

View From the Top: An Interview With Patient Safety Authority Chair, Dr. Nirmal Joshi

By **Nirmal Joshi, MD[†]** & **Caitlyn Allen, MPH^{*♦}**

DOI: 10.33940/001c.74081

Submitted: February 22, 2023 / Accepted: February 22, 2023

In 2002, a dedicated group from Pennsylvania passed the Medical Care Availability and Reduction of Error (MCARE) Act, the most robust state-level legislation of its kind. Its legacy remains 21 years later. Patient Safety Authority chair, Dr. Nirmal Joshi, sat down with *Patient Safety* managing editor, Caitlyn Allen, to discuss ways care has improved, what challenges persist, and how to achieve the unachievable—true culture change.



^{*}Corresponding author

[♦]Patient Safety Authority

[†]Mount Nittany Health

Disclosure: The authors declare that they have no relevant or material financial interests.

Caitlyn Allen: Dr. Joshi, you've been chair of the Patient Safety Authority board since last summer. What were your expectations coming into the role and how did they compare to your experience?

Nirmal Joshi: I had dealt with the Patient Safety Authority from the healthcare management side: running hospitals, running health systems as the chief medical officer. So, I knew Pennsylvania is unique with its large database of patient safety information that is ripe for analysis, for review, for publishing, and—most importantly—for feedback back to the stakeholders to make appropriate changes to improve care.

But until you step on the other side, within the Authority itself, you don't quite grasp the detail. How does the data look on the other end? The analyses? And so on. Most people aren't privy to that piece. I wanted to understand that in my new role, because the single most important thing is safety. You want to make sure patients get quality care when they and their families are their most vulnerable. So, when I was invited to participate as the board chair, I very willingly said yes.

Back to your question around my expectations: At a high level, there were no real surprises. I knew PA-PSRS [Pennsylvania Patient Safety Reporting System] was a large database. I knew it analyzed events from across the commonwealth.

However, the breadth and the depth of what actually happens within the Authority was a surprise—in a good way. Meaning the extent of the research, the

extent of data analysis, and the extent of education that uses that analysis and gives that data back to the stakeholders. There is a lot more that happens than I realized when I was not part of it.

It's always better when it's a good surprise. You mentioned how unique Pennsylvania is, and even though it's been 20 years since we passed the MCARE [Medical Care Availability and Reduction of Error] Act, we still have the most robust reporting laws. We also have the largest event reporting database in the country. Do you think that those two things have to go hand in hand, or are there ways to encourage event reporting without the legislation to back it?

I've always believed accountability is the key for anything. Legislation is one way to ensure that accountability and is an important way to accomplish it. However, there is a delicate balance. When you need people to change or you want systems to improve, you can't depend solely on legislation or being overly firm and prescriptive. That's not how human nature works. If you want to have sustained improvements and improve care, you need to have a critical mass of people who are willing to change and willing to lead the way. You can't do that by the stick, you really can't. It's the difference between "transactional" leadership and "transformational" leadership.

As leaders, we all know that if something needs to be done quickly, you have to say, "Hey, so-and-so, do this now." Take codes for example: Someone suddenly collapses, everyone jumps into action and there are black-and-white orders like the military, and you get it done. That's what I call transactional. It must be that way at that time.

However, for most things, you must be transformational if you want things to improve over extended lengths of time. The Authority does this so well now: Look at the data, analyze the data, and then go back to stakeholders, educate them about what the data means, and in plain English what are some take-home things that they can do.

Back to your question, having the backing of good legislation is crucial. But if we are to make meaningful change, we have to effectively appeal to both people's heads with data and their hearts by asking, "What happens to my loved one when they're in the hospital?" That kind of

”

But if we are to make meaningful change, we have to effectively appeal to both people's heads with data and their hearts by asking, "What happens to my loved one when they're in the hospital?" That kind of messaging allows for truly transformative work in patient safety.

messaging allows for truly transformative work in patient safety. Many people think you can just tell people what to do and they'll somehow comply. Well, that's not really how human behavior works.

You mentioned the military, which is an industry to which healthcare is often likened. Another is aviation. Do you think there are components of these other industries that we should borrow or is healthcare just its own quirky beast?

That's a great question, particularly the comparison to the aviation industry, which has been discussed so often that if you begin raising that in healthcare forums, it's almost irritating.

There are significant components that we should not only borrow but literally replicate from other industries like aviation. One example is processes that need to be followed down to the T. I'm sure you've read the book called *The Checklist Manifesto* by Atul Gawande. The author, who is a well-accomplished surgeon, talks about the importance of discrete checklists. Was X done or was it not done?

And that's where we should strive to mimic the aviation industry: more and more checklists, making as many things dummy-proof, because to err is human, right? We refer to it over and over again,

”
When you need people to change or you want systems to improve, you can't depend solely on legislation or being overly firm and prescriptive. That's not how human nature works.

”

Something immensely humbling for anyone in medicine is that sometimes the human body just decides to respond the way it feels like responding. You get a person who's 80 years old with multiple medical diseases, who is fine. On the other hand, you can get a 50-year-old, where they have almost no other diseases, and for whatever reason that we don't understand, they can have an adverse outcome.

but it's probably the single most important realization that we, as human beings, are inherently prone to making mistakes. So, we'd be better the more we recognize fallibility with checklists and so on. That's the piece that we need to plagiarize from the airline industry.

Where things differ, however, is that we are not dealing with a machine, but we're dealing with the human body. Something immensely humbling for anyone in medicine is that sometimes the human body just decides to respond the way it feels like responding. You get a person who's 80 years old with multiple medical diseases, who is fine. On the other hand, you can get a 50-year-old, where they have almost no other diseases, and for whatever reason that we don't understand, they can have an adverse outcome.

The point being that regarding the human body, two plus two does not always make four. And that's where I think we need to set community expectations in a way that says, "We believe strongly in accountability when it comes to actions that we perform at the bedside. However, despite best efforts from the entire team, things can

go sour," which is very different than the airline industry. If you did everything perfectly other than things like weather, you should have a fairly predictable outcome, while in healthcare, that doesn't always happen.

I read an article in AORN [Association of periOperative Registered Nurses] Journal that cautioned against comparing healthcare to aviation. In healthcare, it's humans working alongside other humans on other humans, and there are too many variables for a direct comparison, which aligns with what you're saying. Speaking of *To Err Is Human*, the landmark report put patient safety on the map in 2000. In many ways, healthcare is infinitely safer than it was 25 years ago, yet incidents of harm continue. Do you think that we'll ever achieve a level of zero patient harm?

We should always strive to accomplish zero patient harm. I don't think any healthcare worker would deny that. I think we go into the field with an inherent intent to help people. And when things don't work out as we hope, we are not only saddened, but we go back and look carefully, "What is something we might have done differently?"

So, yes, we should strive for perfection. However, given A) what I just said earlier is that we're dealing with the human body and B) to your earlier point, we are also dealing with human beings caring for human beings. Those two elements make it hard to accomplish zero patient harm entirely.

So, the question is, "How can we minimize that to the point that we can comfortably say, 'We did the very best we could.'" Having a system in place that we follow 100% of the time is accountability. If there is a checklist prior to surgery, if there is time-out and we look at 20 things, did people follow each one 100% of the time? That's accountability. Then, if there is an adverse outcome, it likely only resulted from things beyond our control.

Your background is in infectious disease. How much did that prepare you to handle the pandemic? How much on-the-job training did you have to do?

I started at Mount Nittany in 2016, and right around late 2019 just before COVID hit, I started my foundation and was going to go part time. That's when my CEO requested

me to stay on more, because I was the chief medical officer of the health system, and I was also trained in infectious diseases, so it made no sense for me to step back.

Handling the pandemic was one of the most rewarding times that I've had in healthcare, because it was an opportunity to do something with the expertise in infectious diseases that I had not been really using. Being in management, I had not done frontline clinical care for a while. And this gave me the opportunity to jump back into it.

When you're thrown in the front lines of managing this whole process, it's a tremendous opportunity to be able to serve and do something with your expertise.

Communicating well is one of the biggest challenges in any industry, let alone healthcare. I know improving doctor-patient communication is an interest of yours.

It's important in healthcare that we communicate well, we understand both sides, we understand the patient and their family's point of view. One reason, among many, is that our diagnostic process starts with information. If we don't get a complete enough picture during the patient interview, one's diagnosis can only be as

”

We should always strive to accomplish zero patient harm. I don't think any healthcare worker would deny that. I think we go into the field with an inherent intent to help people. And when things don't work out as we hope, we are not only saddened, but we go back and look carefully, "What is something we might have done differently?"

”

And if we are unable to communicate to them in a compassionate, empathetic way, then something is missing.

good or bad as the information received. And often, if we are unable to do that well, everything that follows is potentially flawed and can lead to mistakes, poor clinical quality, and so on.

The second of a zillion reasons why doctor-patient communication is so critical is that in the context of disease, we are dealing with real human beings. We're dealing with emotions. We are dealing with people who care about each other—family member expectations. And if we are unable to communicate to them in a compassionate, empathetic way, then something is missing. Our discipline is so unique compared to any other. We deal with people when they are in many ways down-and-out, in many instances when they are so vulnerable that they have no control in their lives because of a stroke of destiny or whatever else.

Some of the most rewarding times in my life have been when I've been able to stand by patients and their families with compassion, with care. And that's something that not only do I strongly believe in, but also I strongly believe in being able to teach the importance of those moments. You can impact people's lives. And those moments never go away.

It's one thing just to believe that, but you walk the walk. And one of the ways you've done that was by founding the Joshi Health Foundation.

That's something that is very near and dear to my heart. We always want to do the best we can, but sometimes we find ourselves in a situation where we think, "Could we have helped more people?"

And then, you ask yourself, "Would there be a time when my livelihood doesn't depend only on being reimbursed for

patient care?" I had hoped that I could become reasonably financially independent to do for others without asking for anything in return—those who may be most vulnerable, who have no way of paying for healthcare.

I read a book called *The Second Mountain* by David Brooks, a *New York Times* reporter that analogizes our lives as mountains: The first mountain is when we are trying to make a living. We're trying to get dinner on the table. We are trying to do everything for ourselves and our families.

And there comes a point after you've done that he refers to as the second mountain, which is when the true joy begins. When, if you can, you give to others, to your community, to other people who are in need. And the joy that you get out of that is unmatched compared to the first mountain, which is more transactional. The second mountain is much more fulfilling, rewarding, and gives inner peace and inner pleasure.

Thankfully, the time came about two or three years ago when I planned to go part time and step down as the chief medical officer to start the Joshi Health Foundation. As they say, charity begins at home. I felt I should do this right where I live, because this is the community that has helped me, my children, my family over the last 35 years. So, I started the Foundation that offers care to individuals, primarily those who have no insurance or means to pay.

I provide clinical consultation and tests, such as, bloodwork, X-rays, and so on, by way of partnerships from local health systems that I have developed over time. I pay the subsidized amount, so the patient does not have to pay anything. So, we can care for those who may be the most vulnerable in our society. It's been a joy and a privilege and a blessing.

Another one of your passions that you mentioned earlier is training the future generation of leaders. What does that look like? And what do you think the challenges are going to be facing future physicians, maybe a decade from now, that you didn't necessarily face during that stage of your career?

For most of my life I have had the good fortune of being intimately connected to education, whether it be graduate medical education or teaching medical students. When I was at Penn State in Hershey, I was strongly involved with training students.

And then, when I was with Pinnacle, now UPMC [University of Pittsburgh Medical Center] Pinnacle, I actively participated in the resident training program. In fact, I was the program director for Medicine for a period as well.

When I became CMO and then subsequently at Mount Nittany, there was no direct opportunity to instruct residents and students, so I have been actively involved with the Pennsylvania Medical Society in training upcoming physician leaders. I've done that for the last eight years or so, where we have very structured courses for physicians who either self-identify themselves as being leaders or who are referred from their institutions for leadership training. We have structured courses throughout the Pennsylvania Medical Society for which I serve as either a leader or as a faculty member.

As I said, I have been blessed that I have both things in my life: the ability to see people who are vulnerable and to educate a new cohort of physician leaders. There were practically no such courses back when I was stepping into these roles. You just showed up, and you learned on the job. Even today, I would venture to say about 80% of the time, physicians walk into a leadership role, big or small, with no formal management training. We've attempted to create processes that train physicians in formal systems of management, whether it be things like finance or communication that look much more like an MBA-type course rather than a traditional medical one.

”

When, if you can, you give to others, to your community, to other people who are in need. And the joy that you get out of that is unmatched.

”

More personally, I also always try to learn from a mistake or something that didn't go well and try to use that as a teaching moment.

More personally, I also always try to learn from a mistake or something that didn't go well and try to use that as a teaching moment.

Pennsylvania is a peculiar place, with two big urban centers and a lot of rural area in between. How do you balance preparing the next generation of physicians and similarly, looking at patient safety on a broad scale where there are these two very diverse environments?

That's an interesting question. I've been in a few health systems now, and each can be quite different in its culture, location, patient expectations, physician expectations, etc.

When it comes to patient safety, and maybe other elements of medicine as well, the basic tenets are the same regardless of where you are. For example, in the operating room, which has been likened to the aviation industry most often, the expectations are the same: strive to minimize patient harm. Follow the checklists and the other standardized processes. Some things are black-and-white and should be followed in the same way regardless of your location.

On the other hand, culturally, how people respond, the methods for educating people, the way to get there, change from place to place. There are places where a slightly more transactional tilt tends to help, while there are other places that wouldn't respond well to that approach. So, the methods can vary, but you have to understand people, and people's expectations are amazingly different from one place to another.

But when it comes to the basic principles of patient safety, the outcomes can be somewhat beyond our control at the end, but compliance in doing things the way they're supposed to be done, that is well accepted by the best available evidence, ought to be something that we hold everyone to the same standard of accountability; whether it's the Eastern part of the commonwealth or the Western part of the commonwealth, rural, urban, semiurban, expectations ought to be similar.

A universal challenge affecting patient safety is staffing shortages. This is occurring on multiple levels: not enough instructors to teach enough students to fill enough spots, and then there are limited residencies available, even if we had more students. How might we be able to address these challenges?

It depends. Consider scope: There are rigid guidelines for what someone can do. For example, can a medical assistant give shots? With staffing shortages, it's sometimes great to have the creativity to say, "OK. If X can't do it, can Y be trained to do the same thing?" But sometimes regulation gets in the way. "No. If this person can't do it, they can't do it." It's inflexible. That's not criticism. Rules exist for a reason but can stifle creative solutions to some of these systemic challenges.

On the other hand, where more regulation and help from the federal government can be very helpful is when there is an absolute shortage. You've tried all this creative stuff, and there is still a shortage.

”

Healthcare, we're dealing with human beings, like we said to begin with, where unfortunately there are no 100% answers or no 100% solutions.

Individual hospitals work on razor-thin margins these days and simply cannot afford to be able to pay people to the point of going bankrupt. And there have been systems within Pennsylvania and elsewhere that have gone bankrupt. So that's where the federal government can treat healthcare differently from other industries and incentivize healthcare workers apart from the institution itself.

That may encourage people to consider healthcare careers, which can be very demanding. Not just physicians, but for everyone. The shifts, the night work, and what sometimes feels a thankless job can be challenging. So, on one end is maybe more help from the federal government, on the other hand, is maybe getting out of the way a little bit. The trick is to find that right balance.

It seems like a theme throughout this conversation has been finding the right balance. Healthcare seems to be best when it exists in lots of shades of gray and not in absolutes.

I think that is so true. Healthcare, we're dealing with human beings, like we said to begin with, where unfortunately there are no 100% answers or no 100% solutions.

About the Authors

Nirmal Joshi is an experienced physician executive and internal medicine physician, with an extensive background in clinical quality and patient safety. *Becker's Hospital Review* recognized Dr. Joshi as one of their "100 Hospital and System CMOs to Know" in 2016. He currently serves as chief medical officer for Population Health at Mount Nittany Health system in State College, Pennsylvania, and as president of the Joshi Health Foundation in Mechanicsburg, Pennsylvania—a nonprofit charitable organization that he founded two years ago with the intent of providing free care to those unable to afford care.

Caitlyn Allen (caiallen@pa.gov) is director of External Affairs for the Patient Safety Authority and managing editor for *Patient Safety*, the PSA's peer-reviewed journal. Before joining the PSA, she was the project manager for Patient Safety at Jefferson Health, where she also was the only nonphysician elected to serve on the House Staff Quality and Safety Leadership Council.