

My Turn

Private Industry Can Provide Direction

By Allan Frankel and Carol Haraden

Private industry is decades ahead of the medical community in its commitment to teambuilding. With its focus on profits, the private sector sees teamwork not as fluff but as an essential component of success.

In healthcare, the single most important ingredient for achieving patient safety is teamwork. In virtually every case of medical error — which now accounts for an estimated 100 deaths per day in U.S. hospitals, according to the Institute of Medicine — a lack of teamwork or poor communication among team members is a major contributing factor.

As early as 1979, United Airlines began training its in-flight crews in Crew Resource Management. They created flight simulators and tested the pilots, and later the entire crew, not only on their technical proficiency but also on their interpersonal skills — their ability to work as a team. And the crews understood at the outset that they had to excel in both or they would not fly.

Aviation realized then, as it does now, that teamwork is crucial, and they made it an early priority. It is not coincidental that aviation has an extraordinary safety record that medicine must work to match.

In medical schools, students are taught technical proficiency, but teamwork has never been a priority. Medicine prizes the autonomy of the doctor and the hierarchical structure of healthcare institutions. Safety in medicine suffers in part because errors tend to occur one patient at a time. They are, therefore, less visible than a plane tragedy and less threatening to the field overall.

Some hospitals have started using high-fidelity simulators, based on research done at Harvard and Stanford Universities, to mimic real-life medical practice and help physicians prepare for emergencies. However, teaching the use of these simulators needs to advance beyond the teaching of critical event skills and become an intrinsic part of the training for the everyday workflow in our hospitals.

Re-creating a culture

Not surprisingly, it is the nonhealthcare industries — like aviation, nuclear power, and space exploration, among others — that can least afford errors, because each mistake is public and potentially catastrophic.

In its early years, NASA was the epitome of a safety-first organizational culture, characterized by a preoccupation with avoiding failure, a deference to expertise wherever it was found, a readiness to adapt, a reluctance to simplify explanations, and above all, a commitment to teamwork and safety.

That culture dissipated as time went on, and the resulting Challenger and Columbia disasters have jeopardized human space travel. NASA is now working to rebuild that earlier safety-first culture, in part because it cannot afford another error.

The Columbia Shuttle accident report is replete with descriptions of situations in which managers did not hear the concerns of engineers — did not listen to the expertise that was available within their own teams — a problem all too common in medicine where the hierarchy discourages employees from voicing concerns about potential dangers.

Nuclear power also focuses on teamwork and on ensuring readiness not only for day-to-day operations but also for worst-case scenarios. Plant operators spend weeks each year training and testing their operating teams in simulated situations. While such simulations may at first seem unnecessary in medicine, how many operating rooms are prepared even for such a simple occurrence as the lights going out?

Healthcare catching on

Fortunately, a growing number of hospitals are discovering the benefits of teamwork. One effective tool is the patient safety leadership “WalkRound,” developed by the Institute for Healthcare Improvement (IHI) and piloted at the Brigham and Women’s Hospital in Boston.

This technique, now being piloted in hospitals around the country, involves the top executives in each hospital walking around the facilities with senior medical and nursing staff at least once a week to evaluate ways in which the hospital environment could undermine safe care and to determine what to do about these situations.

In another case, a Kaiser Permanente hospital in Orange County, Calif., has improved patient safety in its operating rooms by implementing safety briefings prior to procedures. These briefings, at which all members of the surgical team share information and concerns regarding possible safety issues, have resulted in marked improvement in staff perceptions of safety and teamwork and are also associated with decreases in case turnover time and improvements in nursing staff retention.

In a third instance, a recent study conducted by the Johns Hopkins University Hospital, using a concept developed by IHI, found that patients in intensive care improve faster if doctors and nurses and the entire care team together set specific daily goals for each patient’s care. This required that everyone involved in a patient’s care — doctors, nurses, pharmacists, and others — go on rounds together, visiting each patient. Improved teamwork thereby led to enhanced patient care and shortened stays in the intensive care unit.

Technological advances will also improve teamwork. Electronic health records, for instance, will make access to medical histories readily available. The use of electronic prescriptions will reduce drug duplications and incompatibilities. The use of bar coding and radiofrequency devices will provide

better tracking of objects in hospitals, as well as the movement of patients themselves.

But despite medicine’s love of technology, that alone is not the answer. Teamwork is the new frontier for medicine and the cornerstone for patient safety. Medicine ignores the lessons of private industry at its own peril.

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