COLLABORATIVE HEALTHCARE
INTERPROFESSIONAL PRACTICE, EDUCATION, AND EVALUATION

A Provocateur for Improvement

David B. Nash, MD, MBA
Founding Dean Emeritus, College of Population Health
Dr. Raymond C. & Doris N. Grandon Professor of Health Policy
Thomas Jefferson University

I like to think of myself as an internal champion for improving the quality and safety of medical care that we deliver at Jefferson. A central tenet of our work together at the bedside is that care can never be error free because we're working with people. Our goal should always be to make care harm free.

As a result of my dedication to this notion of harm free care, I would like to review some key milestones in my 30 years as a faculty member and connect the dots between my work and certain events. Here is the punch line upfront: burnout among healthcare providers coupled with moral injury, structural racism, misogyny, and lack of transparency, are all known contributors to increasing the number of medical errors and harm to patients. In fact, in 2022, the top four leading causes of death in our great country were heart disease, cancer, COVID, and preventable medical mistakes (NIH, 2022)!

I cannot summarize three decades of work in the space allowed here but let me outline half a dozen milestones in chronological order that reflect the arc of the history of our field and my three decades on the campus.

In August of 1991, I was the second author on a very important paper in the Journal of the American Medical Association (JAMA) (Williams & Nash, 1991) that described the differences in outcomes from open heart surgery in the five major academic medical centers in Philadelphia. This paper (along with papers from other investigators at Dartmouth Medical School) is generally noted as one of the key milestones in the beginning of the outcomes movement.

When my article debuted, I had to literally hide in the CEO's office at Thomas Jefferson University Hospital, because the surgical leadership at Jefferson at that time was adamantly opposed to the publication of surgeon-specific outcomes for procedures like open heart surgery. This was a very scary time for me personally, as I had only joined the faculty one year before. It was a harbinger for many subsequent events related to promoting transparency, and lifting the veil of secrecy that generally surrounds what physicians, nurses, and other health professionals do every day.

The second milestone was in September of 1999, when the National Academy of Medicine (NAM) published the now famous report, To Err Is Human (NAM, 1999). This report made national news for days and I participated in an Associated Press (AP) wire story covered in hundreds of newspapers. When I noted that that the book contained some path-breaking research and that it was true that errors were widespread, I was summoned to the President's office at Thomas Jefferson University for a face-to-face dressing down about my comments to the AP reporter.

In September of 2005, I was asked to investigate three pediatric deaths at a children's hospital in Hartford, Connecticut. I dutifully went to Hartford to investigate on behalf of the Commissioner of Health for the state. He then deliberately leaked my private report to the *Hartford Courant* while I was there. I was shocked that my private report ended up on the front page of a major Northeastern newspaper (see Waldman, 2005). I learned a tough lesson about the bare-knuckle politics involved in quality and safety.

In October of 2006, I participated in a press conference at the National Press Club in Washington DC, declaring that we were going to coin a new term called "Hospital-Acquired Infection" based on the work I was doing with the Pennsylvania Health Care Cost Containment Council located in Harrisburg. This press conference was carried on a page one story in *USA Today* (Appleby, 2006). It resulted in numerous phone calls and difficult subsequent interviews in my attempt to explain how

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healthy persons admitted to most hospitals in America were at risk for acquiring an infection that they did not have when they were originally admitted.

Additionally, from 2006 to 2017, I had the major responsibility of creating and managing a special one-day program for Sidney Kimmel Medical College (SKMC) third-year students entitled "Interclerkship Day for Quality and Safety" with faculty we recruited from our campus and around the nation. This one-day program exposed the third-year students, for eight consecutive years, to the basic tenets of quality and safety. I learned a lot from the hundreds of students involved in this program over nearly a decade and they were very forthcoming about the errors they personally witnessed, even in the first six months of their clinical training. The results of this Interclerkship Day experience were published in the scholarly quality and safety literature (see Moskowitz and Veloski, 2007).

In 2022, I co-authored what has become a major national bestseller, a book entitled *How Covid Crashed the System, a Guide to Fixing American Healthcare* (Nash & Wohlforth, 2022). I poured my heart and soul into this book, to explain to the public some of the major shortcomings in our $4 trillion unsafe and highly variable healthcare system.

These six aforementioned milestones contributed to a major self-reflection with my physician-wife of 42 years. As a result, we committed to endowing the first ever trainee prize in improving the quality and safety of medical care at Jefferson. To our knowledge, no comparable prize exists anywhere in our great country to recognize nurses, pharmacists, physicians and others, at all levels of training and expertise, as they contribute to reducing harm in our system.

I embrace the core mission of JCIPE to promote teamwork and leadership training. I am convinced after 30 years of work in this field, that collaboration, coupled with effective leadership training will save lives. I am looking forward to awarding the Nash Family Prize to future generations of healers, as we work across all levels of expertise, to promote our core mission.

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