

The Patient Safety Battles—Put on Your Armor

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The patient safety arena offers great reward yet great personal and professional risk for its stakeholders. In the final analysis, the patient safety battles include both the conflicts of interests between people and the eternal battle against organizational inertia—a faceless enemy that never sleeps. Patient safety champions must be prepared to arm themselves for the trials they will face. We borrow and adapt an ancient metaphor from the past because it is as pertinent to today as it was many years ago. Our safety champions each need the helmet of knowledge to speak to the mind, the breast plate of values that protects their heart, a shield of faith that will sustain personal attacks, the powerful sword of communication to lay bare the barriers of resistance, and the evidence of truth that binds the armor together. Finally, they need to be shod with the readiness to move quickly as servant leaders in every situation.

THE BATTLEFIELD

The Institute of Medicine report “*To Err is Human*” may have catalyzed our national attention to health care quality.² However, the most recent success of the 100,000 Lives campaign of the Institute for Healthcare Improvement that contributed to the prevention of more than 122,000 deaths³ and the process of coupling payment to quality and safety, such as that which was defined in the Deficit Reduction Act of 2006,⁴ will bring new combatants to the patient safety wars.^{5,6}

Hospital leaders and caregivers who may have had a “wait-and-see” attitude are new to the arena and have been forced into the fray by the demands of transparency and public reporting.

Conversely, the many quality leaders who have been fighting inertia and systematic resistance for years are battle weary at the very time when they could make great gains.

The survival stakes have never been greater and challenges never more demanding.

THE BATTLES

Many patient safety battles are being fought simultaneously in a virtual battlefield. Some battles are with external outside forces, and many are internal within an organization that can be very complex and multidimensional.

Externally, we are being challenged by a seemingly unsynchronized cacophony of requests by certifying, purchasing, and quality organizations.⁷ The phrase of “a thousand measures in a thousand days” is on the lips of many frustrated hospital leaders. We battle unfair and unrealistic requests that appear to have been developed in a sterile vacuum, far removed from the reality of frontline care. Many would agree that public reporting is “in the beginning of its beginning” that it will have its growing pains and its share of inflated egos and contentious concepts. Behind the mask of critical thinking, on the other side, lurk those who just enjoy being critical; as a new science, patient safety is an easy target.

Internally, within our organizations, we fight the age-old financial struggle; health care is characterized by infinite demand and finite resources. Safety is no different. How much is enough investment in patient safety? How far should we go in our disclosure of adverse events causing harm; how much can we put our financial resources at risk?

Even the safety proponents, who we expect to be allies, face off to defend their favorite performance improvement programs and compete for dollars for their pet projects, despite the fact that all good performance improvement programs have the same 5 elements: education, skill building, measurement, process improvement, and reporting.

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THE COMBATANTS

Trustees

Historically, the keepers of the flame of financial accountability, trustees have to learn a whole new vocabulary of quality and patient safety. What is more, they must take on the balancing act of resource allocation in the face of new requirements of certifying, purchasing, and quality organizations. They carry certain personal risk of which they may not be aware.⁸ Many trustees are reevaluating chief executive officers (CEOs) who have been bred and nurtured “to get the numbers” yet do so at the expense of their organization’s stated mission and values.

Chief Executive Officers

Porter and Teisberg state in “Redefining Competition in Healthcare” that the hospital is the most complicated organization in the world to run, yet many of our chief executive officers have to spend much of their time managing “owners, donors, and loaners”; they have had to become asset managers rather than the inspirational leaders of organizations delivering care.⁹

Some, who have discovered that prioritizing quality and safety delivers extraordinary financial performance, are reluctant to speak up. They fear that purchasers will reward their innovation by cutting reimbursement to exploit a new-found profit opportunity. This secret weapon of performance improvement is often kept well hidden and unpublished because it has been demonstrated best in frontline community hospitals.

Without an alternative, those addicted to bad profits have no time out for rehabilitation. Like trustees, they have to learn a new discipline while keeping up with their already demanding “day job.”

Finally, they have to referee the opposing forces of financial and quality proponents within their executive teams and discern a resolution path into an unknown future for one of the most complex industries in the world.

Formal Medical Leaders and Quality Officers

Unfortunately, when a practicing physician becomes employed by an organization and even when the medical staff vote in a new representative, they are often seen as having gone over to the “dark side.” Trust, truth, and teamwork with their colleagues become at risk. It is important to recognize the critical importance of credibility with both the independent and staff physicians. The battles our medical leaders face are often times more polarizing than fighting simple inertia and systems failure. The subtle and not so subtle fiery darts of distrust can hurt them to their very core. Battle lines often form over issues that impact physicians’ income, time, and quality of care. Unfortunately, the priorities are often in that order.

Nursing Leaders

Fighting to either get a place at the table or keep a place at the table, today’s nursing leaders find themselves in a very difficult situation. Although they represent a constituency that can make or break financial and quality performance of an

organization, they are seldom given the respect or authority to make a contribution. Consequently, they often lack the experience, skills, or access to wade into the waters of the “C-Suite” to take a stand.

Patient Safety Officers

So new to the scene and so unclear is their role, safety officers have to establish credibility, fight for budgets, and often become the lightning rod when something goes wrong. They are often handicapped by the “catch 22” of playing a position of accountability without authority.

Pharmacy Leaders

Medication management/adverse drug events is one of the better understood patient safety areas; however, pharmacists are still struggling to have the central role necessary to impact enterprisewide systems performance improvement. Not yet members of the “in crowd” of operations and finance leaders that get much more airtime with the senior officers and board, pharmacy leaders fight a 2-front war of trying to be heard while dealing with an increasingly complex medication system improvement battle.

Frontline Caregivers

We must be very sympathetic to frontline nurses, direct caregivers, and those who interact directly with our patients at all levels of the organization. Those real heroes of health care often feel disenfranchised because our administrative response to their input is often nonexistent or so delayed that they feel powerless to evoke change. Furthermore, they often face criticism from all ranks when they speak up for better care. Many are so battle weary from the demands of caregiving; they give up on either making a difference at an organizational level or the profession entirely.

Middle-level Hospital Managers

Work with midlevel managers reveals a perception gap between them and their senior leaders. Jim Conway, former chief operating officer of the Dana Farber Cancer Institute, now a senior fellow at the Institute for Healthcare Improvement, has been working with and studying the perceptions of more than 400 middle-level managers. “They are looking for focus and prioritization from their leaders in the C-suite, and they are not getting it. Furthermore, they are overwhelmed, cannot do everything, and do not know what success looks like.” A similar survey of CEOs and board chairs shows a dramatically different perception; they believe that there is appropriate focus and direction. Conway believes that this perception gap represents a great opportunity for improvement. (Conway J, Conway J, Kodala L, et al. *Executive Leadership, Physician Leadership and Management: Gaps in Perception as Barriers in the Patient Safety Journey*. Abstract for September 2006 presentation). It could be said that middle-level managers are experiencing the “fog of war” in that they see action all around them and know that they must act; however, they are disoriented and thus are often ineffective.

Patient Safety Organizations

Not-for-profit safety organizations find themselves in the same dilemma that many nonprofit hospitals do: the trap

of “no margin–no mission” where the devils of economic survival can shout down the better angels of their stated mission. For in reality, when the no margin–no mission mantra is claimed or lived through the behaviors of the leaders or board, the real message is that the margin is the mission. Moral relativism, situational ethics, and even clearly compromised ethics are alive and well in organizations where unengaged boards allow these compromises rather than “rocking the boat.” Administrative leaders or staffs that are more interested in their product than patients and their meetings than their mission can put legitimate patient safety champions, the community, and even their own organizations in conflict or at risk.

Patients and Families

Patients and families are having a hard time being heard. Their signal is being lost in the noise of the quality movement. Rarely are their initiatives adequately funded and frequently their stories of harm become “old news” to organizations that are more in the business of producing meetings than in the business of what such meetings should produce—driving change. They feel that their battles are more like a David-and-Goliath conflict with the entire system of health care than anything else. Some, such as Sue Sheridan of Consumers Advancing Patient Safety, Sorrel King of the Josie King Center for Patient Safety at Johns Hopkins, Jennifer Dingman of PULSE, and Nancy Conrad of the Community Emergency Healthcare Initiative, are having impact. They are, however, doing so on sheer personal commitment and assistance of some organizations such as Joint Commission for Accreditation of Healthcare Organizations, the World Health Organization, the Agency for Healthcare Research and Quality, the Institute for Healthcare Improvement, Americans for Quality Healthcare, and the National Patient Safety Foundation.

In the words of Sue Sheridan, “patients and families are often seen as adversaries rather than partners for improvement. We must call on their passion, wisdom, knowledge, and courage to join the powers in health care as partners to drive transformation.”¹⁰

OUR FULL ARMOR

Regardless of one’s faith, the metaphor of battle offers a great analogy for the trials we face in patient safety.

The Torah says of battle, “To fight and win any battle, one needs training and resources.”¹¹

The Art of War provides a different perspective, emphasizing preparedness, and states that “Ultimate excellence lies not in winning every battle but in defeating the enemy without ever fighting. The highest form of warfare is to attack strategy itself.”¹²

Paul, in Ephesians, describes the elements of the full armor, including the helmet, breastplate, shield, belt, sword, and sandals. “Put on the complete armor of God so you may be able to stand your ground in the day of battle.”¹³

Dr David Hunt, of the Centers for Medicare and Medicaid, states that we must have leadership, resources, and a system to have real impact in quality improvement. That

being the case, we can consider our metaphoric armor to be a “system” approach to the preparation for our battle in patient safety.¹⁴

We make the following metaphoric translation:

The Helmet: Paul’s helmet referred to the knowledge of salvation. Knowledge can be defined as the state of knowing and clear perception of fact, truth, or duty. In our metaphoric example, we can consider the knowledge to be the fundamentals of patient safety, such as adoption of the evidence-based National Quality Forum *Safe Practices for Better Healthcare*,¹⁵ the behaviors of High Reliability Organizations,¹⁶ and even the evidence of the impact of the Institute for Healthcare Improvement’s very successful 100,000 Lives campaign.³ (Don Berwick announcement at IHI Redesigning Hospital Care, June 14, 2006).

We must appeal to the minds of those we aim to recruit to the battles of patient safety with a command of the literature, best practices, and fundamentals of performance improvement.

Appealing to the heart alone is not enough. It is the confidence in the ever-increasing knowledge of patient safety that will keep our own minds on our mission. We cannot afford to be distracted by those who just want to argue academic nuances.

In America, it is believed that we have a 17-year adoption rate of best practices; we adopt such practices less than 55% of the time, and less than 25% of what we do is in the medical literature. We certainly have enough evidence in patient safety to make our case now.¹⁷

However, we must be prepared. The knowledge is our salvation.

The Breast Plate: Paul’s breastplate of righteousness protected the heart. It referred to the state of purity and uprightness. In our metaphoric translation, we consider this a breastplate of our values. Our steadfast belief is in the common good of treating our patients with the best care we possibly can: care that is safe, efficient, patient centered, timely, and equitable.

To protect our heart and reach out to the hearts of those we seek to influence, we must make sure our values are pure and motivations are right.

It is time to return to the values that made our country great and our health care the greatest in the world. Such values drive the economics but are not driven by the economics. They are driven by doing the right thing for the right patient every time. They are driven by treating patients the way we would want to be treated. It does not take a randomized trial to figure this out in most circumstances.

We must win the hearts of our colleagues by earning and maintaining their trust; the only way we can do this is making sure that our behaviors mirror our values in every way.

The Truth: In our ancient metaphor, the belt that held the armor together was truth. This translates to our application very well in that we must make sure that, as we engage in the battles of patient safety, we must stay within the envelope of the evidence no matter how tempting it may be to enhance our case for performance improvement.

The integrity of our arguments should pivot on very defensible positions that can sustain the challenges of both fair and unfair critical thinking.

We must build our positions on the solid ground of evidence-based medicine, the principles of patient centeredness, and targeted systems performance. We must examine the integrated performance impact of clinical, operational, and financial metrics, measured in real world situations at point of care, at episode of care, and over payer contract horizons.

We must constantly seek to find better evidence for our arguments and prepare to acknowledge when we are wrong.

The Sword: The sword of the word, cited in Ephesians, represented the word of God. In our metaphoric case, the symbol of the sword represents our ability to communicate; if we cannot tell it, we cannot sell it.¹³

Patient safety champions have a difficult challenge. In some cases, the argument for patient safety is a “flag, mom, and apple pie” issue. However, in many cases, we have to argue for expensive changes to fix systems failures that are invisible.

Studies that produce new knowledge are directionally important but insufficient to create change alone. We need to make all of the stakeholders aware of performance gaps, show them how to couple personal accountability to improvement, how to invest and develop the ability to change, and provide direct line of sight targets for action that can get them moving.

The science and art of communication in a multimedia world has left professorial esoteric attitudes and ineffective teaching modes in the dust. We must learn to transfer knowledge that can be put into action and use the best means possible for our audiences. This requires a formula of medical references, change concepts, and plug-and-play methods that can be put to work rapidly and effectively. Organizations like the Institute for Healthcare Improvement are leading the way in such endeavors.

The Shield of Faith: The definition of faith is “assurance of things hoped for, proof of things not seen.”¹⁸

It will be our shield of faith in the common good of patient safety and the belief in the things not yet seen by our efforts and those in our organizations that will help protect us from the retaliatory attacks of those who are defending the status quo.

Albert Einstein said “Great spirits have always found violent opposition from mediocre minds.” We must lift our shield of faith before us as we move into the battles that are only going to intensify as resources become more limited and the competition for them becomes more fierce.¹⁹

We must be prepared to deflect the attack on the “3 Ps”—product, process, and people. June Edwards, a former special assistant to the NASA administrator for commercialization advises champions of new ideas within bureaucracies to be prepared for attacks on your product, then your process, and then your people. (verbal communication, Washington, DC, 2002).

Our shield of faith needs to be hardened by our confidence in our preparation of our product, our process, and our people.

The Footing of Readiness: In our ancient metaphor, the final piece of the full armor was the footwear of readiness to move quickly to serve.

Servant leadership encourages leaders to serve others while staying focused on achieving results in line with organizational values and integrity.

We must deny ourselves the primary recognition for what we are individually or organizationally accomplishing and seek to serve by bringing others into the movement of patient safety and allowing them to receive attention for the work of their own teams. By leveraging trust, truth, and teamwork, much can be accomplished by swift action to serve.

What is the most important part of our full armor? Jim Collins, the author of 2 best sellers “*Good to Great*”^{20,21} and “*Built to Last*”²² warned hospital leaders at a recent national summit: “If you lose your values, you lose your soul...if you lose your soul you lose it all” (Collins speech given July 13, 2006, at Health Forum and the American Hospital Leadership Summit).

THE MOST IMPORTANT ELEMENT OF ARMOR?

“If you lose your values... you lose your soul... if you lose your soul you lose it all”

As we embark on our next patient safety crusade, we must make sure to put on our full armor. We must ensure that we don our helmet of knowledge, hoist our shield of faith in our mission, polish our sword of words, buckle the belt of the evidence of truth, and shod our feet with readiness to move to be servant leaders.

Above all, we must protect our heart with our breastplate of values as we engage in the battles that are truly life and death.

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We want to acknowledge you and your institution for your current efforts in patient safety. We hope you enjoy this article and find it useful in your future work.

Sincerely,

Charles R. Denham, M.D.
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