had.

Finally, since I am speaking to a room full of leaders, I want to remind you of the admonishment from John P. Kotter, Professor of Management Science at the Harvard Business School, that "The institutionalization of leadership training is one of the key attributes of good leadership." I want to thank you for the opportunity to address this group today and to thank the ACHE for all of the leadership training they provide to help prepare the leaders of tomorrow. Thank you and God bless you.

Well, there you have it. It was a heady experience to address a room full of healthcare leaders from across the country. My comments were very well received and many persons came to speak with me directly at the conclusion of my presentation. The Bachmeyer lecture was followed by a Fellows Forum, where I met in private with nearly 70 attendees to continue the conversation.

The Jefferson School of Population Health is committed to educating leaders for the future. If you had to point with pride, view with alarm, and end with hope for your own organization, what would you consider? ■

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As always I am very interested in your views. You can reach me my email at: david.nash@jefferson.edu

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