Laura Adams
When I got back to work, I started looking at the process that put that medication order in front of me that was a 10 times overdose and of course I didn't catch it. I realized that that order had been hand transcribed six times before it got to me. Two times by people with no pharmacological background that wouldn't know that if you move a decimal point, it could be death by decimal point in a child, and I thought, oh my goodness, our systems can't be designed this unsafely. The more I looked around, the more I became aware of the design of systems, the more horrified I was.

Ellen Kelsay
That's Laura Adams, a leader in health innovation and a driving force at the National Academy of Medicine. Laura is leading a groundbreaking initiative to reduce patient harm across the country using artificial intelligence.

I'm Ellen Kelsey, and this is a Business Group on Health podcast, conversations with experts on the most relevant health and well-being issues facing employers.

Today, we're talking about how artificial intelligence may be the most powerful patient safety tool we've ever had in terms of its capacity to help clinicians catch errors, diagnose conditions earlier, and restore trust and well-being in the workforce.

Laura, welcome to the podcast. We're so happy to have you with us.

Laura Adams
Ellen, it's my pleasure to be here. I really appreciate the opportunity to be with you.

Ellen Kelsay
Well, we are excited to have this conversation and to learn more about your work and an important initiative that you and your team are launching. But for listeners who may not know the scope of the National Academy of Medicine's work, how would you describe its role in shaping U.S. science and health policy?

Laura Adams
The academies were actually formed under an order by President Lincoln some years ago, the National Academies of Science, Engineering, and Medicine. The National Academy of Medicine itself is 50 years old, and it has done seminal publications around climate, publications around issues of, *To Err is Human*, for example, was our first sort of clarion call to the idea that we have patient safety issues that needed to be addressed. We had a publication, *Crossing the Quality Chasm,* that I think presented a set of principles that had a dramatic effect on shaping some of the modern-day techniques that we use to achieve the level of care that we do have, which I think in many cases is quite good.

Ellen Kelsay
One of the publications that you personally have played a big role in is the Code of Conduct for Medicine and AI. Can you tell us why was that document created and how is it being used?

Laura Adams
The document was created, we were excited to see a tsunami of AI coming toward us and as people saw it nearing and began to work with AI, the good news was that everyone started to develop their own sets of guidelines, principles, and frameworks. The bad news was the same. Everyone was developing their own set of guidelines, principles, and frameworks. Most that study

the history of quality improvement and safety improvement in health care would say that the bane of our existence is fragmentation, is our ability and inability to learn because of the separateness and isolation in which we operate. So we had an experience with electronic medical records where we really didn't think through some of the unintended consequences of that and some of the, what we would have foreseen had we put some thought to it as things that we wanted to avoid, for example, the feeling from clinicians that they ended up being data entry clerks, for example. We thought before we get too far into AI, it's really time for us to come together and see if we can put together a code of conduct that represents the best, all those frameworks. So we studied 60 of them and we wanted to find out where are we in areas of real agreement? Where do we have inconsistencies and where do we see out and out gaps? To our astonishment, really, one of the out and out gaps was not a single one of those 60 frameworks, guidelines, or principles that discuss the primacy of human health and human connection as one of the primary aims of where we would be heading. So we had that as our number one code of conduct commitment was to put a priority on human health and human connection. There were other ones in there like we saw that there was no reference to engaging the health care workforce in the design and implementation of these systems. That's exactly what happened with electronic medical records and we've suffered for it and we still are. Those were the kinds of gaps that we wanted to close with this. We have been delighted with the uptake. By the time that that document was published in 2025, just eight months later, we got news from the National Academies Press that that publication was in the top 10% downloads of the National Academies Press of all time and that's the Academies of Science, Engineering, and Medicine. So to hit that top 10% of those three academies of all time in eight months, we really felt like that code of conduct resonated. So we're watching people use it as sort of a compass for every decision point, a framework for thinking through policy, framework for thinking through procurement decisions, evaluation decisions, implementation conduct, and it has broad, broad applicability and I even have been asked to speak about it outside of the health care realm where others are seeing it as broadly applicable in the use of new digital health tools period. I couldn't be more proud of that work.

Ellen Kelsay
Well, you should be and that is remarkable and it's amazing work and it's unbelievably relevant at this point in time, so incredibly timely as well. Congratulations on that. I know it's a labor of love and a lot of effort went into that. Well, in addition to the tsunami that you mentioned, I know that you also have a personal passion on AI, and in particular, AI relative to patient safety. Can you tell us more about that?

Laura Adams
This was an incident that occurred with me very, very early in my career. I worked in a critical access hospital, just 35 beds in rural Colorado when I started my career. In the course of delivering care that night too, we had 35 beds in our hospital if you counted the sofa in the waiting room and the gurneys, it was a small hospital, but people depended upon us literally for their lives in that rural setting. I was leaving the unit after a very hectic night where I had another nurse with me. I heard the intercom come on from downstairs where our surgeon, he had an ominous tone in his voice. I'd worked with him before and I knew something was terribly, terribly wrong in the operating room. He asked the staff to find Laura because he said, we have this seven-year-old child down here; she's seizing; she's going into a coma; and he said, I think she might die. Well, I had administered unknowingly a lethal overdose of that pre-op medication to that seven-year-old child prior to her going down to the operating room that morning. It was a mistake. There's no question about it. At that moment, I felt like I simply was shattered and frightened out of my mind. I think I prayed harder than I've ever prayed in my life for a miracle to happen, and by the force of God, the forces of the universe, whatever, that surgical team saved that child's life that

morning. It was a traumatic experience for that family and for me. And we certainly did not have attorneys that stood between us and the families when I was apologizing to them and looking in the eyes of those anguished parents, telling them how sorry I was that I nearly took their child's life. For me, the hospital let me go home for a couple of days and I did. But when I got my bearings, I started thinking, you know, I think I'm at least average intelligence. I know that this has been my passion. I wanted to do this work for as long as I can remember. How is it that a child nearly dies at my own hands? So when I got back to work, I started looking at the process that put that medication order in front of me that was a 10 times overdose, and of course, I didn't catch it. I realized that that order had been hand transcribed six times before it got to me, two times by people with no pharmacological background that wouldn't know that if you move a decimal point, it could be death by decimal point in the child. And I thought, oh, my goodness, our systems can't be designed this unsafely. The more I looked around, the more I became aware of the design of systems, the more horrified I was because they were designed unsafely. It could have been any nurse, anyone else administering that medication, and they would have had the same chance of making that error that I did. So I thought, we've got to begin to design this more safely. You can see why I was quite excited about the advent of electronic medical records where we would not be hand transcribing orders six times.

Ellen Kelsay
Well, Laura, I just want to say thank you for sharing your story. It's raw hearing you talk about it all these years later. It's I think the third time I've heard you share the story. Every time I hear you speak about it, it's just happened to you again and you're reliving that trauma and sharing the story, but in sharing the story, you really do bring this issue really, really directly in line of sight for all of us about how honestly these mistakes do happen and how well-intended individuals can make mistakes. But the trauma that you and the families and others experience when those mistakes happen are irreparable. The fact that you are using that very personal raw experience to do good in your profession and for all of us is really remarkable. So thank you both for sharing the story, but then also what your experiences inspired you to focus on with such passion in your professional life as well.

Laura Adams
Thank you. It did make a turning point in my career. I look now as it as a silver lining because I don't know that I would have gone out on this trajectory. I'm really glad that I did, because I do feel like every opportunity I have to improve safety is a way to look back on that and turn it into something positive.

Ellen Kelsay
Absolutely and you are having profound impact. We know that we have seen some improvement relative to preventable harm, although it really at a macro level feels as though we're barely moving the needle on harm reduction at scale. Maybe elaborate more on why that is systemically, that we've just not seen enough progress in this space.

Laura Adams
I think we're seeing it multifactorial. Thank you for acknowledging that there has been progress. There have been so many people that have put their shoulder to this wheel. Some have spent their entire careers working on moving the needle. We know that health care is exceedingly complex and it gets more complex all the time - new procedures, new drugs, new devices come out and now AI. It is highly complex. I think we've suffered from some other aspects of this, too, that we're beginning to really understand the impact of. One of them is that we've never had a systematic measure of this. We don't have a taxonomy for defining harm. In fact, as I mentioned before, our definitions of harm are fragmented. Our measurements of harm are fragmented.

Anyone, employers especially, working to improve the quality of whatever products or services they produce, understand the value of a measuring stick where we can track our progress, where we can course correct if we're not headed in the right direction. We've lacked a common taxonomy for harm. There's multiple definitions of it. We have multiple ways of measuring it. So my organization put out *To Err is Human* more than 25 years ago now, almost 27 years ago. That seminal study has never been replicated. We measure angles and aspects of it, each with their set of definitions that are differing. I think we have a lack of ability to really track our progress and understand whether our strategies are working. That, to me, is a major deficit. I'd say that our fragmentation is once again at the root of some of this in that every health system addresses quality and safety basically on their own. We don't have a learning health system whereby when I look at aviation and I see that there is a commercial aviation safety team that when they look at the evidence and the data that they have around safety issues and then they can decide very quickly about systemic changes, changes that are promulgated throughout the entire system of aviation that makes every flight safer as a result of that. We don't have anything like that in health care. We don't have a robust capacity to understand and learn from each other. In fact, there's a famous, infamous maybe, bit of knowledge that we've known about when something is discovered in science, in health care it takes roughly 17 years for it to get propagated through the system and show up consistently and reliably at the bedside. That, to me, is an area ripe for change with artificial intelligence going forward. If we can find a way to learn more quickly from each other.

I also believe that our payment model has something to do with this. When I think of the impact of the payment model, we do get paid largely for procedures, for admissions, for heads in bed, so to speak. When I was a hospital administrator in Louisiana, I remember coming in one day and hearing a news announcement on the radio and I gathered my senior team together and I was excited. I would say almost borderline giddy. I said to my team, I've just got to tell you that I heard the latest announcement, the predictions about the flu season. And I said, it's going to be a horrific flu season. I said, I know we're still going to make budget, aren't we. I meant it. I knew that having that kind of a flu season would put heads in beds, would cause our services, our procedures, everything that that was revenue generating for us and it wasn't until almost a year later that I looked back on that and I thought, what happened to me? Why in the world would I be curing illness and infirmary? When I think back to that flu season, children died, parents died, grandparents died. I was thinking about the quality improvement master, W. Edwards Deming, that said that bad systems bring out the worst in good people and I felt like I'd lost my way. I do feel like our payment model that incents more and not health and prevention and it doesn't incent the things that I think we anticipate and expect our health system to be promoting and standing for. I know that it shaped me. Incentives are a hard thing to go up against. I would also say that I would really like to see methodology devised that begins to make prioritizing patient safety as job one, nothing higher than patient safety. First, do no harm. I'd love to see a payment model that rewards that financially and us design a system where it makes it the easiest path to take, the absolute easiest.

Ellen Kelsay
Well, thank you yet again for being very real and honest with your own experience in that example. Let's talk about AI. I imagine as listeners are hearing you speak, AI can play a significant role in addressing a lot of what you've just mentioned, but what are some of those examples of AI helping with harm reduction?

Laura Adams
What excites me the most about AI is it sees things that we can't. We've known that early on when we started watching AI look at the back of the retina and do retinal fundus scans and it

could tell things like sex assigned at birth. We have no idea how it could do it. It sees patterns and relationships in the data that we human beings don't see. The other thing that excites me about it is not only its ability to detect and therefore inform us, give us real data about what's happening out there. If we can't see it, we can't fix it. I'm excited also about its ability to not only detect, but simultaneously act in real time to prevent. It might be able to tell us, alert within an electronic medical record, that something is about to happen to a patient, a deterioration is about to occur, and it gives us a window of time and opportunity to stop that event from happening. You can see that most of our measures now are all looking in the rearview mirror. They are the aftermath of harm, not looking ahead to see where harm might be coming from and preventing it in real time. We've never had detection systems that have been anticipatory. I am thrilled about that. I look at things like computer vision that has the ability to look to see and understand body movements of patients that might be able to alert us far in advance when a patient is prone to falling or about to fall. We can intervene and prevent that from happening.

When we think about the capacity of AI to expand our abilities to educate and upskill our clinical staff, that excites me as well. When I think about its ability to bring new knowledge, connection, connectivity, shared learning, all of those things are things that we just haven't had the ability to do in the past. I look at its ability, for example, many people are on multiple medications, for a human being to try to go through the chart and see what medications a patient's currently on, what they are on before, reconciling all those medications, that's a computer specialty. That's an AI system specialty. It can go in and do that, make sense of it. It can personalize medication plans so that it's better suited to that individual, their genetic history, the unique parameters that that patient exhibits. It's just super exciting in that way. So I see that detection ability, that ability for us to measure in ways. Here's an example that I find very exciting. We have not invited patients to contribute to the database ever in terms of them reporting when they believe they've been harmed. That's just not been a part of the structure of the system. We had a really prominent, wonderful leader who in December of 2024 had intractable abdominal pain, went into emergency room number one and was told that she had perhaps overindulged in rich holiday food to go home and take a laxative. After excruciating pain in the next 48 hours, she went to a second ED and that emergency department did more extensive studies and realized that she has late stage colon cancer. She's young. She is the only one that knows that a medical error occurred in hospital system A, in hospital number one. She's the only one that knows. But I think we've been worried about how do we collect these measures? How do we sift through the volumes of these measures, of these reports that might be coming from patients? Would they want to tell a story about their incident? Yes, they would and in the past, to think that we would have to put human beings to sift through all of that information, try to see the patterns, the relationships, not possible. It is possible with AI, not only possible, but I think that we're right on the cusp of that now. For me, that's another exciting element where patients can actually partner much more deeply to be a part of the discovery and, you know, if we can't see it, we can't fix it.

Ellen Kelsay
You've talked about this power shift towards patients and patients being more empowered, better informed. They're even asking for AI peer review. Any other commentary there on the power shift in the direction of patients and how AI is enabling that?

Laura Adams
You're so right about that. AI is a revolution and if we think about the definition of a revolution, it's a transfer of power. In this case, we're starting to see just this month, two weeks ago, we saw Open AI put out their ChatGPT Health, and we saw Anthropic's Claude for Health. Both of those have embedded in them capacity capabilities for patients, people to go in and ask it to retrieve their records from wherever those medical records might be. It can pull them in from multiple

sources once all those records are aggregated. I was doing a speech out in California and someone from the audience stood up and asked a question, hey, how long do you think it'll be before a patient feeds their medical record into one of these large language models and ask it to find the medical error, ask it to find the malpractice? I hadn't thought about that, but my answer was it probably happened sometime a year and a half, 18 months ago because things are moving quickly. So with patients having that kind of power to summon their records now, to aggregate their records, also, in these large language models, they're conversing with them. They're chatting with them. That large language model system also has the benefit of hearing the patient's story in depth. It's there to listen 24/7/365. It never gets tired. There's never another patient that's waiting outside the door. It will listen as long as the patient talks, so it can get context. It can also bring in wearables and integrate that. So not only can it compile this very rich database, it has these phenomenal analysis skills, the ability to really to interrogate that data. It's starting to really put some power into the hands of patients. I know that these models hallucinate. They're not always correct. They always sound confident and that's another part of the problem is they sound quite sure of themselves when they respond in this way. But patients aren't comparing these large language models to perfection. They're comparing it to the things like the access that they currently do not have or their sense of not being able to tell their full story or their sense that something has happened to them and they're having a difficult time uncovering what exactly went wrong in their medical care. I see that alone as a tremendous power shift that is the way of the world now and it's important for all of us to recognize that the notion of empowering patients in terms of giving them power, that might be over. Patients are able to seize power in ways that are unprecedented now.

Ellen Kelsay
What does this mean for clinicians? Are they embracing this? You mentioned that malpractice, putting something into the AI tool and identifying potential malpractice exposure. How are clinicians responding? Are they embracing? Is there trepidation? Any thoughts there?

Laura Adams
AI is the one new novel technology I have felt wildly enthusiastic about and deeply troubled at the same time. I think that that is true of a lot of clinicians where they see the unbelievable potential that it has, but they also start to look at such things as right now, the people using AI in the clinical systems are left holding the AI liability bag. I'd be concerned about that, too, if I were still practicing, holding the AI liability bag. I think that there are concerns about this, and yes, there is this sense of let's do uncover the real scope of harm. At the same time, I can imagine a hospital system CEO saying, please don't turn that on in my system, because at this point in time, it would expose me to these liabilities, I don't know that I have the capacity and ability right now to address those. Even though the fire alarm is going off, I may understand someone wanting to put earplugs in. It's not like the harm isn't happening if we don't look at it, but there is a sense of accountability once you do see it. So I think clinicians, there are those that are feeling excited about this and are pursuing it headlong. There are others that are saying, what happens when we do find out? But by and large, I believe that clinicians themselves, in my conversations with them because I've been open about my own experiences, that causes a reciprocal vulnerability and openness in my colleagues. One of them just told me recently that they joined one of the large tech companies because they'd harmed a patient severely and just said the fact that it weighs on my conscience. So at the deepest levels that first do no harm, I think is the greatest motivator, but at the same time, if you're trying to do that and you end up losing your livelihood because of it, we have to find a way forward. We have to make it safe to tell the truth and we have to make it about learning and improvement. It can't be about punishment. But on the other hand, I also see why things go to litigation, because it also can't be optional. We have to make a commitment, a good faith effort, the best faith effort we can make going forward with the use of AI. This is a

complicated challenge for us, but I think we need to find the way to thread that needle where we use AI with all of its capabilities, but at the same time, we give people the opportunity, some protection, so that they have a period of time where learning and improvement can take place. Not forever. Not forever to look the other way because it's hard. That's not possible. One of the things I hope that people recognize is that do no harm is still the first commitment.

Ellen Kelsay
That leads me to ask you about this national initiative that you and your team are leading and are about to embark upon. What's it all about? When's it starting? Give us all the details.

Laura Adams
I'm so excited about this initiative. This initiative is co-chaired by Gianrico Farrugia, the CEO of Mayo. It's also co-chaired by Wright Lasseter, who is the CEO of CommonSpirit Health.

CommonSpirit Health System is the second largest, second only to the VA in our country, and also includes health systems like community hospitals, critical access hospitals. Actually where most Americans get their care is not academic medical centers, but in centers like CommonSpirit that are in that system. Wright Lasseter and his team won the John M. Eisenberg Award in 2024 for innovation and quality and safety. Our third co-chair of this new patient safety initiative is Sue Sheridan. Sue comes about her passion in a painful way, similar to mine, except she was on the receiving end. Her five-day-old son, we missed a bilirubin level in her son, and he sustained significant and profound brain damage from that forever altered the life of her husband and her and her son, of course. Cal is doing well, but his entire life has been a struggle. When Cal was eight and their daughter was six, her husband discovered a lump in his neck that they didn't think was malignant, but subsequent pathology report came back as malignant and it metastasized to his spine before they could discover that it was malignant. He ended up wheelchair bound and asked, Sue, let's take the kids to Disneyland because he felt, I think that maybe time was short for him, and he passed away at Disneyland. That's someone I want at the helm as well.

Our patient safety initiative kicks off on March 3rd and what this initiative is about is there are no national strategies that we know of worldwide that are AI enabled national strategies for patient safety at scale. What we mean by that is we think there is a unique opportunity, there's a confluence of forces, things that are available to us now that were not available before, where we can put together a national strategy that enables every health system in the country to do substantially better on reduction of harm. Many of our approaches in the past have been we'll put out frameworks or blueprints or guidelines, whether that be domestically here in the U.S. or the WHO does it or the Organization for Economic Cooperation and Development does it. Those things are largely directed at individual hospitals where we say, here's what you need to do, good luck, and you're on your own. Again, no ability to collectively learn, no ability for us to lift all boats. We know from our history in the implementation of digital advances, they almost always benefit the urban areas, the well-resourced and people that are not of color. When we think about that history, we wanted to put together a national strategy that starts to use AI, not to bolt it onto the system. We need to use AI as a solvent that dissolves the ineffective processes that we now have. We've already talked about one of them. That's our inability to see, an inability to accurately measure the scope and nature of harm. This strategy will be parsimonious. We expect we will operate in roughly five or fewer domains, meaning the areas of highest leverage. We do not want this to be a 20-point strategy with 20 sub-bullets under each one of those. We feel strongly that our solutions to our problems cannot be more complicated than the problems we're trying to solve with them. This notion of parsimony comes out of complex adaptive systems where simple rules have a remarkable effect to transform complex systems. So we're going the simple rules route here to find the highest leverage domains and under those domains, we don't

want any more than 10. We'd like even fewer priority actions that are the highest leverage, the 80-20 rule, if you will, the 20 percent of things we could do that give us 80 percent of the benefit. This is to design that national strategy and we're already beginning to till the soil so we can put this national strategy in place. One of the national strategies, for example, might be these tools can't work if they're not into our delivery systems, if they're not embedded and particularly in those that are under-resourced. When that was true of electronic health records and we had to get out of the paper-based system, we did a high-tech act for health care where we gave every health system in the country, and in fact, if you were seeing more Medicaid patients than others, you got more resources. So thinking about is it time for one of those for AI that will increase the capacity of every health system in the country to take advantage of these remarkable tools and put them into place. So that's the goal of it. We have brought together, again, patient advocates and people from health plans. We've got the Leapfrog Group because the employers did such a job there. That is one of our shining stars is the work that's been done with the Leapfrog Group. We're quite excited about that idea as well. The initiative will be just a two-year initiative. We will be publishing our domains by July of this year, and then we'll be hard at work on exactly what would be the priority recommendations. Again, we're already tilling the soil so that once this comes out, we're not starting from scratch. Everybody's been anticipating it and everybody knows what to do on the implementation.

Ellen Kelsay
That's amazing. Very excited. I can tell how excited you are and you certainly have assembled a stellar team of very passionate people steeped with expertise. So looking forward to seeing how it rolls out and, of course, how we can support the efforts. You mentioned the Leapfrog Group and the involvement of employers. How else can employers aid in your efforts and assist?

Laura Adams
Employers play such a strong role. Your incentives are aligned for the highest quality care, the most efficient care. You really have that as a number one. Sometimes when we do our measurements of harm and the cost of medical error, we're looking at the cost from the standpoint of what extra tests or extra hospitalizations. You're looking at it from who wasn't able to come to work or who had to take a leave of absence because a family member, a medical error happened to them. When you think of the stresses and the mental strain on people in your employ that have experienced these medical errors themselves or in their families, I think the cost is almost unknown and unknowable. But we did see a strong study from the OECD that suggested that it was about 17 percent of diagnosis alone, a waste rather from misdiagnosis alone, was about $870 billion in the U.S. annually. $870 billion where we could be redirecting that money. Employers, you have the strongest view into that, I think, the best grasp of that idea of the unconscionable waste that's generated by medical errors and harm. What we'd love to see from the employers, first of all, we'd like input from you in our national strategy. When we've got that draft set of domains, that publication will go out in July. When we've got that draft set of what does it look like, what are the actions that we want to take, we would love to hear from you and say this one's a winner, that one's a winner, we don't see how that one's going to help because our experience has been X, Y, Z. That kind of we want to crowdsource this with you, that partnership, that set of eyes that we don't have is something that we would enthusiastically embrace, even if you disagree with us, especially if you disagree with us, because you could be shedding light on a blind spot that we have. All of us are better than any one of us. That kind of engagement from you, once we do settle on those, your policy advocacy, you have tremendous power to help us embed these things that need to be done into policy and we have a receptive policy environment right now. There is a receptivity to doing things differently and so your ability to influence that building of the of the policy structure that embeds this and then our ability also to track the performance of this in policy that says we've got to have a more agile policymaking

capacity because AI is emergent. It changes and adapts and very quickly evolves. Our policymaking has got to be agile as well. Your advocacy there in the policy arena, priceless. Then the third thing is if people felt so inclined to contribute to the financial support of this initiative that we were doing, we would, of course, welcome that with open arms. We do have funding for the initiative, but the more funding, the broader our reach, the greater the span of influence that we would have. That would be the third area and for me immediately, that would be a dream come true. All of those ways would be important to us. If there are more and I've missed them and you see other ways that you could contribute, I'm all ears.

Ellen Kelsay
If listeners wanted to learn more, contact you, where could they find additional information?

Laura Adams
They can contact me directly at Laura Adams. I'm at the National Academy of Medicine and my email is ladams@NAS.edu.

Ellen Kelsay
You're going to get a ton of emails. Get ready. I hope you do. I think there's going to be a lot of interest in what you're doing and how people can help support you. And as you know, our listeners are not only employers, but a lot of other stakeholders across the health care industry. I'm sure this will spark a lot of interest and get their wheels spinning, too, about how they might be able to partner with you.

Well, in closing, I would like to ask you what gives you hope? I imagine there's quite a lot as you think about the intersection of where you sit, the work you're doing in this initiative you're launching, but if you could call out maybe an item or two that you are most optimistic about, what would you say?

Laura Adams
The thing that gives me hope, I do feel that the transfer of power. We've lacked the ability for our consumers and for patients, for people to build a demand for some of the things to actively participate in ways that would call more attention to the imperatives that we have in front of us. I see them activated now in a way I've never seen them before. I see them with tools, capabilities and new understanding of their role. So that right there gives me just tremendous hope. I do think that these tools are novel, the likes of which we have never seen, their ability to evolve very quickly. Someone will say, well, yes, but AI can't do this right now or it does this poorly, and I always think, yeah, for now, give it six months, give it three months, sometimes give it three weeks and it's better. I think of that ability, truly the ubiquity with which this is in the hands of so many people and there's no aspect of health care that I see AI leaving untouched. It isn't like an advance that we've made in digital health that operates in a pocket of health care. These tools are going to be widely diffused and disseminated. They do have great potential. That gives me hope as well. The other thing, I think there's a growing realization among people that sometimes we think of harm in the abstract and we think about it happening over here or happening over there. But there's a dawning that I see among people that recognize that if you have somebody that you love in this health care system now, mother, father, sister, brother, you know they're exposed to it as well. It isn't an abstract concept. I think Don Berwick said it best when he said that the quality of medical care would be far better and the hazards far fewer if we, like pilots, were passengers in our own airplanes. He reminded us that we are passengers in our own airplanes. I think even if we are not engaged directly in working in the health care system, we're passengers in that airplane and so are the people that we love. That gives me hope that there's a growing realization that

someday, one day, this chicken could come home to roost. I think we want to band together for the kind of safer care that our families and our country deserves.

Ellen Kelsay
Well, Laura, I have no doubt with you at the helm and leading the good work with the passion and the authenticity through which you approach it, we will see that achieved and probably lightning fast speed, hopefully, given how fast things are moving. But really, just so delighted to have you with us, grateful for you sharing your knowledge, wisdom and passion with us and look forward to seeing how things unfold in the coming months and year ahead through this initiative and your good work. Thanks again.

Laura Adams
Thank you. It's been my pleasure.

Ellen Kelsay
I've been speaking with Laura Adams, senior advisor at the National Academy of Medicine, about the unique opportunity we have to use AI to improve patient safety. Progress will take leadership, collaboration and aligned action across the country.

I'm Ellen Kelsey, and this podcast is produced by Business Group on Health, with Connected Social Media. If you like this episode, please rate us and leave a review.