Speech made by :
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"The following quote comes from Hippocrates Epidemics Book One:

'As to diseases, make a habit of two things – to help, or at least, do no harm.'

I have been a part of the management of Forsyth Medical Center and later Novant Health for 38 years, and its CEO since 1985.

During the past 23 years, we have grown from a single 700 bed hospital to a 16, soon to be 18 hospital system, with 1,050 associated physician practices. Our revenues have grown from $80 million to $2.9 billion. Cash reserves increased from $40 million to $1 billion, and we have enjoyed the elite credit rating of AA… in hospital administration terms… a successful run.

But I would like to share with you a risk management report that challenged my personal perception of what my job as CEO should focus upon.

I'm going to read this summary to you, which I know is not a preferred characteristic of a good speaker. But I have learned that reading this patient account is the only way I can share it without taking too many pauses to collect my emotions, and my resolve.

Samuel was born March 24th, 2004 to a 19-year-old single mother – her first pregnancy. From all accounts, she had received good prenatal care. Six months into her pregnancy, she experienced ruptured membranes and premature labor. During delivery, the baby presented foot first and because of this and other problems during labor, the mother underwent a cesarean section at Thomasville Medical Center, a community hospital that's part of our health system.

Samuel weighed one pound-nine ounces and required intubation with a breathing tube and mechanical respiratory support. After being stabilized, he was transferred to the Neonatal Intensive Care Unit at a tertiary medical center outside of our region because our local units were at capacity. There, he was placed on mechanical respiratory support for five days until he was strong enough to breathe on his own.

His mother lived with her family about 90 miles from that NICU, so she requested that her baby to be transferred closer to home so she could more easily be with her newborn son.

Now two weeks old, Samuel was transferred to the NICU at Forsyth Medical Center where he could be closer to his mother and receive further medical care for his prematurity. His weight was now one pound-eleven ounces. Things went well with our tiny patient; he was able to tolerate increasing amounts of formula and needed less supplemental oxygen. The family was able to visit more often now that the baby was closer to home. Our social

workers began working with his mother to help prepare for his needs after discharge. Samuel was progressing well and everyone close seemed optimistic about the weeks and months ahead.

Then, at one pound-15 ounces and 24 days old, he developed signs of pneumonia and became clinically unstable. His breathing got worse and he once again required mechanical respiratory support. His medical team suspected an overwhelming infection, so cultures were taken and they preemptively started him on broad spectrum antibiotics. The cultures grew Methicillin Resistant Staph Aureus, which we all know as MRSA.

Samuel was placed on Contact Precautions in conformance with CDC guidelines. This protocol is used to alert caregivers to the MRSA infection and to protect against transmission of this organism to other babies in the unit. Samuel's status rapidly declined despite being on the best antibiotics for his infection. In about one day's time, he developed severely low blood pressure

which was unresponsive to therapy, and his blood chemistry parameters also deteriorated. His overall condition became consistent with “overwhelming sepsis.” Despite the best medicines, the best technology, and compassionate care, the infection won. Samuel was 28 days old. He died in his mother arms, as she held him bedside in OUR nursery.

Our NICU had rarely experienced MRSA infections over the preceding ten years – only a few infections had ever been documented in its 30 years of existence. During this case, the staff agonized about the origin of the MRSA – where did it come from? Could this be the beginnings of an outbreak?

A screen of other infants in our NICU discovered four more babies with MRSA. Clinicians could never confirm which baby brought the MRSA into the unit. But it **was** clear, that because of lapses in standard precautions by caregivers within the unit, MRSA had now spread to five babies, with our patient’s death as the heralding event. Our unit’s nurses and caregivers were

devastated because they know the science – that through adherence to best hand hygiene practices described **over 160 years ago** by Hungarian physician Ignac Semmelweis, our hospitals can actually prevent the spread of these deadly organisms to our patients.

We don't know all the answers to our many questions in this case, but what we do know is that because of this organism and the associated outbreak, 18 infants in the NICU either became infected with or colonized with MRSA. Two other infants died during this outbreak, but their primary cause of death was not the MRSA infection, but it served as a contributing factor because of the infants' extreme prematurity.

The spread of MRSA in the NICU was a direct result of staff and physicians not washing their hands appropriately before, in-between and after caring for these infants. What an enormous cost to pay for neglecting the very simplest of precautionary measures of Infection Control. The true cost had been in human

life, but there was also the significant loss of honor and pride among clinical staff who personally accepted their failure, in careers they devoted to saving life, instead of taking it. The failure was not theirs alone, because others shared in this collapse of priorities.

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My objective today is not to share with you the details of our health system's goal to dramatically improve hand hygiene. I will briefly comment that for the past **36** months, we've been relentless. You'll see a few of our key messages on the screen as I finish my remarks.

Today, my objective is to confess. I have spent very little time inside a NICU during my 38 years as a hospital administrator and health system CEO. Nor have I ever discussed in-depth strategies with infection control staff about how to better prioritize proper hand hygiene. Those specific activities are really not part

of my job. During my career, I have focused on "*executive*" work, my own definition of an administrator's important role. And I have provided NICU and Infection Control with "resources" – such as facilities, technologies, skilled people and training – all things that I usually authorized in a budget and approved on a requisition. Those duties have been and still are part of my role, while **other** staff and leaders assume responsibility for deploying those resources, and for making sure they are properly used. But despite that delineation of roles, I **am** accountable for those unnecessary deaths in our NICU. It's my responsibility to establish a culture of safety. Up until the time I read the document about the young mother's loss of her newborn son, I had been unintentionally relinquishing that duty: in effect, delegating it to others without letting them know they had a responsibility to perform. **I'm** responsible, as CEO, for creating the environment in which every staff person prioritizes proper hand hygiene, and mourns the human consequences of failure.

That's my job, more so than the clinical staff who provide the care.

They see their role as very personal, an interaction with a specific, vulnerable patient in every encounter. This experience brought me to that realization as well…this is not about volumes, or revenues or occupancy rates…it's about that single patient, dependent on us for their very life and health. This has to be about them, each and every one, and what we do to fulfill our obligation to provide them with the best care that we can provide. Anything less is a compromise that we can not accept; that commitment is why we are in healthcare, not in the fields of manufacturing, retail or investment banking. If YOU, as healthcare executives, cannot see the face of YOUR child, YOUR grandchild or other relative in the place of Samuel; if YOU are not able to see the face of the distraught nurse (as in my case, my wife or my daughter) or physician, who agonizes over an adverse outcome caused by their hands for their patient, I suggest your

executive talents would be more appropriate in those other businesses. You and I have an incredible obligation and responsibility, and we need to bring it to a personal level in order to deliver what our patients deserve.

All of us understand the dangerous consequences of healthcare staff working under the influence of alcohol or drugs – we would never tolerate a work environment that allowed behavior so reckless. We've successfully created a culture in which all staff believe that working under the influence is unsafe and dangerous to life; staff accept self-control and, as a result, our disciplinary system rarely gets used. After reading that one single risk management report, about Samuel, and about our lapse in proper hand hygiene, I concluded that I had been tolerating an environment just as dangerous as having impaired staff.

Our hand hygiene efforts at Novant Health will succeed when every employee rejects poor hand hygiene behavior with the same passion as they would working under the influence of drugs

and alcohol. It's that type of culture that we as leaders are obligated to create. I'm hoping my experience can serve as a wake-up call for you and my other colleague healthcare leaders.