Lessons from a Hospital CEO

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Learning Objectives

• Managing crises: Lessons Learned from 45 years in health care, including 26 as a hospital CEO
  – Balancing organizational and public interests
  – Providing effective leadership in a crisis

• Understand the Three Victims in a Crisis
Lessons From Crises at Children’s

- 1980 “mystery” virus
- 2001 surgical error
- 2004 cedar fires
- 2006 child pornography cases

The “Mystery Virus” of 1980

- Three infant deaths
- Act in the public interest - “do no harm”
- Communicate what we knew and didn’t know
- Balance transparency and privacy
- Positive public response – laudatory Union Tribune Editorial
- Winning the Diogynes award for honesty
The Surgical Error of 2001

- The importance of an immediate apology
- Getting to the root cause – a “just culture” vs. a “blame culture”
- Creating our “beyond blame” video story – “unsung heroes”
- Our “promise” to the family
- Repeatedly telling the story to every employee and physician year after year

The Cedar Fires of 2004

- The fire came within 2 miles of Children’s
- Mission over margin: ready to evacuate the hospital within one hour!
- Plan A our individualized “care buddy” system
- Be flexible
  – Plan A vs. Plan B
  – Changing circumstances – shifting smoke
- Multiple lines of communication
- The outcome – no lives lost – no media interest
Lightening Strikes Twice: the Child Pornography Cases of 2006

- A 26 year male employee is accused of trafficking in child pornography, possibly involving our patients

- One month later, a second male employee is accused of a similar crime

- Balancing our needs to protect patient privacy with law enforcement’s needs

When Lightening Strikes (continued)

- Handling the media frenzy while protecting privacy
- Involving all relevant agencies
- Employees feeling betrayed – sharing and acknowledging feelings
- Promise and deliver changes
- The subsequent public response – letters, philanthropy, and awards
Sharing Lessons Learned

• “How A Children’s Hospital Discovered Child Pornographers in Its Midst” by Blair L. Sadler, Narrative Matters, Health Affairs, (September 2011), vol. 30, no.9, 1795-1798.

• ‘Preventing The Exploitation and Abuse of Children,” Letter by Carole Jenny, Health Affairs (April 2012), vol. 31, no.9, 883.

• ‘Preventing Child Abuse: The Author Replies by Blair L. Sadler, Health Affairs (April 2012), vol. 31, no. 9, 883.

The sea change from protectionism to transparency

• With the internet and increasing public expectations, some old rules no longer apply

• Protectionist legal and media advice may be bad advice

• Prompt, appropriate public disclosure and apologies decrease, not increase, legal & financial risk
Mars vs. Venus: Two Contrasting Approaches

- 1982 – Johnson & Johnson Tylenol Crisis
  - (prompt, transparent, leader takes charge and assumes responsibility – leadership acts in the public interest)

- 2011 – Pennsylvania State University Abuse Crisis (delay, obfuscation, no one takes charge or assumes responsibility – leadership acts in their own interest)

The Three Victims in any Crisis

- 1) The person(s) directly harmed

- 2) The employees and others directly involved with the organization

- 3) The organization’s reputation, image, and legal/financial risk
Lessons Learned: MY Guiding Principles from 40 Years on the Front Lines

• Commit to transparent and consistent internal and external communication
• Provide prompt and proactive communication
• Balance transparency with privacy of patients, families, and employees
• Share feelings: empathy, outrage, sadness, and anger

Lessons Learned (continued)

• Provide visible CEO and senior leadership involvement
• Throw away your calendar -- involve all stakeholders around the clock
• Fully collaborate with relevant agencies
• “Own” the problem yourself
• Be cautious of delegating media leadership to an outside firm
Lessons Learned (continued)

- Do the right thing
  - Put mission before margin
  - Act in the public’s interest
- Provide media training
- Have a crisis communications plan
- Provide prompt apologies
- Promise to correct the error and do so
- Share lessons learned

Your Organizational Assessment: A Roadmap

- How prepared is your clinical team to effectively manage a crisis?

Questions?

Contact bsadler@ucsd.edu

Six Areas of Focus

1. Organizational Culture
2. Insurance & Legal Counsel
3. Policy, Guidelines & Practice
4. Training
5. Disclosure
6. Learning From the Crisis
1. Organizational Culture

The organization, board, and leadership are grounded in the core values of compassion and respect, and the responsibility to always tell the truth

Harm is seen as the failure of systems and not people, and is considered in a fair and just culture with policies and practices.

2. Insurance Carrier & Legal Counsel

There is a written understanding of how cases will be managed with the insurance carrier and with legal counsel. There is a commitment to rapid disclosure, compensation, and support. Mechanisms are in place for rapid, respectful resolution.
3. Policy, Guidelines & Disclosure

There is a policy on compassionate patient, family and employee communications.
Informed consent policies and practices are up-to-date and effective.
There are policies on disclosure and documentation including procedures for internal and external communications. There is a written crisis management plan.

4. Training

Training programs are in place for staff on communication, expectations, policies, procedures, guidelines.
There is just-in-time coaching (training) for disclosures.
There is media training for key personnel.
5. Disclosure Policy & Processes

The organization is transparent and takes responsibility for its actions.
There is rapid notification of persons harmed and activation of support.
There is a team to support staff in preparing for disclosure.

6. Learning From the Crisis

The organization conducts a thorough objective assessment of the crisis.
Outside advisors are used where appropriate.
The organization is continually learning and improving its practices.
The organization shares lessons learned.