2019 NCSBN APRN Roundtable The Global Forum on Health Professional Education, Lessons for America Video Transcript

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Event
2019 NCSBN APRN Roundtable

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Presenter
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- [Kathy] "Lessons for America," the title of this. What an audacious goal. That was Maureen's title, I said, "Sure, I can do it." But that's a big lift.

Some of the things that we'll talk about today, and as David reflected, are really global conversations and we just are one component of that. I did start with ANCC, from the accreditation program, which is our continuing nursing education arm and interprofessional continuing education arm.

So, I'm going to give you a learning outcome. This is what I would hope that you achieve at the end of our conversation. I will say, on your tables, there's a handout. And so, if you can also pull this because there's some think-pair-share work that I want to do today. This is not just Kathy giving a PowerPoint presentation. No disclosures.

So, the Global Forum, which is a collaboration of multiple organizations... ANCC is one of the organizations, AACN is also one of the organizations that sits on this. This forum was launched as part of the National Academies and really based on two landmark reports.

And I'm going to go over a bit of a timeline of the seminal reports that have been published and lend themselves to this conversation. But the <i>Health Professionals for the 21st Century</i> that was published in 2010, and <i>The Future of Nursing</i> in 2011, really were the catalyst reports that launched the Global Forum. There are 60 appointed members.

They represent academia, they represent the education arm, they represent practice, 47 of those members have sponsoring organizations. ANCC is a sponsoring organization, and I represent ANCC on that forum. What the Global Forum does is, it looks at the healthcare system through the lens of education.

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So, how can education across the care continuum influence and support the healthcare needs of today's population? And again, this is not U.S.-centric, this is a global forum, so, we are represented. And when we look across the continuum of education, and this is no news to all of you, we're spending, you know, a small amount of time regardless of profession, really, in undergraduate, moving through the post-graduate phase, and then the vast majority of what we do in the practice setting.

So, I'm going to ask you a question. And these recommendations were from the Institute of Medicine at the time, now the National Academies. These were the recommendations, we need to use our existing workforce optimally, we need to produce a workforce that's responsive to the needs of the patient and the healthcare system.

We need to ensure that healthcare providers can practice to their full scope. And it's going to require a cooperative effort of teams. So, my question for you is, when do you think these recommendations were made? Do you know? -

[Audience Member] 2010.

- 2010.

- 1999.

- 1999? Older.

- Much older.

- Much older. In 1972, these were the recommendations from the report that was published by the IOM in 1972. So, what does that say to you about this conversation?

- It means we don't change.

- We don't change. We've been having this conversation for a long, long time, and we're still having a conversation. And I'll show you in the timeline of reports, some of the recommendations that have come out, and you're going to start to see the speed of which these recommendations are coming out and more and more of a focus, because there was a big gap between the time that this report was published, and then the next report.

So, 1972 started with those recommendations, and here's kind of a timeline, this does not go through. I stopped at 2011 with <i>The Future of Nursing</i>. Certainly, there are multiple reports that have been published since then, focusing on the same area. So, between 1972 and 1999, now we get <i>To Err is Human</i>, right?

<i>Building a Safer Healthcare System</i>, what are the recommendations that come out of this report? Again, we need to be educating and training people in teams. We cannot maintain a siloed environment and then expect people to go out and practice together collaboratively in teams.

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We need to have guidelines for interprofessional practice. And we have to collaborate in order to look at and redesign complex healthcare systems. So, in 2001, <i>Crossing the Quality Chasm</i>, again, recommendations, we need to coordinate care.

We need to have open and collaborative communication among members of different professions. We have to have shared responsibility. We have to be looking at restructuring that clinical education across the care continuum to be interprofessional. And here's where we start to see a call out to organizations that do credentialing.

And that organizations that do credentialing have a responsibility to use their levers to move this forward. So, 2003, see, the reports are starting to speed up a bit, right? More and more of a focus. So, now we see the competencies that healthcare providers should have. Nothing new to those of you in the room but patient-centered care, interdisciplinary teams.

So, early in the literature, the term that was used is interdisciplinary, now it's more apt to be used... we're using interprofessional, which I think is more specific. So, I would say in terms of interdisciplinary, often that can be disciplines within a profession. So, we have medicine, we have surgery, we have pediatrics, within the profession of medicine, the profession of nursing.

So, interprofessional really says, these are members of different professions that are interacting, as opposed to interdisciplinary, which could mean you have a group of physicians in the room and they happen to represent different disciplines within the profession. And again, calling out now, very specifically, accreditors, certifying bodies, and licensing bodies, that you need to step up to the plate, that some of the changes that need to be made cannot be made unless you use your levers to force change.

And that is what a credentialing organization does to some extent. Many of the programs that ANCC runs, as you all have participated in or, you know, from your lens, one of the things we do is, we notch up standards and as organizations, or people, or programs meet those standards, then we raise the bar again, and that's how a credentialing organization can move a profession forward in that way.

So, <i>Redesigning Continuing Education in the Health Professions</i>, that looked very specifically at the CPD space and looked at a incredibly siloed model. We still have that to a great extent, but I will say some of the things that came out of this report that are pretty significant, so, HRSA funded…you see this, "Establish a national interprofessional CE institute?"

Following this report, HRSA put out a grant and the National Center for Interprofessional Education and Practice was formed and that's housed at the University of Minnesota. For those of you who are not aware of that, it is a fabulous warehouse research group that looks at interprofessional education, interprofessional continuing education, and interprofessional collaborative practice.

They fund innovation sites all around, and they do a lot of work in the space to look at the relationship between education, collaborative practice, and outcomes. And then, looking at national standards for CPD, one of the things that came out of this that was spurred on really by a conversation between the CEO of ACCME, which is the credentialing organization for CME in medicine, and ANCC, who had a

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nursing commissioner and they had a conversation that said, "How can we work together across professions as accreditors to move this forward?"

And that conversation launched our joint accreditation program. So, we do credential organizations that do interprofessional continuing education. And those organizations have to do 25% of their CE interprofessionally but they can also do 75% single profession under one accreditation. So, medicine, nursing, and pharmacy started that, we've now added four more professions, optometrist, social work, psychology, and the PAs.

So, if you're jointly accredited, you can offer seven different types of CE credit under one accreditation. And that was a result of this kind of a report that says, "You all need to step up to the table," and you know, that was part of what we did. So, going outside of the National Academies, the <i>WHO Framework for Action</i>for interprofessional collaborative practice was published in 2010.

And now, you're starting to see competencies that are reflected in other documents moving forward. So this really looked at the global landscape and how education systems around the world are not training people or educating people to be collaborative practice-ready.

And this was the incredible piece of work by some researchers around the world and all free. All of these documents are free-download PDF documents. And then in 2010, the Lancet Commission report and that, again, was looking at the global landscape.

I'm going to put on my glasses here for just a minute and share with you a couple of pieces. So, this report looked at a competency-driven approach to instructional design and a competency-driven approach to education, looking at breaking down professional silos, using information technology, and promoting a new kind of professionalism that did not have a global boundary.

And then, <i>The Future of Nursing</i> report, as you all are familiar with. So, what else was happening at the same time along this trajectory of the National Academies or IOM reports and the WHO reports? The academic accreditors got together and wrote this report and developed competencies for interprofessional collaborative practice and those were six different professions there.

We came out with better care at lower cost. And then, MACRA looking at a value-based system, and then the IPEC Competencies were updated in 2016. Those IPEC Competencies from the 2011 took those four domains and really said, "At the end of the day, what are we trying to do?We're trying to improve interprofessional collaborative practice."

And so, they pulled those under one larger domain. And this is the WHO framework that basically says we have to revise our education model in order to develop a collaborative practice workforce, in order to meet the healthcare needs of today's world outside the United States. So, what is the type of work that the Global Forum does?

We meet twice a year, we do a series of conversations that are global, representing different perspectives and we produce reports on a regular basis. Again, these are all downloadable, and free PDFs. So, this is the conversation, the sheet that I put out for you on your table.

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I'm going to ask you to pause, and think silently for about 15 or 20 seconds, and think about, why is the work of an organization like the Global Forum so important to you in your individual role? And I have some bullets here just for thought, but silently reflect and I'll put on my little timer for about 15 seconds, and think about why that's so important.

All right. So, I'm going to bring it to a group conversation and ask…and I can…I'm a walker anyway, I [inaudible]. Ask if you want to share from your table, why is this work important or is this work important?

Is this work that we should be investing in? What do you think? There was a lot of chatter just a second ago. So I know you all have ideas. Is this something that we should be spending time and energy on? - [inaudible]

- Why? - [inaudible]

- Hey, you know what, I can…Yeah, I'm better.

- That's okay. So, I was chatting with one of my colleagues from Emory and we're so interconnected. And I think back to the 2014 Ebola, within a matter of a week, we had a patient who was in Liberia, came to Dallas, then, we had all of these other patients, then at Emory, in Maryland, and in seven days, all of this is happening.

And so, it just makes sense, if our patients are global, we should be global.

- Yeah, absolutely. Absolutely. That was a great example. Great example. How about anybody else? Is that important for the nursing profession? Is it important for you in your role to have a conversation with your other professions?

Yeah, yeah. Do you think that we can achieve what we need to achieve if we stay in our single siloed models?

- No way.

- No way. No way. I think at the end of the day that seems to me the biggest, you know, why. Why we have to work together, because we've spent 45 years having a conversation in silos. And we're going to have to have a different type of conversation and a different model going forward. So, what's happening in the practice environment? I'll walk back up here now.

In the practice environment now, and I think, certainly, to err is human, and 1999 highlighted this, the errors that happen in practice when we don't work together and if you look at the Joint Commission's sentinel reports, communication over, and over, and over again, is one of the top three causes of a sentinel event or factors associated with a sentinel event.

So, happening in 2009, still happening. 2017, Vanderbilt hit with a $25.5 million lawsuit. Somebody who put a stent in the wrong kidney. And this woman is now on dialysis for life.

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You think with all of the work that we do on the OR checklist and signing, etc., etc., and we are still having this type of... I mean, these events are still happening today. Ultimately, you know that no surgeon went in and wanted to put a stent in the wrong place. I mean, I worked as a hospice...I mean, all of us have worked in nursing for a long time.

I have never worked with somebody who doesn't want to come in and do a good job at their job. It's always a function of a larger problem. So, I want to tell you a short story, and you know who this is, right? Atul Gawande. And this is a conversation that I actually heard at another event in Canada relaying this story.

And I wanted to make sure that this story…and it was something that Dr. Gawande had said. And I wanted to make sure that this wasn't, you know, somebody told a story and it was attributed to Dr. Gawande. So, I had a conversation with him and I said, "Can I share this story?A, I want to make sure it was really you?" And he said, "Yes, it was really me."

And I said, "Can I share this story?Because I think it's really important?" And he said, "Sure." So, Atul Gawande wanted to become a better surgeon. So, he reached out to a colleague a mentor that he thought was a fantastic surgeon and he said, "Can you come in to the operating room and watch me operate and can you give me feedback on how well I'm doing?"

And so, the other surgeon said, "Sure." So, he said, you know, "Watching how you operate, if you move the drape over this way, think you can access the surgical site a little bit better. If you position this, your..." hopefully, the RN at first assist doesn't go away. But you know, "The others in the operating room have an easier time doing their job." And very effective, very effective.

But what Atul Gawande recognized later, was there was a ton of people in the operating room who operated with him every single day, who could have given him that feedback. They knew how he operated. They knew when he did well, and when he didn't, and if they move the drape this way a little bit, that they would have had an easier access to help him.

But he didn't feel like he could reach out to somebody else in the operating room who wasn't a member of his own profession. So, for those of you who have been, you know, in surgery or working with many surgeons, you know, that feeling of, "Can I ask somebody who's outside my profession to give me feedback?" is a bit of a risky proposition, right?

You have to be humble in that space. But how valuable that feedback would have been and how much earlier he could have gotten that feedback as opposed to waiting for another surgeon to come in and give him that type of feedback. And what they did at Harvard, based on that understanding or that realization is, they implemented a 360 review for all physicians within that medical system.

And they had to go out and ask other people who are not members of their own profession to give them feedback. And I think something like 85% or 88% of the physicians who participated in that said that they absolutely received feedback that made them a better physician ultimately.

And they're continuing to replicate that model. And I thought to myself, as a nurse, I have never been evaluated by somebody who wasn't a nurse. And what a waste, you know? Why in our models, we don't

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even go outside of our own professions and say, "Can you give me feedback on how I am?I'm an ICU, an ER nurse by background, and I've never had anybody but a nurse give me feedback."

And what a missed opportunity, I think, on both sides to have a conversation that would change the trajectory. ANCC started doing some work with ACGME in the residency space, based on our joint accreditation program, and I went to the head of ACGME and I said, "Do you want to have a conversation about interprofessional collaboration in the residency space?"

And he was like...and I was ready to lay all the reasons why. And he said, "Absolutely, absolutely." They have so much trouble in medical residency programs of waiting till a physician gets to the end of the residency program, and then somebody saying, "Yeah, you're not competent, you know, you're not really meeting the goals that we want you to…" and that feedback loop that wasn't going on along.

And he said, "You know, basically, Kathy, I want to the nurse in the ICU to tell me how that resident is at 3 a.m.on a Saturday night, because you know what that resident is like at 3 a.m.on a Saturday night, as compared to when they have an interview with their supervising faculty." There can be a big difference in that type of performance. So, looking at…I'm in the literature a lot in the interprofessional space.

So, just looking at perceptions of teams and teamwork, how teams were perceived when you talk to surgeons in the operating room. Teams exist because I need them to be there to take care of the patient. They are described as people who are co-located or having a shared clinical space.

And I would argue that that's not teamwork, that happens to be you happen to be in the same space. And we know this happens not only between conversations between professions or battles between professions that occur, but, frankly, they also occur intraprofessionally. So, when's the hardest time to get a patient out of the ED?

- Change of shift.

- Change of shift. There's a battle every day between the… as soon as change of shift, nobody on the floor wants to take the call, right? Inpatient to outpatient, patients discharged to the nursing home, they get broken, they come back, they get fixed, they go back, you know, that's not a collaborative conversation.

And at the end of the day, who's the one that is harmed in that conversation? The patient, every single time. We also know in the practice environment that we are burning out our healthcare professionals across every profession, we are burning them out. And if we don't work collaboratively together, the research will show you that when we work together collaboratively, and we have a shared sense of accountability and shared responsibilities, we actually decrease everybody's stress because we have a sense of community and a sense of collaboration.

And we're in the middle of a pretty significant opioid crisis that, again, we're not going to be able to have the impact that we need until we're collaboratively working together. So, where is the evidence? And this is a brief dive into what…from the practice setting where most of you were at least practicing if you don't have a foot in academia, also.

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Interprofessional continuing education when two or more professions collaborate, learn from, with, and about each other, which means you have to have interaction. You can't just have people sitting in the room, in their own separate silos and not interacting. So, any kind of interprofessional education requires people to learn from, with, and about each other, which means they have to talk together, they have to be seated together.

They have to work together somehow. And it's not just co-locating. Often in interprofessional, particularly, the practice space, we say, "Oh, we do interprofessional education.We had this educational activity.And physicians came and nurse practitioners came and the pharmacist came, so it's interprofessional." Well, I would call that interprofessional registration, not actually interprofessional education.

Interprofessional education means you actually have to plan, specifically, for those professions, and there's a reason why. Because we each are coming with our own lens, and we can say that this education meets the needs...you know, the practice gaps of that particular profession. We do know that from the literature, this was a really nice systematic review in the interprofessional space.

This literature review is about 50% in the academic setting, so with students and 50% in the practice setting, that the vast majority of outcomes are positive, or they're not measured, and we also measure very low level. So one of the areas from a research perspective is moving into evaluating actually impact on practice or impact on outcomes, not impact on, "I feel better about myself."

We do a ton of research in the smiley scale area. And we need to move beyond that to actually looking at impact on practice and outcomes. But we do know in those studies that looked at impact on practice and outcomes, they are pretty significant, not only from a patient outcome perspective but also from a cost and efficiency perspective. So, if you look at, was there an impact of participating in interprofessional continuing education on a change in organizational practice?

So, improved screening, improved safety practice. Or was there a benefit to the client or patient and you see improvements in mortality rates, reduced clinical errors, reduced patient length of stay and improvements in clinical outcomes, blood pressure and cholesterol. We absolutely can demonstrate that when you bring people into an educational environment and work collaboratively together, particularly about a patient problem, which galvanizes people together, if you say, "We're going to bring people together, we're going to talk about communication," then what ends up happening?

Like, "I don't have a problem communicating, I communicate fine, I do not need to go to this." But if you have a conversation about, "We have a high rate of acute renal failure in our post-surgical cardiac population," that's somebody that people can galvanize around.

So, some of it is, you know, putting cheese on the broccoli, but it does then bring people to the table. And more outcomes of interprofessional collaboration, so, interprofessional education in the academic side, moving into interprofessional continuing education and moving into interprofessional collaborative practice. And these are the kinds of outcomes that we see.

All right, so this is a test yourself. So, can you guys see this from this side? Okay. I, on the other hand, have to put on my glasses, okay. So, influences on collaboration. Do you think working…and this is

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based on a research study. Working in close proximity to my colleagues, does that help or hinder interprofessional collaboration or could it do both?

It helps. How about, "I have a heavy workload?"

- Hinders.

- Hinders. Turnover is high?

- Hinders.

- Hinders. Physicians and nurse practitioners are the leaders of the team? [inaudible] said that doesn't happen. This is looking at primary care clinics, actually. What do you think?

- Both.

- Both. Both? Both. If there's shared accountability and there's a good working relationship between the physician and APRN, this happened to be nurse practitioners, it actually improves patient outcomes. If they are battling each other over control of that patient, it that can hinder.

Team members rotate often?

- Hinders.

- Hinders, right? You don't have that sense of continuity. There's actually some... looking at geographic admitting criteria where you're putting patients in the same area with the same, particularly, physician and nurse because they happen to be the professions that collaborate most just by sheer volume, actually improves patient outcomes. Oh, shoot.

Okay. Well, I told you the answer on this one. So, when you understand each other's roles and responsibilities, you can work collaboratively together, you can, you know, certainly depend on each other for different reasons. I interact on a personal and professional level with my colleagues. Help?

Helped, right? So, when medical resident, there's a nurse and we're having a conversation and we're talking about how do you potty-train a two-year-old, right? You're two people talking, you're not then...you know, it gives a different depth to the conversation and a different type of collaboration than if you're just talking over being, you know, the care of Mrs.

Jones in room 14. So, that goes to co-locating, right? When you put people together, when you're charting together, when you're having conversations together, those are really effective strategies that can be done now. Those don't require a huge...you know, blowing up the healthcare system and doing something differently, just co-locating as a strategy to improve interprofessional collaboration.

My leaders hold formal meetings for me and my colleagues.

- Helps.

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- Helps? My colleagues have relevant knowledge that I need.

- Helps.

- It helps. This is my patient.

- Hinders. It hinders. So, looking at..and this is, again, you know, a dive into literature, but...and this was with two parents. I think they were both nurse practitioners who wrote this article, looking at the interprofessional collaboration skills need to be examined and revised, and that there are models.

And I think we reflected on this earlier in terms of the conversations about the need for preceptors, different clinical settings, that having that collaboration there actually improves the ability for all of those in training. I don't care whether you're a medical resident, whether you're a nursing school, whether you're an APRN...improves that ability to collaborate, because we do have to teach that for people to go out.

And then there's a lot of conversation if when should there be collaboration? Should it be early? Should it be late? Do people need to have an individual sense of their own professional identity before we put them in with others? The fact is people come in with a professional identity before they even enter into school.

So they have some preconceived ideas about what it means to be a nurse or what it means to be a physician or a pharmacist. And that professional identity continues to evolve over education and training and into practice. So what's the global conversation? And David, this reflects a little bit on the presentation that you did. Certainly, we're in an era where there is a huge explosion of evidence.

And it's very difficult for any practitioner now to keep up, clinically, with the amount of evidence that's being published. And I just pulled a few very narrow areas where you see the amount in peer-reviewed journals that's being published. I would say you're seeing not only in the United States, but globally, a trend toward more and more specialization.

So not only are you an orthopedic physician, who cares for the knee, who cares for the left knee, you're starting to see that more and more. There is...in Europe, I sit on an organization called the Association for Medical Education in Europe, and they brought in a group from the WAMC, General Medical Council, and two other...

I was representing the nurse component of this but fast-tracking into specialty practice. So, instead of going through medical school...undergraduate, medical school, residency, ultimately, to be a orthopedic surgeon, why don't we fast-track right into that?

Why do you have to go through your, you know, OB rotation, your this rotation, your this rotation? If ultimately, you want to do that, we can not only fast-track you into that and, ultimately, meet, potentially, population needs, but we can reduce the cost to the countries that are funding this and in many models, the countries are funding the education system.

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And then, what is the ultimate impact on medicine and advanced practice providers if you see, particularly, the medical community fast-tracking into specialty faster than where is…and I would say it's a huge opportunity for nursing to move into that space. Other discussions, Macy Foundation launched…did a workshop on a competency-based time-variable education model.

So, we all have competencies that are embedded and people are expected to be able to demonstrate to graduate. But this is a competency-based time-variable model. So, when you demonstrate those competencies in practice, you move on to the next stage of your educational program. So, makes a lot of sense in some ways.

Again, from a cost standpoint, from an individual need perspective, why do we keep people in a yearlong rotation if they've mastered those competencies by six months? It can create havoc on the educational model where we have cohorts of students that are entering and moving through. And I think Barbara reflected, you know, even schools that say, this many clinical hours, versus this many clinical hours, versus this many clinical hours, right?

That it is really difficult for the practice setting to be able to manage this kind of rotation schedule. So, what this group, this workgroup and again, a free published report, maybe it's competency-based time variable, but time variable within a parameter.

So, somebody demonstrates the competencies that they need to have at the end of six months, that the last six months isn't just sitting there in the same program, you know, doing the same old thing, but they move into and have an expanded skill set. So, maybe they move into research, maybe they move into a different area. So, they're using that time differently, but it puts some parameters so that the education models and practice settings can have some sort of structure around that.

And so, I think in conclusion, I'd like you to just think about what are the opportunities when you talk about looking at a global conversation in education? And where the opportunities are at the undergraduate level, at the postgraduate level or in practice, where are the opportunities for you?

When you're looking at how medicine, I think, it's evolving into more and more sub-specialization, what does that do for you from an opportunistic standpoint? And I think for those of us, particularly, certifying bodies, accreditors, regulation, and all of you practitioners, what is the call to profession?

Do we have a duty to act and to use whatever our levers are, to move this forward and, ultimately, take this conversation about interprofessional education, interprofessional continuing education to improve interprofessional collaborative practice?

And I think David and I have the same thank you slide. [inaudible]. I do have... reference list I included at the end of the slides for you and happy to answer any questions or move into lunch.

Oh, actually, three minutes. I have a couple of minutes. All anxious, it's always hard to be between food and…- It's okay, I'd just like...just more of a comment here and, like, I really appreciate your discussion in the role of interprofessional, but to be provocative in our discussion today, it is a huge barrier in the workplace.

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When you said, "Our peers, that we're supposed to reach out intercollaboratively or interprofessionally,"they don't understand our role as advanced practice nurses. How can we ask for feedback from our physician colleagues, when they view and define our role differently than we do ourselves? You know, it's easier for a physician and an RN to have that kind of collaborative feedback relationship.

But different states across this country that conversation between the physician and the APRN, like, who should be doing their evaluations, is just...I don't... we're just not there yet or we're not there in certain parts of this country or certain states in this country too. So, more of a comment than a question, but...

- Yeah. You know, I'll say two things. And I actually think probably peers in the room may have more advice for you than I do. The positive experiences I have had are reaching out to somebody on a one-on-one basis and somebody who I feel is a change agent, or who would be more amenable to having that conversation.

So, you know, all of us have been environments where there are people that..."I'm just not going to have the conversation, you're not going to be at the leading edge of this." But there are people who, you know, we have a good working relationship. And so, I feel like I could reach out and have a trust. But I will say, I believe that many of your peers are experiencing the same thing and probably have strategies that they could share.

I don't know if anybody wants to share today, but…- [Jackie] I was just going to say, I'm Jackie Baer, I'm on the board of nursing from South Carolina. And I participate in a project called Project ECHO for opioid use disorder, which is out of New Mexico. And it really is a bridge for me because I work in a rural health clinic. And it's a platform where I get on the internet and I move and I interact with social workers, pharmacists, you know, doctors, psychiatrists, and so, it's a force multiplier for me because I get the expertise from everybody to help my patient best that doesn't have the resources, doesn't have access to any of the services.

So, I think that, you know, it's not a barrier to care when you talk to these other professions, I think it can actually be a bridge for many of my patients. And it's really been amazing to learn that these modalities exist, you know, even in rural South Carolina.

- Thank you. - [Maureen] Kathy, I think I could give one example of where that 360 kind of feedback can work. I had the great good fortune at one point to work for the Aflac Cancer Center in Atlanta and the group there was...the pediatric cancer group was divided into specialty teams, so, there was leukemia team, a solid tumor team.

And what they required was that every member of that team, including the nursing assistant in the outpatient, was part of the evaluation of each member of the team. The great part of that when you...I mean, it takes some time and it takes a little effort, but it did educate everyone on the team as to those other team members' roles.

So, there was no doubt that you understood and I think it's a little bit like Dr. Gawande's article, there was never a time that you didn't learn something about your own performance from the richness of that feedback.

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- Yeah, that's a great example. Great example.

- So, with that, let's break for lunch.

- Okay. We're in a ballroom F for lunch.

- Thank you.

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