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# In Conversation with...Sorrel King

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**Editor's Note:** *Sorrel King is the mother of Josie King, who died tragically in 2001 at age 18 months because of medical errors during a hospitalization at Johns Hopkins Hospital. She has subsequently become one of the nation's foremost patient advocates for safety, forming an influential foundation (the Josie King Foundation) and partnering with Johns Hopkins to promote the field of patient safety around the world.*

**Dr. Robert Wachter, Editor, AHRQ WebM&M:** What led to your partnership with Hopkins? Was it your idea, their idea, or did it come to both of you at the same time?

**Sorrel King:** It definitely wasn't their idea. When Josie died, we were angry and sad and struggling with those two emotions. Before that time, I had no idea that people died from medical errors. And we hired a lawyer; we wanted answers. You know, there were moments in time where I wanted a blood bath, I wanted to destroy Hopkins. There was an investigation, and they came to us with a settlement deal, but it wasn't money we wanted. Then someone said something that made some sense. They said, "Don't be an idiot, take the money and do something good with it." So we did. We were going to give the money to cancer research for children, build a playground for kids with cancer, or do something for kids in the health care setting. After we signed the legal papers, I called Rick Kidwell, the lawyer at Hopkins, and said, "What happened to Josie, that little strike of lightning, that doesn't happen very often." And I'll never forget his answer. His answer was, "Sorrel, it is happening everywhere, every day, every hospital, all over the country, all over the world?98,000 people are dying from medical errors." Then I began reading about it and talking to people. And it became apparent to us that we needed to do something about preventing medical errors.

**RW:** What have you come to understand about the way hospitals work and the way doctors work that you didn't know when you started this journey?

**SK:** I didn't understand that there were these silos of care. You had your nursing team, the surgical team, the pain management team, and all these teams, yet there was never really one person who was leading people or communicating with everyone. I did not know that there was this dysfunctional culture between patients and doctors, or families and nurses, or nurses and doctors. I always thought people communicated

better and they paid attention. When Josie was in the hospital, I learned that's not the case; I saw it happening before my very eyes.

**RW:** Do you think things are getting better?

**SK:** Yes, I think they are. But I think there's still a long way to go. I think we need to focus on this next generation of nursing students and medical students. That's exciting to get into these fresh minds.

**RW:** In trying to figure out how to fix it, you have to try to understand why the students evolve in the way that they do. Do you have a sense of what goes on over time that makes things the way they have been?

**SK:** Well, I think the way my foundation can change things and the way we all can change things is to talk to these medical students and nursing students. If we can get into their hearts and into their souls and into their minds, share these stories and make them understand. They have to slow down, to listen to a mother or a father when that parent is afraid. You've got to look at the patient. Not all the answers are on your computer screen or on your clipboard. You have to communicate, you have to listen to the nurse, and you have to listen to each other. You must slow down. I've found that sharing my story has made a huge difference to these people. I didn't go to medical school and I didn't go to nursing school, so I'm just saying what I've heard from people who have, and that is, we weren't taught this stuff in school.

**RW:** Are you sympathetic to the plight of the individual doctor or nurse who hears you and says, I need to slow down, and then goes back into the machine and the machine is operating at 98 miles an hour and you have *x* amount of work to be done in *y* amount of time?it's very difficult to slow down in that environment.

**SK:** I'm totally sympathetic to that. Especially with the nursing shortage, these nurses are just pulled in a million directions. You know, I can't solve the problem, but it's sad that they have to go back into this environment where there are faulty systems. These systems are eventually going to break down and something is going to happen that wasn't that doctor's fault or that nurse's fault. It was a system thing. But something bad is going to happen and it's going to look like it's that person's fault or that person is going to feel like it was their fault that they hurt this patient.

**RW:** In your mind, have you reconciled this balance between the system needs to be better but at times there are "bad apples"?

**SK:** I've never heard a story where the doctor or nurse did something on purpose. I come across stories all the time in which the doctor or nurse didn't listen or didn't pay attention. From what I see and hear, it's constantly a communication thing.

**RW:** What do you think the role of transparency is? In some ways, you look at the steps that Hopkins has taken and it shows a lot of good people getting together and it shows your leadership. But it's also because there were bad errors that were embarrassing and ended up in the media. That tension comes up a lot, where hospitals will often say leave us alone because if it's too public people will just hide everything, and on the other hand, the publicness sometimes catalyzes the changes.

**SK:** When the media reports about some hospital that screwed up, it's really, "here's the story." Then the next day, everyone's forgotten about it, and then what was the point of it? The media came to us a year or

two after Josie died, and it was a story about a hospital that really screwed up. But the more important thing about that story was that the hospital and the family came together and they're making changes. They're making a difference and they're affecting hospitals all over the country. The hospitals have to offer full disclosure. When something goes wrong, they have to go to the family. They've got to apologize, they've got to tell the truth, and they've got to fix the problem. As far as the media is concerned, I don't know, hopefully families would figure out not to go to the media until they have created some solutions at these hospitals. Then the hospital and the family can share the story together, and hopefully people can learn from their mistakes.

**RW:** What have you come to believe about the role of patients in protecting themselves?

**SK:** I think patients need to trust the hospital they're in. They need to trust the doctors and the nurses and they cannot put up this wall of animosity in front of themselves. They need to trust where they are, trust the people who are caring for them. But they need to be on their toes. They need to never be afraid to raise their hand and ask questions. They need to keep notes, they need to keep track of medications, who's doing this and what's happening here, and what the child is eating and not eating. I hope patients have a better understanding that they need to pay attention and that hospitals can be dangerous places.

**RW:** What are you proudest of in terms of what you've accomplished?

**SK:** Well, it's good to know that Josie's short life and her death are making a difference in the way that doctors and nurses are taking care of their patients. That's why we keep going on with what we're doing. The second thing I'm most proud of is all the good stuff that we've done since she's died. All the programs the foundation is funding, all the traveling and talking to people. They're great things that happened. That makes me really happy.