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The revolutionary

The Boston Globe

Donald Berwick says our nation's world-class hospitals and doctors are delivering health care that is unsafe and unreliable. But his call to dismantle the system makes the medical establishment uneasy -- especially since he used to be part of it.

By Neil Swidey, Globe Staff, 1/4/2004

He is coughing. He is limping. He is not doing well. Still, Donald Berwick manages to move briskly as he wends his way through the warren of hospitals, office buildings, and research labs that make up Boston's vast, ever-expanding medical-industrial complex. Berwick grew up professionally in this dense, intense Longwood Medical Area populated with residents in blue scrubs and technicians in white lab coats. In many ways, he is the ultimate insider, a Harvard-trained physician who is a professor at both Harvard Medical School and the Harvard School of Public Health; and the home base for his organization, the Institute for Healthcare Improvement, is right on Longwood Avenue. But what he has to say could shake the very foundation of this place.

Health care leaders outside of Boston -- from all over the globe, actually -- can't seem to get enough of Berwick lately. On this raw, rainy morning, he is coughing because of the nasty cold he picked up from too much air travel. In one five-day period in November, he was in Washington, Geneva, London, Memphis, and Boston, advising, among others, the US Agency for Healthcare Research and Quality, the World Health Organization, the American Medical Association, and the United Kingdom's National Health Service. A few weeks before that, the UK's secretary of state for health, John

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Health care reformer Donald Berwick of Boston at a convention in New Orleans. Addressing hundreds of health care professionals, Berwick assumed the role of a beleaguered hospital patient, dreaded johnny and all. (Chris Granger / The Times-Picayune)

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Reid, requested a private audience with Berwick at the British Embassy in Washington. Reid outlined the daunting task before him in remaking Britain's health care system and then looked across the long conference table to Berwick and said, "Don, what should we do?"

Berwick has been sought out by the Bush administration and Democratic presidential candidates Howard Dean and John Kerry for help in formulating health care policy. In 2002, the weekly trade publication *Modern Healthcare* ranked Berwick the third most powerful person in American health care, eclipsed only by Secretary of Health and Human Services Tommy Thompson and his top lieutenant, Tom Scully, who runs the \$435 billion Medicare and Medicaid system. None of the traditional luminaries in Boston medicine came anywhere near him in the ranking.

Berwick is limping because, well, his knee is shot, and he knows he will have to have it replaced. If he can find the time. And if he can ever get over the psychological hurdle of knowing just how much harm hospitals do every day. Berwick has spent so much time analyzing, and railing about, the dangers embedded in the health care system that for him to voluntarily surrender his knee to the knife now would be a little like Upton Sinclair bellying up to a diner counter to order a double cheeseburger after writing *The Jungle*. Berwick ticks off some of the ways a hospital might kill him: giving him an infection; mixing up a blood transfusion; giving him a medication he is allergic to; failing to prevent a pulmonary embolism; giving him respirator-associated pneumonia; mistakenly placing an endotracheal tube in his esophagus.

These are not idle worries. Every year, up to 98,000 people are believed to die in American hospitals because of medical mistakes. The studies that provided the basis for that chilling estimate were not Berwick's, yet no one has done more to ensure that the findings remain at the top of the national health care agenda. And Berwick is committed to doing more than just sounding alarms. He believes health care can be dramatically improved if it takes to heart the systems-improvement work that has transformed other industries, and if it focuses on eliminating the danger, waste, confusion, and arrogance that are pulling medicine down. He and his institute are working with several hundred health care organizations, large and small, in an effort to post results that would back up his theories. The swelling ranks of Berwick's acolytes speak of him in almost messianic terms. "Don Berwick

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should win the Nobel Prize for Medicine," says Blair Sadler, who runs San Diego Children's Hospital. "I think he has saved more lives than any doctor alive today."

But the deeper Berwick has gotten into the problem over the last decade, the more radicalized he has become. At this point, mild-mannered, soft-spoken, self-effacing 57-year-old Don Berwick can best be described as a revolutionary. A lot of people say the current health care system is broken, but by that they mean the manner of financing it. Berwick gets irritated when health care leaders complain about a lack of resources. There's too much money in the system already, he says. His critique takes aim at the medical profession's exalted view of itself. He's convinced that the fundamentals of the current system -- the same fundamentals Boston used to build its reputation as the world's medical leader -- are so screwed up that it is no longer possible for the medical profession to provide reliable, high-quality care, no matter how many innovations its renowned doctors roll out, no matter how many awards they rack up. "They want to cure cancer," Berwick says. "Well, how about curing health care?"

His conclusion: To save the health care system, it first needs to be blown up.

This is what health care would look like if Don Berwick ruled the world, rather than just traveled it:

When you wanted to see your doctor, you would call in the morning and get an appointment that afternoon. And it would start on time, not an hour and three outdated *People* magazines later.

You would maintain control of your medical record, rather than needing a subpoena just to get a peek at it.

Hospitals would have genuine one-stop registration, and every employee would be trained to have the customer-service touch of a Ritz-Carlton concierge. No one would ask you to wear one of those open-backed johnnies.

Waiting would be kept to a minimum, because the hospital will have embraced flow management, anticipating rather than just reacting. There would be no visiting hours in the intensive care unit, since any family member could visit at any time.

Medication errors -- overdoses, allergic reactions, and other adverse responses -- would be all but eliminated by the universal adoption of computerized drug-ordering systems. Hospitals would impose a zero-tolerance policy for workers failing to wash their hands, a move that could save upward of 10,000 lives a year.

Communication and patient-advocacy systems would put an end to horror stories like the one

involving the 5-year-old boy who died at Children's Hospital last year because each of his many doctors assumed another doctor was in charge.

Waste would be systematically reduced. Hospital performance would become so transparent that finding the best place to get an operation would be almost as easy as shopping for a new TV online.

And the treatment you receive from your doctors would be made far more effective by a system that gave them less discretion. Physician habit and ego would take a back seat to science in determining standardized courses of medical action. Berwick argues that in terms of improving safety, health care could learn a lot from aviation, where commercial pilots have much less discretion than they used to. On a recent flight from Washington to Atlanta, he waves over Lisa, the bubbly Delta flight attendant, after she finishes her numbingly familiar safety spiel.

"I wonder how much you can deviate when you're explaining the FAA safety regulations to the passengers," Berwick says.

"Most of it is dictated by the FAA," Lisa replies, before retrieving her manual and showing it to Berwick.

After she walks away, Berwick turns to me and says, "The more I have studied it, the more I believe that less discretion for doctors would improve patient safety." He then looks down. "Doctors will hate me for saying that."

Berwick distills his vision for health care into five concepts: no needless death, no needless pain, no helplessness, no unwanted waits, and no waste. In many ways, it's utopian. But he's no dreamer. He is part systems analyst, part proselytizer, and part scold. His nonprofit Institute for Healthcare Improvement, or IHI, has about 70 full-time employees, another 400 adjunct faculty members, and an annual budget of \$27 million, with revenue coming from contracts with health care systems and foundation grants. Berwick is paid a base annual salary of \$377,000.

More movement than consultancy, IHI runs courses, conferences, improvement projects, and a website and membership network designed to let health care institutions learn from one another. With Berwick forever on airplanes, the overall management of IHI rests heavily with his number two, Maureen Bisognano, a 50-year-old former hospital executive who brings financial discipline and a spirit of innovation to the organization. Still, more than a decade after its founding, IHI remains indivisible from Berwick, and the people who sign up for its services expect to get him with the package -- even if they're not always happy to hear what he has to say.

Speaking to physicians and administrators at Emory University Hospital in Atlanta in October, Berwick notes that teaching hospitals like theirs have the steepest hill to climb in fixing

themselves, given their complexity, but also hold the biggest potential for reshaping health care, given their established leadership positions.

He also tells the crowd: "When I give talks like this, I'm always reminded of a paper my son Dan wrote when he was in the third grade: 'Socrates was a very smart man in ancient Greece who went around and gave people advice.' " Long pause. " 'They killed him.' "

From his bedroom, Don Berwick would hear the car start up -- usually around 2 or 3 a.m. It was his father leaving for another house call. Philip Berwick was the quintessential rural doctor. If someone got sick in Moodus, a smudge on the map of south-central Connecticut, it was up to him to make things right. He was a highly respected -- and feared -- man around town. And in his own home.

Don was the oldest of three boys. His best friend, Richard Bernstein, who is now the Berlin bureau chief for *The New York Times*, explains what life was like for the two friends in their village of 2,000: "We were Jewish in a non-Jewish environment. We were brainy kids who did well in school when the primary value was on sports. We were admired but not popular."

Bernstein says what set his best friend apart most was his searing intelligence. "I've always assumed that I was a bright person. But Don always gave me a little bit of an inferiority complex. It was so effortless with him, yet he was so unassuming." During high school, Berwick and another friend decided to form a debate team -- just the two of them. They went on to win the state tournament.

In 1961, when Berwick was 14, his mother developed ovarian cancer. She died within the year. The death took an incalculable toll on the family. Bernstein says Berwick's mother was warm and supportive, much like her oldest son and quite unlike her intimidating though caring husband.

Berwick recalls an incident in which his father, interrupted by yet another patient phone call during dinner, thundered, "Look, I'm the doctor. I'll decide when you get medicine!" and then slammed down the phone receiver so hard that it shattered.

Relief for Berwick came in his undergraduate admission a few years later to Harvard -- a first for a Moodus native son. On his first day of freshman biology, a petite Rhode Island native named Ann Greenberg sat down next to him. They became lab partners. "He was very funny, and he was really good at explaining things," she recalls. "I decided very quickly he would be a great partner to have."

Berwick always knew he would follow his father into medicine, but he was determined not to return to small-town life. In his senior year, he won a traveling scholarship. But this was 1968, and the draft board in Moodus told him that unless he went directly to medical school, his only

travel would be to Southeast Asia. So after graduating *summa cum laude* from Harvard, he went directly to Harvard Medical School. While earning his medical degree, he picked up a master's in public policy from the Kennedy School of Government.

Berwick did his residency in pediatrics at Children's Hospital in Boston. He saw miraculous medical care in action. But he also learned, intimately, how good people in health care, with good intentions, can sometimes unwittingly do harm.

"I was taking care of a boy who had cancer. He was dying. I got close to him," Berwick recalls. "One day, he got more and more distressed. I gave him an increase of his sedative dose. I pushed in some medicine to try to make him more comfortable. I did something wrong. The medicine precipitated in his IV tube. I didn't know what was happening. He was more and more distressed, saying, 'Please help!' Somewhere during this period, I realized that his parents were upstairs. They were resting. I said to someone, 'Go get his parents.' By the time they got to the room, he was unconscious. And I remember the mother looked at me, and she said, 'How could you not call us?' "

From a systems point of view, Berwick can find an answer. He was an overworked resident in an incredibly complex hospital trying to do his best to bring relief to his terminally ill patient. But from a personal point of view, the answer is far more elusive. "I was overwhelmed with tasks, but what I did was irreparable," he says. "You can't go back."

But there would be happier times. He and Ann Greenberg, his former lab partner, married, moved to Newton, and soon had the first of four children. He took a job as a pediatrician for the Harvard Community Health Plan, which at that point was among the nation's most creative health maintenance organizations. Thomas Pyle, the health plan's CEO, came to health care after having worked in the advertising, cosmetics, and shoe industries. He was amazed at how little health care knew about measuring the quality of its output. He created a new job -- vice president of quality-of-care measurement -- and tapped Berwick to fill it. That was in 1983.

In 1985, Pyle suggested that Berwick travel around the country to pick the brains of quality-improvement leaders in other industries. For six months, Berwick met with people at places like NASA, Gillette, Sheraton, and Bell Labs. He rubbed shoulders with W. Edwards Deming and Joseph Juran, the godfathers of the quality movement who had transformed Japan's manufacturing industry. Berwick was hooked and became convinced that health care could also be transformed if it embraced the same techniques.

Slight problem: Pyle had hired Berwick to be in charge of measuring quality so he could gauge how his system was performing. But, Pyle says, Berwick lost interest in measuring quality and increasingly recoiled from playing the heavy in assessing the performance of his fellow doctors. He wanted to focus on improvement rather than measurement.

"Don and I didn't see eye to eye on this," Pyle recalls. "I had some disappointment that he

wasn't pursuing the original mission we had talked about."

For Berwick, though, there was no turning back. He started meeting regularly with a group of quality-improvement soul mates. In 1987, Berwick and one of those soul mates got a grant to run a national demonstration project, teaching quality improvement to 21 health care organizations in the hopes of turning them into Toyotas that could revolutionize health care the way the Japanese carmaker had scared Detroit straight. In 1989, he left his measurement job at HCHP. Other grants followed. He and his colleagues started running courses. Because organizations were paying for their services, by 1991, Berwick was still sitting on more than \$1 million in grant money. So he used it to start the Institute for Healthcare Improvement; he became CEO, and his cofounder, Paul Batalden of Dartmouth Medical School, chaired the board. Though quality improvement had clearly become Berwick's passion, he assumed he would stay in this new post for about a year before taking a "real" job somewhere. Reality never set in.

In March of 1999, Ann Berwick completed a 28-kilometer cross-country ski race in Alaska. Three months later, she could barely walk. For Ann, an environmental lawyer almost unbounded in her love of hiking and skiing and everything outdoors -- she and Don had climbed Mount Rainier together -- this sudden loss of mobility was terrifying. Worse still was not knowing what was causing it or how much worse it might get.

Don used his many connections to get her the best care possible. Ann would spend about three months hospitalized in some of the nation's most respected health facilities, mainly Brigham and Women's Hospital as well as the Mayo Clinic and Spaulding Rehabilitation Hospital. Don checked out of his work at IHI to help manage his wife's care.

It became clear early on that no one would be able to tell Ann much more than that she was suffering from some kind of rare autoimmune spinal-cord problem. It also became clear that all those problems with health care Don had spent the last decade complaining about were even worse than he thought. "I was not surprised," he says, "but I was shocked."

There were medication errors. One morning, a neurologist warned that Ann shouldn't get a certain kind of drug. By that afternoon, someone had given it to her. Another medication was discontinued by her doctor on her first day of admission, but the nurses continued to bring it every night for the next two weeks. Later, her doctors decided to put her through chemotherapy to try to stop the deterioration of her condition. "Time is of the essence," her doctor told her. The first dose was given 60 hours later. She was to get a single dose of the extremely dangerous chemotherapy drug daily for five days.

On the third day, the nurse came in and hung up the intravenous bag and started to put it in. "The bag said 'Number 2,'" Berwick recalls. "But it was the third dose. I was there. I had seen the others. I told the nurse. She just assumed I was wrong. If I had been 10 years old, she would have been patting me on the head, saying, 'I know, I know, don't worry, honey.' I almost

wanted to grab her by the lapels and say, 'Listen! I know something!' " (The nurse eventually checked the record, and agreed.)

He and Ann also saw how profound the system's amnesia is. He estimates she came into contact with about 100 doctors in three months. How could she get effective care when it was painfully clear that almost none of the doctors were comparing notes?

They also saw unbelievable waste, much of which would ultimately show up on their hospital bills.

With some notable exceptions, the people they came into contact with seemed to be trying their best to provide good care. It was the system that made that impossible.

Ann's condition eventually improved, and she slowly regained her ability to walk, though she still has considerable pain. For that turnaround, the Berwicks are extremely grateful. Still, the illness remains shrouded in mystery. "If I had stayed in a lovely hotel and been waited on hand and foot for three months, maybe I would have gotten better faster," Ann says. "It would have been more pleasant, *much* cheaper, more fun. I had two really major medical interventions. They may have saved my life or maybe were just terribly invasive and didn't do anything. We just don't know."

What Don did come away knowing was that, if this was how the best hospitals were capable of performing, how bad must the average care be? "My wife's care made me angry -- angry at very, very good people," he says.

So here's what Don Berwick did about it. With Ann's permission, he talked publicly about the experience, to the more than 3,000 people who gathered that December for the IHI's annual National Forum.

To understand the significance of this move, you must first understand how deeply private Ann is and what an extremely gifted public speaker Don is. Even now, four years later, she is still uncomfortable talking about the experience. Even now, four years later, people are still talking about the speech.

Videotaped copies have even become a standard part of some medical training programs. Azita Hamedani first saw a copy as a Yale medical school student. She is now a 30-year-old chief resident in the combined emergency-medicine program at Brigham and Women's and Massachusetts General hospitals. In November she happened to be sitting next to Berwick in the back row of a Harvard lecture hall for a talk given by France's leading authority on medical safety. Afterward, Berwick turned to Hamedani and introduced himself. Outside the hall, the dark-haired resident still looked almost star-struck as she told me, "I don't know the speaker. But to have Don Berwick there in the room means that I'm in the right place. He's a hero. This is

a *revolution* in health care he's trying to pursue."

Just from appearance and demeanor, you'd expect the 5-foot-10 Berwick to deliver an earnest but dull PowerPoint speech. He doesn't wave his arms and never raises his voice, which has a low, occasionally rasping quality to it.

In fact, about the only way to detect his level of intensity is to look at his forehead. When he is most enraged, that large unlined swath of skin becomes grooved like a lunar landscape and his thin eyebrows just about pop off his head, like a comic-strip character's.

But there is a quiet charisma about him. He knows how to simultaneously play on the emotional and logical sides of his listeners' brains. He is also the king of metaphors. Over the years, his listeners have heard him explain health care in relation to his younger daughter's soccer team; the sinking of a Swedish warship; the Boston Red Sox; Harry Potter; NASA; the contrasting behaviors of eagles and weasels; his wimpy Ford Windstar (a dated reference since he now drives a used BMW convertible); and his left knee.

And he has a nice touch with levity. During that speech about surgery on his left knee, which he delivered last month before 4,000 people (and another 6,000 on satellite hookup), he said: "I haven't met my first grandchild yet. My wife and I want to take a trip to Nunavut someday. I want to hike in the Himalayas . . . And if you take that stuff away from me by killing me, I will be very, very upset with you."

His keynote address has become the basis by which the IHI National Forums are judged. In his measured way, he can be quite daring on the dais. In 2001, he went into character to make his point about the foolishness of doctors resisting his call for change. He alternately wore green and yellow cowboy hats to show how "Dr. Olderway" and "Dr. Newerway" would handle the same patient. Kitschy? You bet. But he managed to pull it off.

(He can occasionally be careless. That winning Socrates line he attributed to his son in his Atlanta speech actually comes from a sixth-grader whose work has been circulating on the Internet for years.)

But none of his speeches has had quite the staying power of his 1999 talk. He called it "Escape Fire," because, in addition to dealing with his wife's hospitalization, he spoke at length about a famous wildfire in Montana in 1949 in which one of the cornered firefighters lit a small "escape fire"; that blaze spread quickly uphill, leaving a burned patch behind. The firefighter hunkered down there and let the larger fire roar past him. Though his bold improvisation would change the practice of firefighting, on that day his response was too radical for any of his fellow firefighters to follow. They died, he lived.

Berwick told the crowd that health care needed no less a radical plan to get out of its current

mess: "We are causing harm, and we need to stop it."

After Berwick finishes his speech at Emory University Hospital in October, Dr. Jeffrey Koplan stands up to ask him a question. Koplan, the former head of the Centers for Disease Control and now an Emory vice president, has known Berwick for 30 years.

"Don, within a few yards of your office, there's a cluster of academic hospitals. If one of them were to invite you over and say, 'Take it over,' where would you start? And what would you see as the biggest obstacles?"

Berwick smiles. "My office overlooks the Brigham and the Beth Israel medical center, and I admire those places so much. The [National Institutes of Health] thinks they're great. So does the Nobel Prize Committee. They *are* great. But to go in and say to great places, 'Let's talk defects,' it's very hard."

His response says a lot about why Berwick has had less traction in Boston than outside of it. (Berwick's collaborative model asks all hospitals to learn from each other. But as one Boston doctor says, "Can you imagine world-class Mass. General being asked to follow the lead of some hospital in *Milwaukee*?")

But Berwick never really answered Koplan's question. Flying back to Boston with Berwick that October night, I press him on it: "If someone offered you the keys to one of those respected hospitals, would you take them?"

"I'd better not try," he says, smiling. "It's a *really* hard job. You have to have many, many skills. I don't think I have them all."

In fact, Berwick knows all too well how tough the job can be. In 1998, Dr. James Reinertsen, his friend and fellow soldier in the quality-improvement movement, took over as CEO of Beth Israel Deaconess Medical Center. Berwick served as one of his references. Three years later, amid a sea of red ink and open hostility from the medical staff, Reinertsen was forced out.

No one suggests that Reinertsen's agenda for quality improvement was responsible for his overall ineffectiveness as leader of the newly merged institution, but it's a sobering lesson.

Today, Reinertsen stresses that the financial fundamentals have to be in place before you can attack quality improvement. "If you're fighting for air and water, it's kind of hard to be doing opera," he says. Reinertsen now works for Berwick as a senior faculty member of the IHI, where his focus is teaching CEOs how to improve quality in their hospitals.

To date, Berwick has been much less successful in winning converts in the corner office than on the front lines. And even some people who consider themselves Berwick fans says it's a

recipe for burnout for him to ask the self-motivated doctors, nurses, and mid-level managers who are his disciples to shoulder more and more of the soul-sapping improvement work without ensuring complete buy-in from their bosses.

"It takes really significant commitment from the top to get the attitude of continuous quality improvement spread throughout an institution," says Dr. Troyen Brennan, president of the Brigham and Women's Physician Organization and author of groundbreaking studies on medical-error deaths. "And it takes a *lot* of effort. You have to keep pounding at it. People fatigue. But it's hard for a CEO to identify other CEOs who have used this as their means to success, who have really survived and thrived as a result of it."

David Blumenthal, director of Massachusetts General Hospital's Institute for Health Policy, says that unless the reform movement tackles the 800-pound gorilla of health care financing, "fatigue and erosion in gains" will be inevitable.

Even CEOs who buy into Berwick's message will only go so far. Dr. James Mongan, chief executive of Partners HealthCare, the parent company of Massachusetts General and Brigham and Women's hospitals, says any call to blow up the system is ultimately unworkable, because it is impossible to shut down the 24/7 health care system to rebuild it. "Nobody, not even Don, has a whistle they can blow so we can stop health care and then start it again," Mongan says. "I'm a believer that the world improves more through evolution than revolution."

A setback for the campaign to enlist more CEOs came last year with the publication of a study showing that there is currently no "business model" for quality improvement. Right now, the medical institutions that undertake improvement measures do not see any financial rewards, because either the savings show up too many years down the line or they go to another party, such as an insurance company. This is not a reality Berwick runs from. After all, he was the study's coauthor.

In fact, for someone who's staked his claim as a revolutionary, Berwick can at times be surprisingly realistic about how winnable the war might be. "Progress is just much, much slower than I thought it would be," he says. "It's so obvious to me. I just don't get why the leaders of health care don't see what I see. Sometimes I wonder, am I wrong? I'm not smarter than these people, so maybe [change is] not possible."

It's true that, for every component of his utopian vision for health care, Berwick can now point to at least one institution working with IHI that has posted stunning improvement, from Dominican Hospital in Santa Cruz, California, which has wiped out ventilator-associated pneumonia, to Dr. Gordon Moore's high-tech practice in Rochester, New York, which has wiped out waiting and inefficiency. But Berwick acknowledges that there is no system that has put it all together. "Five thousand hospitals in this country, and not one Toyota," he says. While that incremental progress might have satisfied him a few years back, his wife's hospital experiences convinced him that revolution holds the only chance for sustained change. "I wonder if I'm less effective for

having been radicalized," he says. "I can no longer take moderation."

But here's the irony. Any self-doubt he may experience comes at a time when Berwick is increasingly being embraced by the mainstream. The evidence is everywhere. When he recently addressed the board of the American Medical Association, for so long an old boys' collection of traditionalists, it was at the AMA's request -- something that would have been unheard of just a few years ago. Even in Boston, Berwick is beginning to get more respect from the traditional power centers. Mongan, who took over as CEO of Partners a year ago, has made quality improvement a priority and plans to spend more than \$30 million over five years on technology designed to improve patient safety. Mongan gave Berwick a copy of his improvement plan in draft form and asked for his input.

The fact is, Berwick's proselytizing has produced so much more awareness about safety and quality problems in hospitals that most health care leaders no longer argue with his diagnosis, even if many still take issue with his prescription. (The areas of medicine that have adopted systems improvement, notably anesthesiology, have made huge leaps in safety.) Brigham's Troy Brennan puts it this way: "The changes are small, but slowly people's attitudes are changing. That's something that should be very gratifying to Don."

And at his core, Berwick is an optimist, so the bouts of self-doubt seldom last long. At an IHI staff meeting in November, a staffer named Jose says he worries about falling behind on his projects when they all decamp for the IHI's annual weeklong National Forum. Berwick immediately starts furiously scribbling on a piece of scrap paper.

A minute later, Berwick jumps up. He rattles off a series of calculations he had just made, taking into account statistics on medical errors, the numbers of people who would be in the audience for the conference, and the success rates so far from IHI error-reduction programs. Then he offers his conclusion, which puts to rest any concerns Jose may have had. "Every single person in this room," Berwick says, "is going to save five lives during the forum."

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