

February 21, 2000

MEDICAL ERRORS EVENT

DATE: February 22, 2000
LOCATION: Presidential Hall – OEOB 450
BRIEFING TIME: 12:00pm – 12:15pm
EVENT TIME: 12:25pm – 1:05pm
FROM: Bruce Reed, Chris Jennings, Mary Beth Cahill

I. PURPOSE

To accept a report from the Quality Interagency Coordination Task Force (QuIC) which evaluates and endorses the recommendations of the Institute of Medicine's study of medical errors, and to unveil a series of initiatives to significantly enhance patient safety.

II. BACKGROUND

Last December, you hosted a meeting at the White House to commend the Institute of Medicine for its report on medical errors. At that event, you directed the OPM to ensure that all future contracts with health plans would emphasize a commitment to the establishment of medical error reduction systems. You also directed Federal agencies to work collaboratively to review the IOM report and provide you with recommendations.

Today, you will receive that report and endorse its recommendations, including its goal of reducing preventable medical errors by 50 percent over the next five years. As is outlined below, you will embrace the IOM recommendations but actually go further, particularly with respect to the operations of Federal health systems.

We had scheduled a hospital administrator from Boston to outline the latest error techniques utilized in hospitals, as well as to be supportive of your patient safety recommendations. However, at the last moment this afternoon, he cancelled, citing his discomfort and that of the Massachusetts Hospital Association (MHA) in taking a position that was too far ahead of the American Hospital Association (AHA). The AHA strongly suggested that MHA not participate, for fear that their presence would be perceived as an implicit endorsement of the announcement you are unveiling. They had major concerns that it would reflect (accurately) that several hospital associations, such as those from New York, California, and Massachusetts would not impose – and in fact, live under – mandatory reporting systems.

Rather than seek a major public confrontation with the AHA on this issue, we chose to get a representative from the American Nurses Association. The nurse, Barbara Blakely, will relay the ANA's unconditional endorsement for your proposal and describe its importance to improving patient safety in the health care delivery system.

Today, you will unveil a comprehensive plan to improve patient safety, and announce the following new actions:

A new Center for Quality Improvement and Patient Safety. Today, you will announce that your FY 2001 budget includes \$20 million, a 500 percent increase over last year's funding level, to conduct research on medical errors reduction and create a new, IOM-recommended Center for Quality Improvement and Patient Safety. The Center will: fund research on patient safety; develop national goals for patient safety; issue an annual report on the state of patient safety; promote the translation of research findings into improved practices and policies; and educate the public.

The development of a regulation assuring that all hospitals participating in Medicare implement patient safety programs. This year, the Health Care Financing Administration intends to publish regulations requiring the over 6,000 hospitals participating in Medicare to have in place error reduction programs that include new systems to decrease medication errors. This action mirrors contractual requirements planned by the Federal Employees Health Benefits Plans and by many private sector purchasers. It also complements the voluntary efforts recently announced by the American Hospital Association.

The development of new standards to ensure that pharmaceuticals are packaged and marketed in a manner that promotes patient safety. Within one year, the Food and Drug Administration will develop new standards to help prevent medical errors caused by proprietary drug names and packaging that are easily confused with other those of other drugs. The agency will also develop new label standards that highlight common drug-drug interaction problems and other dosage errors related to medications. It will also implement a system that makes it possible to report serious adverse drug events on-line. You are committing \$33 million in the FY 2001 budget, a 65 percent increase over last year's funding level, for medical error and adverse event reporting systems at FDA.

Modernized patient safety systems at the Department of Veterans Affairs and the Department of Defense to improve medication safety. The VA and DOD have been and continue to be leaders in the use of automated and other systems to reduce medical errors. You will announce:

- *Full implementation of VA patient safety programs.*
- *Launch of new DOD patient safety programs.*

Comprehensive plans for a nationwide system of error reporting. Currently, 23 states (18 of which require hospital reporting) have reporting systems to track preventable medical errors and to help providers take corrective actions. Today you will announce support for a nationwide system of error reporting – one that will be state-based and phased in over time.

When fully implemented, this system will require mandatory reporting of preventable medical errors that cause serious injury or death, and will encourage voluntary reporting of other medical errors and “close calls.” Information will be aggregated and made public (without identifying patients or individual health care professionals) to educate the public about the safety of their health systems. Both mandatory and voluntary reporting will enable providers to target widespread problems and develop the best preventive interventions. The Administration will take several actions to promote the importance of developing and using medical error reporting systems, including:

- *Launching new research to help implement mandatory reporting systems.*
- *Supporting expansion of “peer review protections” to encourage development of post-error review processes.*
- *Implementing a required reporting system at the Department of Defense.*
- *Expanding mandatory reporting requirements for all blood banks.*
- *Implementing a voluntary reporting system nationwide for veterans’ hospitals.*
- *Encouraging the development of voluntary systems and learning from existing systems.*

III. PARTICIPANTS

Briefing Participants:

Secretary Donna Shalala
Secretary Alexis Herman
Bruce Reed
Mary Beth Cahill
Loretta Ucelli
Chris Jennings
Dan Mendelson
Sam Afridi

Event Participants:

YOU

Secretary Donna Shalala

Secretary Alexis Herman

Barbara Blakeney, First Vice President of the American Nurses Association

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

- **YOU** will be announced onto the stage, accompanied by Secretary Donna Shalala, Secretary Alexis Herman, and Barbara Blakeney.
- Secretary Alexis Herman will make brief remarks and introduce Secretary Donna Shalala.
- Secretary Donna Shalala will make brief remarks and introduce Barbara Blakeney.
- Barbara Blakeney will make brief remarks and introduce **YOU**.
- **YOU** will make remarks, work a ropeline, and depart.

VI. REMARKS

To be provided by speechwriting.

Health
Care -
Medical
Errors

**CLINTON-GORE ADMINISTRATION ANNOUNCES NEW ACTIONS TO IMPROVE
PATIENT SAFETY AND ASSURE HEALTH CARE QUALITY**
Goal to Reduce Preventable Medical Errors By 50 Percent Within Five Years
February 22, 2000

President Clinton today will receive a new report on medical errors from the Administration's Quality Interagency Coordination Task Force (QuIC) and unveil a series of landmark initiatives to boost patient safety. These initiatives will help create an environment and a system in which providers, consumers, and private and public purchasers work to achieve the goal set by the Institute of Medicine (IOM) to cut preventable medical errors by 50 percent over five years.

Developed in response to the President's call for action in December, the QuIC response endorses virtually every IOM recommendation proposed and includes actions that go beyond it. Consistent with the QuIC recommendations, the President will call for: a new Center for Patient Safety; the development of a regulation requiring each of the over 6,000 hospitals participating in Medicare to have in place error reduction programs; new actions to improve the safety of medications, blood products, and medical devices; a mandatory reporting system in the 500 military hospitals and clinics serving over 8 million patients; and a nationwide state-based system of mandatory and voluntary error reporting, to be phased in over time. The President will also commend the Vice President for his leadership on this issue, thank members of Congress in both parties for their work, and praise the efforts of consumers, doctors, hospitals, nurses, health plans and businesses to improve patient safety.

PREVENTABLE MEDICAL ERRORS: A NATIONAL CHALLENGE. Although the U.S. offers some of the best health care in the world, the number of medical errors is still too high.

- **Medical errors are common and costly.** The IOM estimates that over half of adverse medical events are due to preventable medical errors, causing 98,000 deaths a year and costing as much as \$29 billion annually. One study of over 30,000 patients indicated that nearly 60 percent of patients suffering adverse events in a hospital stay were subjected to a preventable medical error.
- **Medication errors account for a significant portion of preventable adverse events.** The IOM estimates the number of lives lost to preventable medication errors account for over 7,000 deaths annually in hospitals alone and tens of thousands more in outpatient facilities nationwide. These errors increase hospital costs by an estimated \$2 billion, and nursing homes costs by over \$3 billion. A study of hospitals in New York State indicated that drug complications represent 19 percent of all adverse events, and that 45 percent of these adverse events were caused by medical errors. In this study, 30 percent of individuals with drug-related injuries died.

PRESIDENT UNVEILS NEW COMPREHENSIVE PLAN TO IMPROVE PATIENT SAFETY. Today, the President will announce the following new actions to assure patient safety:

A new Center for Quality Improvement and Patient Safety. Today, the President will announce that his FY 2001 budget includes \$20 million, a 500 percent increase over last year's funding level, to conduct research on medical errors reduction and create a new, IOM-recommended Center for Quality Improvement and Patient Safety. The Center will: fund research on patient safety; develop national goals for patient safety; issue an annual report on the state of patient safety; promote the translation of research findings into improved practices and policies; and educate the public.

The development of a regulation assuring that all hospitals participating in Medicare implement patient safety programs. This year, the Health Care Financing Administration will publish regulations requiring the over 6,000 hospitals participating in Medicare to have in place error reduction programs that include new systems to decrease medication errors. This action mirrors contractual requirements planned by the Federal Employees Health Benefits Plans and by many private sector purchasers. It also complements the voluntary efforts recently announced by the American Hospital Association.

The development of new standards to ensure that pharmaceuticals are packaged and marketed in a manner that promotes patient safety. Within one year, the Food and Drug Administration will develop new standards to help prevent medical errors caused by proprietary drug names and packaging that are easily confused with other those of other drugs. The agency will also develop new label standards that highlight common drug-drug interaction problems and other dosage errors related to medications. It will also implement a system that makes it possible to report serious adverse drug events on-line. The President is committing \$33 million in the FY 2001 budget, a 65 percent increase over last year's funding level, for medical error and adverse event reporting systems at FDA.

Modernized patient safety systems at the Department of Veterans Affairs and the Department of Defense to improve medication safety. The VA and DOD have been and continue to be leaders in the use of automated and other systems to reduce medical errors. The President will announce:

- *Full implementation of VA patient safety programs.* This year, VA will complete implementation of an automated order entry system in all its health care facilities, along with a barcoding system for medication administration. These systems match patients with the medication they are supposed to receive. A 1999 pilot test indicates that they can reduce medication errors by up to 70 percent. In addition, the VA will increase patient safety training for staff from 15 to 20 hours a year and place "patient safety checklists" in operating rooms at every VA hospital.
- *Launch of new DOD patient safety programs.* The DOD will launch an integrated pharmacy system for their over 8 million beneficiaries by the end of 2000. This new system will allow DOD physicians to accurately track prescriptions as they are filled in both public and private pharmacies worldwide. This fall, DOD will begin implementing a new computerized medical record that makes all relevant clinical information on a patient available when and where it is needed. It will be phased to all 500 DOD hospitals and clinics over three years.

Comprehensive plans for a nationwide system of error reporting. Currently, 23 states (18 of which require hospital reporting) have reporting systems to track preventable medical errors and to help providers take corrective actions. Today the President will announce support for a nationwide system of error reporting – one that will be state-based and phased in over time.

When fully implemented, this system will require mandatory reporting of preventable medical errors that cause serious injury or death, and will encourage voluntary reporting of other medical errors and "close calls." Information will be aggregated and made public (without identifying patients or individual health care professionals) to educate the public about the safety of their health systems. Both mandatory and voluntary reporting will enable providers to target widespread problems and develop the best preventive interventions. The Administration will take several actions to promote the importance of developing and using medical error reporting systems, including:

- *Launching new research to help implement mandatory reporting systems.* The QuIC will ask the National Quality Forum to develop a set of patient safety measurements that can lay the foundation for a uniform system of medical errors data collection. HCFA will launch a pilot project in up to 100 hospitals to help them implement confidential mandatory reporting systems. HCFA will also work with hospitals in states that currently have mandatory reporting systems to identify and address issues associated with presenting medical errors data to the public.
- *Supporting expansion of "peer review protections" to encourage development of post-error review processes.* Individuals or family members should have access to information about a preventable medical error causing serious injury or death. But analyses to determine the shortcomings of the hospital's delivery system (root-cause analysis) and subsequent action to prevent such errors in the future should not be "discoverable information" used in litigation. That is why the Administration will support legislation that protects provider and patient confidentiality in order to encourage post-error review – without undermining individual rights to redress for malpractice. Such legislation should be enacted in conjunction with, or prior to implementation of, nationwide mandatory and voluntary reporting systems.
- *Implementing a required reporting system at the Department of Defense.* Beginning this spring, DOD will implement a new mandatory reporting system in its 500 hospitals and clinics, which serve approximately 8 million patients.
- *Expanding mandatory reporting requirements for all blood banks.* By the end of the year, FDA will release regulations requiring the over 3,000 blood banks and establishments dealing with blood products to report serious errors affecting patient safety.
- *Implementing a voluntary reporting system nationwide for veterans' hospitals.* VA currently operates a mandatory reporting system. By the end of the year, VA will also implement a voluntary nationwide reporting system for adverse events and "close calls." Information will be collected by an independent entity and disseminated to all VA health care networks. Implementing this system is likely to lead to a richer database of information, as incidents are reported on a de-identified basis, and will allow researchers to compare the effectiveness of identified systems to de-identified ones.
- *Encouraging the development of voluntary systems and learning from existing systems.* The Center for Quality Improvement and Patient Safety, with its Task Force partners, will evaluate current voluntary reporting systems at the federal and state levels and develop recommendations to improve them. This study will demonstrate which entity or entities would be best to collect, analyze, and disseminate information on frequently occurring errors and the best interventions to prevent them.

If all states have not implemented mandatory reporting systems within three years, the QuIC will deliver recommendations to the President that assure all health care institutions are reporting serious preventable adverse events. If research conducted by the Agency for Healthcare Research and Quality and other agencies indicates that the implementation of these systems does not enhance (or even detracts from) patient safety, the QuIC will modify its recommendations accordingly.

COMMENDS CONGRESS AND THE PRIVATE SECTOR FOR WORKING TO PROMOTE PATIENT SAFETY. Today, President Clinton noted the strong bipartisan interest in improving patient safety and that committees in the House and Senate held hearings to explore possible avenues to address this issue. The President noted that the Senate Appropriations and Health, Education, Labor, and Pensions (HELP) Committee will hold a joint hearing today, and have separately held several previously. He thanked the members of these Committees and other leaders in the Congress on this issue, including Senators Kennedy, Jeffords, Spector, Harkin, Dodd, Frist, Lieberman, Kerrey, Grassley, and several members of the House in both parties for their work. He also recognized and commended the ongoing work of the American Hospital Association, the American Medical Association, the American Nurses Association, and the Business Roundtable's "Leapfrog Group".

BUILDS ON THE CLINTON-GORE ADMINISTRATION'S LONGSTANDING COMMITMENT TO IMPROVING PATIENT SAFETY. In early 1997, the President established the Advisory Commission on Consumer Protection and Quality in the Health Care Industry (Quality Commission) and appointed Health and Human Services Secretary Shalala and Labor Secretary Herman as co-chairs. The Quality Commission released two seminal reports on patient protections and quality improvement. Subsequent to the Commission's second report on patient safety and quality improvement, and consistent with its recommendations, the President established the Quality Interagency Coordination Task Force (QulC), an umbrella organization also co-chaired by Secretary Shalala and Secretary Herman, to coordinate Administration efforts to improve quality. Also consistent with the Quality Commission's recommendations, Vice President Gore launched the National Forum for Health Care Quality Measurement and Reporting. The "Quality Forum" is a broad-based, widely-representative private advisory body that develops standard quality measurement tools to help purchasers, providers, and consumers better evaluate and ensure the delivery of health care services. In addition to the work and significant potential of the QulC and Quality Forum, other Federal agencies have made significant efforts to reduce medical errors and increase attention on patient safety. Last December, at the President's direction, the Office of Personnel Management announced it will require all plans participating in the federal health program to implement error reduction and patient safety techniques.

December 6, 1999

MEETING AND STATEMENT ON MEDICAL ERRORS

DATE: December 7, 1999
LOCATION: Cabinet Room (Meeting)
Rose Garden (Statement)
BRIEFING TIME: 10:20am – 10:45am
MEETING TIME: 10:45am – 11:15am
STATEMENT TIME: 11:20am – 11:45am
FROM: Bruce Reed, Mary Beth Cahill, Chris Jennings

I. PURPOSE

You are unveiling a new initiative to improve health care quality, improve patient safety, and prevent medical errors.

II. BACKGROUND

Today, you will:

- **Issue an Executive Memorandum directing the Quality Interagency Coordination Task Force (QuIC) to develop new strategies to improve health care quality and protect patient safety.** Today, you will sign an executive memorandum directing the QuIC to report back recommendations to you, through the Vice President, within 60 days that: identify prevalent threats to patient safety and reduce medical errors that can be prevented through the use of decision support systems, such as automated patient monitoring and reminder systems; evaluate the feasibility and advisability of the recommendations of the Institute of Medicine on patient safety; develop additional strategies, including the use of information technology, to reduce medical errors and ensure patient safety in Federal health care programs; evaluate the extent to which medical errors are caused by misuse of medications and medical devices and consider steps to further strengthen FDA's response to this challenge; and identify opportunities for the Federal government to take specific action to improve patient safety and improve health care quality through collaboration with the private sector, including the newly constituted National Forum for Health Care Quality Measurement and Reporting.

- **Announce that each of the more than 300 private health plans participating in the Federal Employee Health Benefits Program will be required to institute quality improvement and patient safety initiatives.** Today, you will announce that the Office of Personnel Management, which oversees plans serving 9 million Americans, will include in its annual call letter to be issued next spring a requirement that FEHBP plans use error reduction and other patient safety techniques in order to improve the quality of care in the program. In addition, OPM will supplement this initiative using workplace campaigns to improve mammography and medical screening rates among Federal employees, retirees, and their families. Finally, OPM will initiate new ways to measure and report on the quality of care that plans deliver to enrollees.
- **Instruct Federal agencies administering health plans to evaluate and, where feasible, implement the latest error reduction techniques.** You will request that the Departments of Health and Human Services, Veterans Affairs, and Defense, and the Office of Personnel Management evaluate and, where feasible, implement the latest error reduction techniques in a manner consistent with the Administration's recently released draft regulations on patient privacy. These agencies administer Medicare, Medicaid, CHIP, the Federal Employees Health Benefits Program, the nationwide network of veterans hospitals and outpatient clinics, and the military health care system, serving over 85 million Americans.
- **Announce the reauthorization of the Agency for Healthcare Research and Quality, ensuring a multi-million dollar investment in research programs to improve health care quality.** You will announce that you signed legislation yesterday reauthorizing the Agency for Healthcare Research and Quality (AHRQ). To achieve the goals of this legislation, which is the result of the bipartisan efforts of Senators Frist and Kennedy and Congressmen Bliley and Brown, the FY 2000 budget increases the agency's resources by 16 percent over FY 1999 funding levels, for a multi-million dollar investment in health care quality. These new funds will be used for important quality improvement research, including the over-and-under utilization of services, variation in the delivery of services, and efforts to prevent medical errors. In recognition of the critical role that states do and will play in assuring and improving health care quality, AHRQ will hold a nationwide conference this March with senior state health officials to promote best medical practices, to prevent medical errors and improve patient safety, and to better develop a working relationship between the Federal and state governments in this area.
- **Direct the Office of Management and Budget, the Domestic Policy Council, and other agencies to develop additional health care quality and patient safety initiatives for the FY 2001 budget.** You will direct the Office of Management and Budget, the Domestic Policy Council, and the Office of the Vice President to work with the Department of Health and Human Services and other agencies to develop additional initiatives within the context of the FY 2001 budget that build on our current error prevention, quality improvement, and patient safety initiatives.

- **Praise the American Hospital Association for launching a new medication safety campaign.** You will praise the American Hospital Association for launching a new partnership with the Institute for Safe Medication Practices to prevent patient medication errors. Today, the AHA will send a list of "best practices" on prevention medication errors to all 5,000 of their member hospitals. In the coming months, they will also begin to: develop a medication safety awareness test that surveys hospitals' medication error prevention systems; track implementation by the hospital and health system field of the practices for reducing and preventing errors; and working with national experts to develop a model medication error reporting process. By taking these actions today, the AHA joins numerous other health care organizations making an important commitment to this area, including the American Medical Association's initiative to establish the National Patient Safety Foundation.

HIGHLIGHT THE CLINTON-GORE ADMINISTRATION'S LONGSTANDING COMMITMENT TO IMPROVING HEALTH CARE QUALITY. Over the past two years you and Vice President Gore have provided critical consumer protections to the 85 million Americans enrolled in Federal health plans and set the stage for the Congress to pass a strong, enforceable, Patients' Bill of Rights. In March of 1998, you established the Quality Interagency Coordination Task Force, which has been instrumental in promoting advances in health care quality nationwide. You also asked the Vice President to help launch the National Forum for Health Care Quality Measurement and Reporting, a broad-based, widely representative private advisory body that develops standard quality measurement tools to help all purchasers, providers, and consumers of health care better evaluate and ensure the delivery of quality services. In addition to the work and significant potential of the QuIC and Quality Forum, the Departments of Veterans Affairs and Defense have been leaders in patient safety and quality improvement programs. The Department of Veterans Affairs also spearheaded the development of the National Patient Safety Partnership to address issues related to adverse medical events. Finally, the Health Care Financing Administration has implemented new quality improvement initiatives through its peer review organization efforts, and the Food and Drug Administration is working to implement new reporting systems that allow for a rapid response to medical errors causing patient injury.

III. PARTICIPANTS

Briefing Participants:

Bruce Reed

Mary Beth Cahill

Loretta Ucelli

Joe Lockhart

Chris Jennings

Sam Afridi

Meeting Participants:

YOU

Federal participants:

Secretary Alexis Herman

Director Janice LaChance

FDA Administrator Jane Henney

HCFA Administrator Nancy Ann Min DeParle

John Eisenberg, Director of the Agency for Healthcare Research and Quality

Paul London, Department of Commerce

Tom Garthwaite, Acting Undersecretary for Health at the Department of Veterans Affairs

Private sector participants:

Bruce E. Bradley, Director of Managed Care Plans for General Motors

Dr. Christine Cassel, Chairman of the Department of Geriatrics and Adult Development
at Mt. Sinai School of Medicine

Richard J. Davidson, President of the American Hospital Association

Mary Foley, MSN and RN, First Vice President of the American Nurses Association

Karen Ignani, President and CEO of the American Association of Health Plans

Dr. William Richardson, Chair of the IOM Committee on Quality of Health Care in
America and President and CEO of the W. K. Kellogg Foundation

John C. Rother, Director for Legislation and Public Policy of the American Association
of Retired Persons

Gerald M. Shea, Assistant to the President for Government Affairs of the AFL-CIO

Dr. Kenneth W. Kizer, President and CEO of the National Forum for Health Care Quality
Measurement and Reporting

IV. PRESS PLAN

Meeting – Closed Press

Statement – Open Press

V. SEQUENCE OF EVENTS

- **YOU** will meet with representatives of the health care academic and advocate, consumer, provider, and business communities.
- **YOU** will proceed to the Rose Garden to make a statement.
- **YOU** will make opening remarks and introduce Richard Davidson, President, American Hospital Association.
- Richard Davidson will make brief remarks.
- **YOU** will make remarks and depart.

VI. REMARKS

To be provided by speechwriting.

VI. ATTACHMENTS

Seating Chart

Talking Points

Participant Biographies and Statement Summaries

SUGGESTED TALKING POINTS ON ENSURING PATIENT SAFETY

BEFORE THE DISCUSSION:

- Thank you for coming today to discuss how we can reduce medical errors, enhance patient safety, and improve overall quality in the health care delivery system. You all come from different backgrounds, but you share a strong and unified commitment to this issue, and I appreciate your presence today.
- Just last week, as we all know, the Institute of Medicine, under the leadership of Ken Shine, William Richardson, and Janet Corrigan, released their report on medical error prevention entitled "To Err Is Human: Building a Safer Health Care System". I want to commend the IOM and their staff for their fine work, and in a moment I'll want to ask Dr. William Richardson to briefly summarize its findings.
- But first, I want to ask Secretary Herman to make a few opening remarks. As you know, under her and Secretary Shalala's extraordinary leadership, the Quality Commission produced an extremely impressive report on these issues, and the Quality Interagency Coordination Task Force (QuIC), which I established last year, has begun to help coordinate Administration efforts in this area. Almost every one of the member agencies on the QuIC are represented today, and I am pleased that John Eisenberg, who coordinates its work, is here as well.
- The Vice President has also exhibited a great deal of leadership in this area. He helped launch the Quality Forum, a private entity that is developing measurement tools to help evaluate and ensure the delivery of quality health care services. And I am pleased that Ken Kizer, the new President and CEO of the National Quality Forum, is here with us today.
- All of us in this room have been working on this issue for years. Your collective work has been impressive, and I think that you have come a long way in helping the nation address these important issues. I want to thank each and every one of you for your dedication. Now I'd like to turn it over to Secretary Herman.

AFTER THE DISCUSSION:

- I think that the announcement that AHA is making today represents great progress, and I want to commend Dick Davidson and the AHA for it. In addition to highlighting the AHA's initiative, as many of you know, I will be highlighting a number of announcements I'll be making today in order to continue to focus much needed attention on this issue and move forward to apply some of the best practices for avoiding errors and improving patient safety.
- The announcements I'll be making today include:

Issuing an Executive Memorandum directing the Quality Interagency Coordination Task Force (QuIC) to develop new strategies to improve health care quality and protect patient safety.

Announcing that each of the more than 300 private health plans serving more than 9 million Americans participating in the Federal Employee Health Benefits Program will be required to institute quality improvement and patient safety initiatives.

Instructing Federal agencies administering health plans, including Departments of Health and Human Services, Veterans Affairs, and Defense, and others participating within the Quality Interagency Task Force to evaluate and, where feasible, implement the latest error reduction techniques.

Announcing the reauthorization of the Agency for Healthcare Research and Quality, ensuring a multi-million investment in research programs to improve health care quality.

Direct the Office of Management and Budget, the Domestic Policy Council, and other agencies to develop additional health care quality and patient safety initiatives for the FY 2001 budget.

- I believe that these initiatives will further build on the contributions you have already made. I know that I speak for the whole Administration when I say that I look forward to working with each and every one of you. Now, I'd like to invite you to join me in the Rose Garden for these announcements.

PARTICIPANT BIOGRAPHIES AND STATEMENT SUMMARIES

Secretary Herman, the co-chair of the Quality Commission and the QuIC, together with Secretary Shalala, will acknowledge your role as well as the role of everyone in the room for their commitment to improving quality health care. She will speak immediately after your opening remarks and will introduce Dr. William Richardson, the Chairman of the Institute of Medicine's Committee on the Quality of Health Care in America.

Dr. William Richardson is the Chairman of the Institute of Medicine's Committee on the Quality of Health Care in America and the Chief Executive Officer of the W.K. Kellogg Foundation of Battle Creek, Michigan. He will acknowledge the role of Quality Commission in successfully highlighting these issues, present some of the key findings from the report the Institute of Medicine released last week on medical errors, and provide a summary of its key recommendations.

John Rother, Director for Legislation and Public Policy of the AARP, will represent the consumer's perspective and underscore the importance of a proactive effort to eliminate medical errors to patients. He is likely to use the analogy of the safety initiatives at the Federal Aviation Agency as an analogy for what should be done in the health care system. He will also briefly reference the importance of balancing the need for improvements in this area with the importance of protecting the privacy of medical records, although he wants to make sure that we do not overreact to the concerns of privacy advocates and lose out on the opportunity to improve quality.

Chris Cassell, former President of the American College of Physicians and Professor and Chairman, Department of Geriatrics and Adult Development at the Mount Sinai School of Medicine, will present the physician's perspective on quality assurance and the importance of creating approaches to medical error reductions that are designed to improve quality rather than threaten providers. She will acknowledge, however, that numerous errors do take place that are preventable, and that research similar to that put forth by the Institute of Medicine and the Quality Commission are essential to enhancing quality and constraining cost.

Bruce Bradley, the Director of Managed Care Plans for General Motors, will represent General Motors and the entire Business Round Table (BRT). Mr. Bradley has been instrumental in engaging the business community's interest in this issue and has been essential in getting the BRT to support quality improvement tools such as the Health Employer Information Data and Information Set. The business community is extremely interested in being associated with this issue, not only because of its potential to constrain costs and improve quality, but because it allows them to be associated with a pro-patient initiative at a time when they are primarily associated with their opposition to the Patients Bill of Rights.

Mary Foley, a First Vice President of the ANA, will focus on the unique role that nurses play as a front line deliverer and enforcer of quality health care. She will thank you and the Administration for the consistent recognition of their role in the health care delivery system and our consistent records of ensuring that they are at the table for discussions on these and other important health policies.

Kenneth Kizer is the President and CEO of the National Quality Forum and the former Undersecretary for Health at the Department of Veterans Affairs. Ken left the Administration under less than ideal circumstances, as he and OMB frequently tangled over his unwillingness to follow protocol on decisions related to Veterans Affairs health programs. As a consequence, he was not reappointed to his position. Having said this, he is a great innovator on health systems issues and an visionary on the use of information technology to improve the health care delivery system. We are expecting him to praise the Quality Commission's work and the launch of the Quality Forum by the Vice President. He will also emphasize the need for uniform quality standards to evaluate health care delivery, and may compare the use of such standards with the desirability of utilizing similar standards to improve education in the schools.

Gerry Shea, the Assistant to the President for Government Affairs for the AFL-CIO, will represent Labor's commitment in this area. The AFL-CIO has been extremely active in the quality debate, at least partly because they believe it to be useful camouflage for their interest in assuring adequate staffing in health care settings rather than insisting upon specific patient to health care personnel ratios. They believe tough quality standards will serve to achieve that outcome without an explicit personnel to patient ratio mandate. Having said this, they, like the business industry, are always looking for ways to constrain costs so that dollars spent on health benefits for the workforce are not wasted.

Karen Ignagni is President and Chief Executive Officer of the American Association of Health Plans. Although AAHP has been a strong defender of the managed care industry and a steadfast critic of the Administration on the Patients Bill of Rights, she will no doubt highlight the constructive role that managed care plans can play in implementing error reduction programs and improving the quality of care. She has agreed not to raise our differences on the Patients Bill Of Rights publicly at this meeting, but will indicate her commitment to work with the Administration on at least this element of the health care quality agenda.

Dick Davidson, the President of the American Hospital Association, is likely to thank you for your assistance in passing the Balanced Budget Refinement Act, which returned over \$16 billion to Medicare providers over the next five years. He will highlight the commitment that the AHA has in reducing medical errors and summarize the initiative he and the Institute for Safe Medication Practices are unveiling with you, including: sending a list of "best practices" on prevention medication errors to all 5,000 of their member hospitals; developing a medication safety awareness test that surveys hospitals' medication error prevention systems; tracking implementation by the hospital and health system field of the practices for reducing and preventing errors; and working with national experts to develop a model medication error reporting process.

John Eisenberg is the head of the Agency for Research and Healthcare Quality, which you reauthorized yesterday when you signed the Healthcare Research and Quality Act of 1999, and also serves as the lead quality coordinator for the QulC. John's role will be to wrap up the discussion and underscore the importance of all the interests in and outside of this meeting working together for the common purpose of patient safety enhancement, error reduction, and quality improvement. He will focus on the role of Federal agencies in serving as model programs in these areas and might cite a few examples. He will then turn the meeting over to you to make a few final comments about your announcements for today and your appreciation for work of the parties in the meeting on this issue.

December 7, 1999

MEMORANDUM FOR THE QUALITY INTERAGENCY COORDINATION TASK FORCE

SUBJECT: IMPROVING HEALTH CARE QUALITY AND ENSURING PATIENT SAFETY

Assuring quality through patient protections is a longstanding priority for this Administration. Over the past two years, with the invaluable assistance of the Vice President, Secretary Shalala, Secretary Herman, this Administration produced the landmark report on health care quality from the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. I extended the patient protection provisions from this report to the 85 million Americans enrolled in Federal health plans by executive action, setting the stage for the Congress to pass a strong, enforceable, Patients' Bill of Rights. Equally as important as that patient protections are in place, however, is improving the quality of the services available to these patients.

The United States has some of the finest medical institutions and best trained health care professionals in the world. However, as the Quality Commission reported last year, millions of Americans are harmed - or even killed - each year as a result of inappropriate or erroneous medical treatment. These health care quality problems include the underutilization of needed services, the overutilization of unnecessary services, and medical errors in the delivery of care. In addition, there is a continuing pattern of wide variation in health care practice.

As the recent Institute of Medicine study confirms, preventable medical errors present an extraordinary example of the importance of improving the quality of health care in our nation. Over half of the adverse medical events that occur each year are preventable, causing the deaths of as many as 98,000 Americans annually and adding as much as \$29 billion to our nation's health care spending. These costs are far outweighed by the impact these errors have on the lives of individuals and families and in the trust of the American people in the quality of the care they receive.

To build on the initial efforts of the Quality Commission and the leadership of the Departments of Health and Human Services, Labor, Veterans Affairs, and Defense, the Office of Personnel Management, and other agencies in implementing a range of quality improvement initiatives, I established the Quality Interagency Coordination Task Force (QuIC) to help coordinate Administration efforts in this area. I also asked the Vice President to help launch the National Forum for Health Care Quality Measurement and Reporting. This broad-based, widely representative private advisory body, which includes senior government participants is developing standard quality measurement tools to help all purchasers, providers, and consumers of health care better evaluate and ensure the delivery of quality services.

In addition to the work and significant potential of the QulC and Quality Forum, the Departments of Veterans Affairs and Defense have been leaders in employing information technology to enhance their ability to provide higher quality of care to patients. Moreover, the Food and Drug Administration is working to implement new reporting systems that allow for a rapid response to medical errors causing patient injury. However, despite all the progress that has been made, it is clear that more must be done.

Recent advances in technology and information systems can help eliminate dangerous medical errors, lower costs by improving communications between doctors, eliminate redundant tests and procedures, and build automatic safeguards against harmful drug interactions and other adverse side effects into the treatment process. Despite this fact, very few public and private health plans, hospitals, and employers appropriately use these new techniques.

Therefore, I hereby direct the Quality Interagency Coordination Task Force, to report to me a set of recommendations on specific actions to improve health care outcomes and prevent medical errors in both the public and private sectors in a manner that consistent with the strong privacy protections we have proposed. This report shall:

- Identify prevalent threats to patient safety and medical errors that can be prevented through the use of decision support systems, such as patient monitoring and reminder systems;
- Evaluate the feasibility and advisability of the recommendations of the Institute of Medicine's Quality of Health Care in America Committee on patient safety;
- Identify additional strategies to reduce medical errors and ensure patient safety in Federal health care programs;
- Evaluate the extent to which medical errors are caused by misuse of medications and medical devices and consider steps to strengthen the Food and Drug Administration's surveillance and response system to reduce their incidence; and
- Identify opportunities for the Federal government to take specific action to improve patient safety and health care quality nationwide through collaboration with the private sector, including the National Forum for Health Care Quality Measurement and Reporting.

I direct the Department of Health and Human Services and the Department of Labor to serve as the coordinating agencies to assist in the development and integration of recommendations and to report back to me within 60 days. The recommended actions should lay the foundation for a national system that prevents adverse medical events before they occur.

CLINTON-GORE ADMINISTRATION TAKES STRONG NEW STEPS TO IMPROVE HEALTH CARE QUALITY AND ENSURE PATIENT SAFETY

December 7, 1999

Today, President Clinton will meet with representatives of the Institute of Medicine (IOM), health care consumers, providers, purchasers, and members of the business and labor communities, and sign an executive memorandum directing the Federal Quality Interagency Coordination (QuIC) Task Force to report back within 60 days, through the Vice President, with recommendations to improve health care quality through the prevention of medical errors and enhancements in patient safety. The President will also instruct Federal agencies administering health plans to evaluate and, where feasible, implement the latest error reduction techniques; announce that each of the over 300 private health plans participating in the Federal Employee Health Benefits Program will be required to institute quality improvement and patient safety initiatives; direct the Office of Management and Budget, the Domestic Policy Council, and other agencies throughout the government to develop meaningful health care quality and patient safety initiatives for the FY 2001 budget; and announce his signing of the reauthorization of the Agency for Healthcare Research and Quality, ensuring a new, multi-million dollar investment in research programs to improve health care quality. In addition, the President will praise the American Hospital Association for its landmark announcement of a multi-faceted campaign to prevent unnecessary, harmful, and expensive medication errors in 5,000 member hospitals.

INCONSISTENCIES AND AVOIDABLE ERRORS IN MEDICAL PRACTICE COST LIVES AND UNDERMINE HEALTH. Inappropriate utilization of services, unnecessary variations in the delivery of health care, and preventable medical errors are responsible for tens of thousands of deaths, unnecessary illnesses, and instances of prolonged disability each year. In addition to these severe health consequences, these variations in medical practice increase national health care spending by billions of dollars annually.

- **Preventable medical errors.** A study released last week by the Institute of Medicine estimates that more than half of the adverse medical events occurring each year are due to preventable medical errors, placing as many as 98,000 Americans at unnecessary risk. The cost associated with these errors in lost income, disability, and health care costs is as much as \$29 billion annually. The financial cost of these errors are far outweighed by the impact they have on the lives of patients and the trust of patients in the quality of the care they receive.
- **Under-utilization of services.** Early detection and treatment for illnesses prevents unnecessary complications, higher costs, and premature mortality. For instance, despite the fact that early detection of breast cancer can prevent up to 30 percent of breast cancer deaths annually, 30 percent of women aged 52 to 69 do not receive regular mammograms.
- **Overuse of services.** The excessive and unnecessary delivery of health care services can increase costs without improving health and place patients at greater risk for injuries and complications. For example, the overuse of antibiotics creates unnecessary health care costs and contributes to the emergence of antibiotic-resistant pathogens, resulting in as much as \$7.5 billion in unnecessary expenditures annually.
- **Variation in services.** There is a continuing pattern of wide variation in health care practice that cannot be accounted for by differences in the health status of patients, available

resources, patient preferences, or clinical uncertainty. For example, hospital discharge rates and lengths of stay in the Northeast were over 40 percent higher than in Western states.

NEW ACTION TO IMPROVE HEALTH CARE QUALITY AND ENSURE PATIENT SAFETY. Today, President Clinton will:

- **Issue an Executive Memorandum directing the Quality Interagency Coordination Task Force (QuIC) to develop new strategies to improve health care quality and protect patient safety.** Today, President Clinton will sign an executive memorandum directing the QuIC to report back recommendations to him, through the Vice President, within 60 days that: identify prevalent threats to patient safety and reduce medical errors that can be prevented through the use of decision support systems, such as automated patient monitoring and reminder systems; evaluate the feasibility and advisability of the recommendations of the Institute of Medicine on patient safety; develop additional strategies, including the use of information technology, to reduce medical errors and ensure patient safety in Federal health care programs; evaluate the extent to which medical errors are caused by misuse of medications and medical devices and consider steps to further strengthen FDA's response to this challenge; and identify opportunities for the Federal government to take specific action to improve patient safety and improve health care quality through collaboration with the private sector, including the newly constituted National Forum for Health Care Quality Measurement and Reporting.
- **Announce that each of the more than 300 private health plans participating in the Federal Employee Health Benefits Program will be required to institute quality improvement and patient safety initiatives.** Today, the President will announce that the Office of Personnel Management, which oversees plans serving 9 million Americans, will include in its annual call letter to be issued next spring a requirement that FEHBP plans use error reduction and other patient safety techniques in order to improve the quality of care in the program. In addition, OPM will supplement this initiative using workplace campaigns to improve mammography and medical screening rates among Federal employees, retirees, and their families. Finally, OPM will initiate new ways to measure and report on the quality of care that plans deliver to enrollees.
- **Instruct Federal agencies administering health plans to evaluate and, where feasible, implement the latest error reduction techniques.** The President will request that the Departments of Health and Human Services, Veterans Affairs, and Defense, and the Office of Personnel Management evaluate and, where feasible, implement the latest error reduction techniques in a manner consistent with the Administration's recently released draft regulations on patient privacy. These agencies administer Medicare, Medicaid, CHIP, the Federal Employees Health Benefits Program, the nationwide network of veterans hospitals and outpatient clinics, and the military health care system, serving over 85 million Americans.
- **Announce the reauthorization of the Agency for Healthcare Quality and Research, ensuring a multi-million dollar investment in research programs to improve health care quality.** President Clinton will announce that he signed legislation yesterday reauthorizing the Agency for Healthcare Research and Quality (AHRQ). To achieve the goals of this legislation, which is the result of the bipartisan efforts of Senators Frist and Kennedy and Congressmen Bliley and Brown, the FY 2000 budget increases the agency's resources by 16 percent over FY 1999 funding levels, for a total investment of \$200 million. These new funds will be used for important quality improvement research, including the over-and-under utilization of services, variation in the delivery of services, and efforts to prevent medical errors. In recognition of the critical role that states do and will play in assuring and

- **Direct the Office of Management and Budget, the Domestic Policy Council, and other agencies to develop additional health care quality and patient safety initiatives for the FY 2001 budget.** The President will direct the Office of Management and Budget, the Domestic Policy Council, and the Office of the Vice President to work with the Department of Health and Human Services and other agencies to develop additional initiatives within the context of the FY 2001 budget that build on our current error prevention, quality improvement, and patient safety initiatives.
- **Praise the American Hospital Association for launching a new medication safety campaign.** The President will praise the American Hospital Association for launching a new partnership with the Institute for Safe Medication Practices to prevent patient medication errors. Today, the AHA will send a list of "best practices" on prevention medication errors to all 5,000 of their member hospitals. In the coming months, they will also begin to develop a medication safety awareness test that surveys hospitals' medication error prevention systems; track implementation by the hospital and health system field of the practices for reducing and preventing errors; and working with national experts to develop a model medication error reporting process. By taking these actions today, the AHA joins numerous other health care organizations making an important commitment to this area, including the American Medical Association's initiative with the Department of Veterans Affairs and other public and private agencies, which helped establish the National Patient Safety Foundation.

THE CLINTON-GORE ADMINISTRATION'S LONGSTANDING COMMITMENT TO IMPROVING HEALTH CARE QUALITY. Assuring quality through providing patient protections is a longstanding priority for the Clinton-Gore Administration. Over the past two years President Clinton and Vice President Gore have provided critical consumer protections to the 85 million Americans enrolled in Federal health plans and set the stage for the Congress to pass a strong, enforceable, Patients' Bill of Rights. In March of 1998, the President established the Quality Interagency Coordination Task Force, which has been instrumental in promoting advances in health care quality nationwide. The President also asked the Vice President to help launch the National Forum for Health Care Quality Measurement and Reporting, a broad-based, widely representative private advisory body that develops standard quality measurement tools to help all purchasers, providers, and consumers of health care better evaluate and ensure the delivery of quality services. In addition to the work and significant potential of the QuIC and Quality Forum, the Departments of Veterans Affairs and Defense have been leaders in patient safety and quality improvement programs. Finally, the Health Care Financing Administration has implemented new quality improvement initiatives through its peer review organization efforts, and the Food and Drug Administration is working to implement new reporting systems that allow for a rapid response to medical errors causing patient injury.

improving health care quality, AHRQ will hold a nationwide conference this March with senior state health officials to promote best medical practices, to prevent medical errors and improve patient safety, and to better develop a working relationship between the Federal and state governments in this area.

Health Care
Medical
Errors

Medical Errors Blamed for Many Deaths

As Many as 98,000 a Year In U.S. Linked to Mistakes

By RICK WEISS
Washington Post Staff Writer **A1**

As many as 98,000 Americans die unnecessarily every year from medical mistakes made by physicians, pharmacists and other health care professionals, according to an independent report released yesterday that calls for a major overhaul of how the nation addresses medical errors.

More Americans die from medical mistakes than from breast cancer, highway accidents or AIDS, according to the report from the Institute of Medicine, an arm of the National Academy of Sciences. That costs the nation almost \$9 billion a year, the congressionally chartered research group concluded.

Yet while other areas of the U.S. economy have coordinated safety programs that collect and analyze accident trends, including those that track nuclear reactor accidents, highway crashes and airline disasters, there is no centralized system for keeping tabs on medical errors and using that information to prevent future mistakes.

If such a system were put in place, the report predicts, the number of deaths from medical mistakes could be cut in half within five years.

"These stunningly high rates of medical errors, resulting in deaths, permanent disability and unnecessary suffering, are simply unacceptable in a medical system that promises first to 'do no harm,'" said William C. Richardson, president of the W.K. Kellogg Foundation and chairman of the expert committee that compiled the blunt, 223-page report.

Several medical and public policy organizations have addressed the issue of medical errors since the widely reported death of Boston Globe health columnist Betsy Lehman, who died from a chemotherapy overdose in 1995. But experts said the prestige of the National Academy of Sciences, and in particular its specific proposal to create a federal office to oversee medical accident trends and devise strategies for prevention, could spur real change.

"There's not a controversy here," said David Eddy, a senior adviser to the Pasadena-based health mainte-

nance organization Kaiser Permanente Southern California and an expert in evidence-based medicine. "It's an ideal opportunity to increase quality and decrease costs."

Medical errors can range from a simple miscommunication about a drug's name during a telephone call between a doctor and a nurse to the erroneous programming of a complex medical device at the end of a busy hospital night shift. They include wrong diagnoses from mislabeled blood tubes, mistaken treatments because of poorly labeled drugs, improper dosing because of faulty calculations and a simple lack of communication as a patient gets passed from one provider to the next.

To address the wide range of problems, the report calls for mandatory federal reporting requirements for serious medical accidents. And it calls upon Congress to create and fund a national patient safety center within the Department of Health and Human Services, which would be charged with developing better systems for tracking and preventing patient injuries.

The report also suggests that minor medical errors that have not resulted in serious injuries or death be collected in a confidential database, not available for public review. The hope is that by reducing health care providers' legal exposure and the risk of lawsuits, doctors, hospitals and others may be more open about their errors, and thus give the nation a chance to learn from their mistakes.

"Safety is a cultural matter, and unless you create a cultural environment in which it becomes safe to talk about errors and near misses, you can't get to work on the root causes of error," said Donald M. Berwick, a Harvard professor of health care policy and president of the Institute for Healthcare Improvement, a not-for-profit educational and research organization, who was one of 19 experts who worked on the report.

"You can't use fear or blaming of individuals as a foundation for safety improvement," Berwick said. "We want to set up an environment where more errors will be revealed."

The report concludes that most errors are not the result of flagrant recklessness but occur because of the cumulative opportunities for human error that arise in today's

complex medical system. Most are medication errors, Berwick said. "People get the wrong drug or the wrong dose or they get it at the wrong time or it's given to the wrong patient."

Part of the problem is that many new drugs have similar names, which are easily confused when orders are given by voice or are handwritten.

"Physician handwriting has traditionally not been something that has been looked upon highly by calligraphers," said Peter Honig, deputy director of the Food and Drug Administration's office of postmarketing drug risk assessment, the federal unit responsible for tracking medication errors.

Within the past year, Honig said, the FDA has created a "medical errors group" with the explicit job of

preventing medication errors. The team reviews new package designs and proposed names for new drugs to make sure they are not too similar to existing ones. In some cases, companies are also addressing the problem, Honig said. Recent ads in medical journals from the makers of the arthritis drug Celebrex, for example, warn doctors not to confuse their product with the anti-seizure drug Cerebyx or the antidepressant Celexa.

Most serious mistakes occur in busy settings such as emergency rooms and intensive care units, according to the report. In some cases they occur because medicines are kept in stock at concentrations known to be toxic, when they probably should be stored in the diluted forms in which they are intended to be given.

Bradley: U.S. Spread Too Thin

Candidate Calls for Fewer Interventions and More Alliances

By MIKE ALLEN
Washington Post Staff Writer

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MEDFORD, Mass., Nov. 29—Bill Bradley called today for the United States to reduce its unilateral overseas interventions and instead work with the United Nations and other international organizations to build security in a world that lacks the Cold War's predictability.

"We cannot give an open-ended humanitarian commitment to the world," Bradley said, charting his foreign policy in a discussion with Tufts University students. "The United States has been spread very thin over a wide territory in the world and has not had the impact that we seek to have in places that we do get involved."

Bradley contended that America has neither the resources nor the wisdom to soothe every hot spot. "The key is to get multilateral efforts to intervene earlier, before things reach the point where only there is a military option," he said. "That requires partners in the world to do this, alliances with international organizations."

In a rebuke to Vice President Gore, his rival for the Democratic presidential nomination, Bradley also said that the United States had "missed a real opportunity" in responding to overtures from Rus-

sian leaders in the years since the fall of communism. He said the Clinton administration focused too much on encouraging Russia to adopt domestic economic reforms, instead of pushing for deep reductions in nuclear arms and other weapons.

Though carefully measured, Bradley's comments placed him firmly to the left of Gore and other presidential candidates on foreign policy issues. While Republican frontrunner George W. Bush and other GOP candidates have also criticized the Clinton administration's foreign interventions, Brad-

ley differs from them in calling for greater reliance on the United Nations and other international organizations.

Bradley's call for more extensive and far-reaching negotiations with Russia on arms control and other issues is also distinctive. He said today he would work to negotiate a new missile-reduction treaty with Moscow, even though

the START II treaty reducing nuclear warheads has never been ratified by the Russian parliament. "I am in favor of moving beyond START II, even in the absence of ratification by Russia, to negotiations on START III," he said, giving a goal of reducing arms stocks to 1,000 to 2,000 warheads for each side.

Bradley opposes the immediate deployment of a national missile defense, a step that would require renegotiating or breaking the antiballistic missile treaty with Russia. He favors ongoing research but is concerned about the diplomatic consequences of deployment. Gore has said he wants to negotiate with Russia about the deployment of the system while Bush has said he would build it even over Russian objections.

Bradley endorsed an open world trading system, but said the World Trade Organization should give labor organizations and environmentalists a role in shaping the rules of international commerce, allow such groups to file "friend-of-the-court" briefs in trade disputes and let such organizations participate in subcommittees within the WTO.

But the former senator's most striking comments concerned U.S. interventions abroad, an area where the Clinton administration has built a long and controversial record with missions in Haiti, Bosnia, Kosovo and elsewhere. Robert Kagan, a specialist in foreign policy at the Carnegie Endowment for International Peace, said Bradley "wants to wrap overseas intervention around Al Gore's neck in the same way that Republicans in Congress have wanted to wrap it around President Clinton's neck."

Speaking at the Fletcher School of Law and Diplomacy, which was founded in the midst of the Great Depression in an effort to boost internationalism at a time of isolationism, Bradley described "a disturbing paradox, where we're more powerful than ever before, but we're also more vulnerable to a variety of threats."

"The great risk of nuclear holocaust with the Soviet Union has receded," he said. "But there are a multitude of smaller threats—from troubling dictatorialships like Iraq, to poorly safeguarded nuclear warheads in Russia, to the increasingly dangerous situation on the Korean peninsula to transnational terrorists."

Bradley declared that "in this new world, the next president has an even heavier burden, which is to try to create a comprehensive framework for peace and security and prosperity." He said the United States must work through international institutions to "help mold this international system."

He said that too many United States policies, and even its military strategy, are remnants from those days when enemies were

clear and friends were obvious. "The choices are no longer so stark," he said.

Bradley said he would work to restore one mindset of the Cold War, when "men and women of goodwill in both parties joined together to do what was in America's best interest."

"There was an old saying that political division stopped at the water's edge," he said. "Sadly, that consensus has vanished. Foreign policy has become more of a political football, or is made to score domestic political points. I deplore that. One of the things that I will try to restore if I become president of the United States is a bipartisan foreign policy consensus."

Drawing an implicit contrast with Bush, Bradley said he was comfortable with international affairs and had needed no crash course. "I've been thinking and speaking and writing about foreign policy for more than 20 years," he said.

Bradley had planned to give a formal foreign policy address today, but postponed that to an un-

determined time for reasons his staff would not disclose. Instead he simply outlined the framework of his policy and then answered questions from the students, joking that he would move to the next questioner if he didn't know the answer or thought the inquiry was stupid. At one point, he said that when he was 9 or 10 years old, he had designed his own bomb shelter, marking spaces for a cot, his favorite books and his basketball.

Walter Mead, senior fellow at the Council on Foreign Relations,

said Bradley's approach distinguished him at a time when the other candidates were promoting "an aggressive style of national leadership."

"Bradley is saying that United States influence in the world is greatest, and costs the least, when the United States cooperates with other leading powers," he said.

However, Ted Galen Carpenter, the Cato Institute's vice president for defense and foreign policy studies, said he saw "a fundamental contradiction" in the idea of a more robust United Nations and a more passive United States, given the country's dominance in that organization.