How leadership and a focus on quality rescued Beth Israel Deaconess Medical Center
‘His strategy was to create a burning platform...escape was only possible by making hard decisions and by doing things radically different’

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About the Author
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Following five years in hospital medicine, Kamran moved into medical journalism and has been deputy editor and acting editor of the BMJ (British Medical Journal) and editor of the World Health Organisation’s Bulletin, an international public health journal.

Kamran has played a leading role in online learning and knowledge sharing for health professionals. He created BMJ Learning, a website providing formal online learning for doctors; has been medical director of Dr Foster Ltd and Chief Executive of OnMedica Ltd, a specialist company in online learning technologies in this field. He is also an honorary senior lecturer at Imperial College and a Patron of the South Asian Health Foundation.

Currently, Kamran is editor of Journal of the Royal Society of Medicine and editor of the new online journal, JRSM Short Reports. He also writes for cricinfo.com, a highly rated cricket website, and is author of the popular cricket blog Pak Spin.
For many NHS leaders, there will be much that is familiar in the challenges faced by Paul Levy. When he became CEO of Beth Israel Deaconess in 2002, the organisation faced financial crisis, deep seated problems with the quality and safety of patient care, poor staff morale and fractious relationships, and all played out in the media spotlight.

Eight years later, Levy acknowledges that he still has much to do and that some of the journey has been through stormy waters. But there can be little doubt that with his leadership the organisation has salvaged its reputation and is now thriving in the unforgiving US healthcare environment.

There is much for established and aspiring leaders in the UK health sector to reflect on when they read this case study. Levy’s approach was an interesting mix of challenge and support. He did not shy away from revealing the depth of the financial and reputational crisis the medical centre faced. Indeed, his strategy was to create a burning platform where escape was only possible by making hard decisions and by doing things radically different.

At the same time, he knew he could only achieve change by impassioning his staff with a sense of common purpose. He chose to advocate an absolute commitment to providing high quality care and to using systematic approaches to continuous quality improvement. When times have been hard, it has been Levy’s unrelenting focus on quality and safety that has kept the organisation moving forward. What makes his approach stand out is his belief that transparency is key to delivering high quality care. By being open with his staff and with the community that the medical centre serves, he has managed to build a level of trust which is an essential element of a culture of continuous improvement.

Much of the learning from this case study resonates with our understanding about improvement and about leadership for improvement. It isn’t easy territory and there are few right answers. A delicate balance of technical and interpersonal skills is required. Success is about conveying a compelling vision that focuses on patients and those who use health services. People respond positively when you engage with their core values and internal motivations. High quality data, and a willingness to be open with the data, underpins success.

These are not new messages but we all need reminding of their importance. And herein lies the contribution that stories such as this can make to our understanding of how to improve patient care. We hope you enjoy reading it and share it with your colleagues, and we look forward to hearing your reflections.
A competitive healthcare environment in Boston was the backdrop to a merger between two large hospitals with differing cultures. The merger was followed by a period of uncertainty, staff cuts, and loss of patient confidence, culminating in the threat of financial collapse. Financial rescue was achieved, but how would the newly-merged and dysfunctional Beth Israel Deaconess Medical Center become valued by patients, staff, and referrers?

The recovery plan was underpinned by sound leadership values that prioritised transparency and accountability, with a sharp focus on quality improvement for better patient outcomes.

Chief executive and leadership team, operational plans, and the publication of hospital performance data.

Beth Israel Deaconess is now an important player in Boston healthcare, and competes effectively with other major healthcare organisations. Quality improvement is central to the organisation's approach. A culture of transparency and accountability has been established. Challenges remain, but past ones have been overcome by adhering to these organisational values.

Sound leadership principles and a focus on quality can galvanise a troubled institution, restore patient satisfaction and improve financial performance. Transparency is an important tool in quality improvement, provided it is linked to accountability. Data can be used meaningfully to improve quality provided that clinicians feel a sense of ownership in the development of the measures. All staff can be engaged with the financial goals of a healthcare institution and participate in setting operational plans.
In January 2002, Paul Levy was appointed chief executive of Beth Israel Deaconess Medical Center. The hospital was created in 1996 through the merger of Beth Israel Hospital and Deaconess Hospital and had been a troubled institution from the outset. By 2002, the hospital was facing financial meltdown.

Levy was new to healthcare and the Beth Israel Deaconess staff didn’t quite know what to expect. It was a time for strong leadership and Levy had to quickly convert people to his cause or the hospital would become bankrupt.

This case study is based on a series of interviews with senior staff at the Beth Israel Deaconess Medical Center in June 2010. The objective is to explain the transformation of the hospital’s financial situation and its subsequent focus on quality improvement, from the perspective of those responsible for managing the organisation through a decade of change.
Healthcare in Boston is a competitive business. The Beth Israel and Deaconess hospitals vied for patients with the Massachusetts General Hospital and the Brigham Women's Hospital, among others. A merger made business sense as it would create a hospital big enough to compete. However, the Beth Israel Deaconess Medical Center needed to be efficient as well as big, and it was anything but.

A clash of cultures presented further challenges when it came to integrating the two hospitals. Beth Israel Hospital is fondly remembered by staff as having a more casual management style, emphasising professional autonomy and creativity. Deaconess Hospital, by contrast, was known for rules-based, top-down management.

Both sets of staff were fiercely loyal to their parent organisation and many employees were anxious about giving up their hospital's culture and values. After the merger, it was the Beth Israel culture that appeared to dominate, leaving former Deaconess employees feeling disempowered and reluctant to stay. Many of the nursing staff, for example, moved to the Massachusetts General Hospital. In the years following the merger, unhappy staff left and were replaced by new recruits who were excited about the mission and values of the new institution.

‘People underestimated the importance of culture in merging two organisations,’ recalls Dr Kenneth Sands, Director of Healthcare Quality. ‘The approach was a giant consensus exercise, which was not possible. The distance between frontline clinicians and the new hospital's leadership was too great.’

Staff joked that all meetings at Beth Israel started ten minutes late, while meetings at Deaconess began promptly. Nobody could question either hospital's commitment to better patient care, however, and survivors of the merger believed that this common bond could unite Beth Israel and Deaconess.

With staff suffering from low morale and feeling anxious about the future, the press had a field day. The new hospital was developing a reputation as the place not to receive care. It was also on the verge of financial collapse. When healthcare consultants, The Hunter Group, were brought in to turn the hospital around, they recommended drastic measures.
A brief history of Beth Israel Deaconess Medical Center

Beth Israel Deaconess Medical Center is a teaching hospital of the Harvard Medical School. It was formed in 1996 as a result of a merger between the Beth Israel and Deaconess hospitals.

The two hospitals united to improve patient care for Boston residents and forge a more compelling proposition for healthcare payers.

In 1896, as part of their missionary charter, Methodist deaconesses founded Deaconess Hospital. Beth Israel Hospital was founded by the Boston Jewish community in 1916, to meet the needs of the city’s growing immigrant population.

Hospitals in the Boston area began exploring mergers in the early 1990s. A merger between Brigham and Women’s Hospital and the Massachusetts General Hospital, to form the Partners Healthcare System, persuaded the Beth Israel management to approach Deaconess and create the CareGroup System. The two hospitals then recruited others to join the group.

The objective of the mergers was to negotiate better agreements with medical insurance companies. Partners Healthcare was deemed a success because it integrated back-office functions but did not attempt to integrate clinical work.

CareGroup, however, struggled to integrate clinical work and also failed to make back-office work more efficient. Healthcare payers saw few benefits from the merger. With mounting financial losses at Beth Israel Deaconess, other CareGroup hospitals had to shore up the group’s earnings. Reductions in Medicare payment rates put further financial pressure on CareGroup hospitals.

The hospital management’s response to the financial problems was to launch a series of major strategic plans, all of which were either poorly executed or not implemented at all. There was a lack of direction and no real understanding of how to halt the worsening financial situation.

A new approach in 1999 focused on competing directly with other health providers in the Boston area, but again exposed CareGroup’s failings.

In January 2002, Paul Levy was appointed President and Chief Executive Officer of Beth Israel Deaconess Medical Center. His previous roles included spells at Harvard Medical School, Massachusetts Water Resources Authority and Massachusetts Department of Public Utilities.

Levy led the financial turn-around of the organisation and Beth Israel Deaconess is now regarded as one of the leading academic health centres in the USA. The 621 bed hospital provides state of the art clinical care, research and teaching and generates revenue of more than $1.2bn each year.
Levy inherited the Hunter Group report when he joined the hospital. He shared it with his new colleagues, telling them that the hospital was in bad shape and they weren’t going to hide it. Levy accepted some recommendations made in the report but rejected others, such as reducing nursing levels. He admitted that he didn’t know much about hospitals, believing that the act of being transparent would drive change. It did. The dynamic with the staff and the press changed quickly. The Beth Israel Deaconess Medical Center had nothing to hide anymore.

The value of leadership

Phase one in Levy’s plan to save the hospital was to figure out what the previous leader did and do the opposite. According to Levy this was the easy part, but it left a strong impression on staff. ‘I had an advantage in that I had no background in healthcare,’ he explains. ‘Nobody here thinks I’m trying to practice medicine. I don’t have a clinical view. I can be the honest broker.’

Patricia Folcarelli, Director of Patient Safety, recalls, ‘When Levy started, the hospital was bleeding money. It was paralysed by the leadership. There was scepticism among the staff about a chief executive with no experience of healthcare.’

‘Levy listened, communicated well and was very frank. It was an evolutionary process and you were either with the process or against it’

‘Levy listened, communicated well and was very frank,’ remembers Kenneth Sands. ‘As a result, people sat up and started to take notice. It was an evolutionary process and you were either with the process or against it. Many staff moved on but we were left with a strong core of committed people in a dynamic organisation.’

The hospital had spent its $200m endowment and was losing almost $100m a year. By sharing the extent of the financial calamity with staff, Levy created a burning platform for change and used it to create urgency for his rescue plan. Some of his decisions had painful consequences, as several hundred staff lost their jobs. But the hospital survived; Levy’s primary objective was achieved.
The second phase of Levy’s recovery plan kicked in during 2003–4, once the acute financial crisis had been resolved. Levy’s approach was based on the concept of making money by finding out what you’re good at and doing more of it. A strategic plan for the organisation, linked closely to operational goals and a strong sense of ownership among staff, was the vehicle to delivering success in this phase.

Michael Epstein, an academic physician, was brought in as Chief Operating Officer. The clinicians that had stayed with the new organisation were aware that their performance would be monitored, but they were also tired of the dysfunctional relationship between clinicians and managers. Epstein met with each clinical department, with the aim of improving clinician’s engagement with the hospital’s non-clinical objectives. He encouraged clinical leaders and other staff to familiarise themselves with an ‘elevator speech’ on the financial situation and progress of the hospital, the key messages for which were shared at monthly leadership meetings.

Julius Yang, Medical Director of Inpatient Quality, believes that clinician leadership has been vital. ‘We’ve been able to adopt a much more joined-up approach, which has stopped people focusing on their silos. The clinicians have been able to contribute to how the organisation is run operationally. It’s shown me the importance of appointing the right clinical leader.’

‘IT’S SHOWN ME THE IMPORTANCE OF APPOINTING THE RIGHT CLINICAL LEADER’

JULIUS YANG, MEDICAL DIRECTOR OF INPATIENT QUALITY
Kathleen Murray, Director of Performance Assessment and Regulatory Compliance, joined Beth Israel Deaconess in 2002. She describes her role as an internal consultant working with every department to improve healthcare quality. ‘I asked the question: is there an annual operating plan? The answer was no, so I put one in place and then cascaded it out.’ The success of the plan and regulatory changes in public performance, payment for performance and quality measurement ensured that her role expanded.

Winning over clinical leaders was a challenge. Murray decided to focus on orthopaedics and pancreatic surgery, two departments that had volunteered to take part in the first phase. The objective was to make staff proud of outcomes and to use the sense of achievement to drive further improvement in outcomes. Over time, other clinical departments bought into the approach and clinicians started to engage in the design, production and analysis of data. Nothing was made publicly available until clinicians had agreed the data and were comfortable with them being shared.

Patricia Folcarelli agrees that introducing annual operating plans was a major turning point, ‘It had become clear that the hospital would go out of business if people didn’t take on board financial cuts. The motto became: know your budget, defend your budget and stick to it. There was a sharp financial focus and a lot of success came about from everybody knowing where we were going.’ Annual operating plans enabled managers to maintain focus. Each operating plan contained three or four major goals, the first of which would always be focused on quality and safety. The second goal would focus on patient satisfaction and the third would be a financial goal. The quality and safety goal was underpinned by improvement in workforce, staff and referrer satisfaction.
The underlying problem with many medical professionals is that they are willing to accept that a certain amount of harm is a statistical eventuality, says Levy. “The management task is to work with those people and demonstrate that a proportion of harm is preventable, as we did with the drop in the rate of central line infections brought about by an intervention introduced by Dr Zeidel.”

The results of the central line initiative were encouraging and, without asking permission from clinicians, Levy posted the data for public consumption on his blog. He wondered whether this might provoke a backlash from clinicians, but he found that staff were proud that the hospital’s chief executive was proud of them and that it provided motivation to improve performance further. Levy believes that the staff trusted his judgment, as he had already saved the hospital from financial disaster.

‘Achieving tough goals requires continuous evaluation...and for changes to be implemented across all departments and disciplines’

The hospital’s board of directors took more convincing of the benefits of making the hospital’s performance data publicly available. Levy arranged board meetings to explain his motives, allay their fears and engage them in the process.
Beth Israel Deaconess is committed to providing understandable, usable and timely information on quality and safety. These quality measurements are used to assess progress and compare quality of care with that found in similar organisations. The data are published on the hospital’s website and is also used by staff to drive quality improvement.

The quality measures are based on the Institute of Medicine’s 2001 report, *Crossing the Quality Chasm*. The measures assess whether care is evidence-based, effective, safe, patient-centred, timely, efficient and equitable. Data is published for the hospital as a whole and for specific departments.

The progress of each year’s priorities for quality and safety improvement can be tracked on the hospital’s website. Sharing information in this way enables consumers and physicians to exercise choice. The standardised measures of quality make it easy to evaluate benchmarks and to compare data.

The other publishing platform for data is Paul Levy’s *Running a hospital* blog.

In December 2006, Levy posted the hospital’s data for central line infections on his blog. Mortality rates of up to 25% have been reported for central line infections, with national healthcare costs in the region of $25,000 for each infection. The Beth Israel Deaconess data showed some improvement in performance over a 12 month period.

Levy was characteristically frank in his assessment of the data, writing:

‘As you can see, the figure goes up and down, although progress is good. The key thing is that every single case of infection is analyzed thoroughly, with the results shared across the broad range of hospital staff in the ICUs. What goes wrong? As many things as there are people. For example, one day, our chief of medicine happened to go by as another member of the staff was not following the protocol. When he pointed it out – and none too gently! – the person was embarrassed and really had no excuse for doing it wrong. So human nature often comes to play. Sometimes more technical factors arise. Regardless of the cause, each case is used to reinforce the program.’

The outcome, again, was a refreshing one. The board decided to incorporate targets to completely eliminate preventable harm and to post quality and safety data on the hospital’s website. Whether through design, serendipity, or coincidence, Levy had achieved alignment between clinicians, management and the board. All had come together to work in a positive and respectful spirit.

In December 2007, the board of directors voted to support two ambitious, long-term goals for improving the quality and safety of care. The first was to eliminate preventable harm by 1 January 2012. The second was to achieve patient satisfaction scores that place Beth Israel Deaconess among the top 2% of hospitals, also by January 2012.

Achieving these tough goals requires continuous evaluation of performance and for changes to be implemented across all departments and disciplines. Each year, staff are invited to summarise their improvement work in a poster format that captures the essence of a project in a single page. The session features the work of more than 95 process improvement teams from across the hospital. It is a chance for everyone to share experiences and learn about efforts to improve quality and safety at the hospital.

The other publishing platform for data is Paul Levy’s *Running a hospital* blog.
The difficulties of achieving a harm-free environment were highlighted in 2008 when an operation was performed on the wrong side of a patient. The enormity of the error was immediately conveyed to all staff in a letter from Levy and Sands. The letter was also shared with the Boston Globe newspaper to bring the issue fully out into the open. Levy and Sands wrote:

‘The strength of an organization is measured not by counting the number of successes, but by its response to failure. We have made an institutional commitment to eliminating harm, and that requires sharing information about cases such as this so that we all have a chance to learn from it. We still have more to learn from this case, and changes that need to be made, and so will be providing more information in the future’
The success of the central line initiative had encouraged Levy to tackle issues as specific projects. He brought in staff who were experts in the LEAN approach, an improvement methodology developed by Toyota and increasingly popular in quality improvement circles. The question that Levy repeatedly asked himself and his staff was: how can we organise the hospital’s work to achieve better care?

‘We had an issue with analgesic pumps,’ recalls Levy. ‘A nurse couldn’t find one on a ward, so she went looking. The longer she took, the more she started fretting because the patient was in pain. She called central supplies but got fed up of waiting and went looking on the next floor. Eventually, she found a pump hidden away on another unit. It was hidden away because staff on that unit were hoarding them in case other staff took their supplies. Our nurse wasted half an hour looking for a pump, which is unacceptable. A nurse called out the problem and a new system for distributing pumps was developed – a systematic solution to an everyday problem.’

Data gathering is a crucial element of quality and safety improvement. Each clinical department has a quality improvement director and these directors meet twice a month to discuss cases. Some of the cases are direct referrals, while others are identified from clinical decision support reports on readmissions and through the Institute of Health Improvement’s Global Trigger Tool. The Global Trigger Tool is used on a random sample of cases each month and is known to identify adverse events in 35% of records.

Chairs of clinical departments have a regular slot in departmental meetings to discuss adverse event cases, while the Patient Care Assessment Committee – a subcommittee of the board – fulfils a statutory requirement for board oversight of quality and safety.

‘We use data to validate, educate and motivate,’ explains Murray. ‘When we’re good at something we know it and we feed it back. When we are stuck we look outside the organisation to see how others do it. When there is something new, we can educate people using data. We want information that can easily be generalised, transferred and taught.’

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**Continuous learning & improvement**

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Beth Israel Deaconess case study 15
The hospital’s Office of Decision Support helps with data gathering for a wide range of measures, including complication rates, infection rates, department-specific measures and financial measures. Hospital staff and clinical teams spend time validating the internally generated data, following an iterative process. Large administrative data sets are used and as the data is linked to reimbursement, the coding is of high quality.

Quality is a winner on multiple fronts,’ believes Sands. ‘It makes the staff feel good, it acts as a motivator. It lends itself to a good strategic approach by ensuring there is openness about information. It’s better for patients and you could even call it a moral obligation.’

‘We always wanted to provide quality care,’ says Phyllis West, Nursing Director. We knew we were good from a caring perspective but we became fragile during the merger. Still, quality wasn’t a part of my day to day life. It was something everybody else did. This changed with Paul Levy. We felt a sense of ownership with issues of quality. We have dashboards up in the units to see how we are doing. Staff know what the annual operating goals are, as they are actively involved in setting them and integrating them into their work. It makes sense to them and everything meshes together. You’ll find posters all over the hospital telling patients that we are listening. I’m not sure how patients react to this but we try to publicise what we are doing.’

Beth Israel Deaconess Medical Center prides itself on its collaborative environment. Its nurses are respected by its physicians. Joyce Clifford, a heroine of the nursing profession, worked there and has inspired many generations of nurses to follow her. Indeed, patients often choose Beth Israel Deaconess because of the quality of the nursing care. ‘People are proud of what we are able to deliver and we have a strong sense of pride because we are part of it,’ says West. Inevitably, not everyone was happy with the new focus on quality and transparency, and this was something that management had to address. ‘Our approach parallels that taken at the Institute of Medicine,’ says Yang. ‘We persuaded colleagues by focusing on how to improve results. Clinical chiefs are comfortable with quality and using data to drive quality improvement. We recruited the right clinical chiefs and chairs, and explained our public obligation of being transparent and the national requirements in terms of reporting data.’
'We have moved beyond quality simply being a compliance issue. It’s been important to have a consolidated group of clinicians who can help integrate the quality instructions with the clinical work. We have been able to introduce change that is effective. People don’t want change but they will tolerate it if it leads to improvement. The focus on safety and transparency is now established. It has become a central plank in helping us continue our tradition of caring and excellence in delivery of care.’

Quality and safety have become central pillars of training for hospital interns and residents. What was once an ‘elective’ period in quality and safety became a compulsory part of training in 2006 and interns and residents are required to take part in improvement projects. The programme at Beth Israel Deaconess, which is affiliated to Harvard Medical School, is one of 17 similar educational innovation projects across the USA.
Levy’s greatest triumph, however, might be his use of the internet to share information about his organisation, engage the public and the media, and steer the debate towards a constructive dialogue about quality and patient safety. Running a hospital (http://runningahospital.blogspot.com) is the blog he started in 2006. He thought some people might like reading and learning about a complex organisation like a hospital.

A new era of transparency

I started telling stories. It was initially read by staff, then people in Boston, people in the USA and now around the world,’ explains Levy. ‘The blog created a network, a community of interest. Readers have become a part of the life and the world of the hospital, with more than 10,000 unique visitors each day.’

‘It was a conscious commitment to being transparent and responsible – a deliberate transparency policy,’ adds Murray. ‘The tenets of transparency are to provide salient information in a timely manner with context, give people data in comparison with benchmarks and offer an explanation when we fall short or perform particularly well.

‘We have an environment of accountability here and transparency helped to strengthen the theme of accountability. The transparency website is the engine of our work. People like to see how they compare with others, they like to see improvements. Transparency is also important for clinical leaders and our external audience of patients and insurers. We receive encouraging feedback from patients. We’ve also managed to avoid a major controversy with the media despite our openness.

‘Transparency’s major societal and strategic imperative is to provide creative tension within hospitals so that they hold themselves accountable,’ says Levy. ‘This accountability is what will drive doctors, nurses and administrators to seek constant improvements in the quality and safety of patient care.’

18 Improvement in practice
It is hard to avoid the conclusion that the leadership instincts of Levy rescued Beth Israel Deaconess from financial collapse. His championing of quality and transparency has fuelled significant progress over the last decade.

Murray says, ‘Levy created a ‘just’ culture, based on trust, accountability and transparency. He chose the right path with the right people and the right tools. Management have trusted staff and opened up conversations. Engaging clinical leaders in goal setting has spread a sense of shared ownership.’

‘Levy is good at straight talking and holding open meetings,’ adds Sands. ‘He appealed to the traditional values of the Beth Israel and Deaconess hospitals despite their differences in culture. He told us we should be proud of what we’re good at and he renewed our sense of purpose.’

‘It’s straightforward,’ shrugs Yang. ‘The story of Beth Israel Deaconess is a lesson in the importance of appointing the right leader.’

Levy himself has a simple explanation: ‘I took the job on as a public service. Perhaps I had an overly developed sense of confidence but my management approach is that people want to do well and want to do good and I create an appropriate environment. I trust people. When people make mistakes it isn’t incompetence, it’s insufficient training or the wrong environment. What I’ve learned is that my management style can work.’
The Health Foundation wants the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable. We believe that in order to achieve this, health services need to continually improve the way they work.

We are here to inspire and create the space for people, teams, organisations and systems to make lasting improvements to health services.

Working at every level of the healthcare system, we aim to develop the technical skills, leadership, capacity, knowledge, and the will for change, that are essential for real and lasting improvement.

Footnote
On 7 January 2011 Paul Levy’s resignation was accepted by the Board of the Directors of Beth Israel Deaconess Medical Center.

"It is with deep regret that the board has accepted Paul’s resignation," said Stephen Kay, Chair of BIDMC’s Board of Directors. "For nearly 10 years, Paul has provided thoughtful and able leadership to this medical center, and was instrumental in restoring BIDMC’s fiscal health during a very serious financial crisis.

"Paul has significantly strengthened the medical center during his tenure, including making improvements in quality and patient safety, and has led BIDMC into a new era of accountability and excellence. The board is profoundly grateful to Paul for bringing to our hospital qualities that are uniquely his own. When the situation demanded a bold vision, Paul delivered. When austerity was the order of the day, Paul answered with compassion, so much so that our employees and patients became our ambassadors."


In a letter to colleagues, Levy explained his decision: “I have been coming to a conclusion over the last several months, perhaps prompted by reaching my 60th birthday, which is often a time for checking in and deciding on the next stage of life. I recently traveled to Africa and while biking through the Atlas Mountains had plenty of time in a less cluttered environment to think this through.

"I felt some ambivalence as I was writing yesterday’s blog post entitled "Resolve." I realized that my own place here at BIDMC in the role I outlined in that blog post had run its course. While I remain strongly committed to the fight for patient quality and safety, worker-led process improvement, and transparency, our organization needs a fresh perspective to reach new heights in these arenas. Likewise, for me personally, while it has been nine great years working with outstanding people, that is longer than I have spent in any one job, and I need some new challenges."

Typically, Levy posted the full letter on his blog: http://runningahospital.blogspot.com/2011/01/transitions.html