Engaging Physicians In Efforts To Improve Patient Safety and Clinical Quality
By
Joseph S. Bujak, MD, FACP

(Published by The Governance Institute, December, 2009)

Today health care in the United States is too often unaffordable, unsafe, impersonal, uncoordinated, and wasteful. There is considerable overuse, under use, or misuse of health care resources. As a result there is an increasing emphasis on demands for improvements in patient safety, the consistent application of evidence-based medical practice, initiatives to reduce variation, requirements for public reporting of data to include patient satisfaction, and efforts to audit processes of care in an attempt to influence clinical outcomes. The Joint Commission and other regulatory bodies have become the enforcer of these expectations. Pay for performance initiatives have quickly morphed to no payment for failure to perform. The payer community led by Medicare will no longer pay for "never events" or for hospital readmissions within 30 days for the same condition.

Physicians can no longer simply focus on the effectiveness of their interventions. This changing environment demands a responsibility for assessing the efficiency and the appropriateness of care and the quality of the patient experience as well. What is required is a more balanced and integrative accountability.

There are three main drivers for improving patient safety and clinical quality. There is a professional and ethical responsibility. Shouldn’t physicians seek to identify and adopt best practices of care because it is the right thing to do? There is a strong economic case for avoiding complications and creating predictable outcomes. Fixed reimbursement demands that the best outcomes be achieved with maximum efficiency. Waste must be identified and eliminated. Publicly reported data is an attempt to influence value based purchasing in hopes of rewarding the low cost high quality providers. Finally, there is a proliferation of regulatory requirements. These include judicial, legisliative, and regulatory body mandates. Payer and patient expectations are changing and there is always the threat of potential litigation. It is a "shame on us" situation that the regulatory requirements are by far the dominant motivator and that CMS is leading the initiatives to improve patient safety and clinical quality.

When the Dartmouth Atlas was first published it focused attention on the wide geographic variation in application of health care resources. The legitimate question to be asked was whether or not certain areas were being either over served or underserved with regards a particular intervention. At this point the payer's for healthcare services began to demand evidence to prove that they were obtaining optimum value. The provider community’s response was that the issue was too complicated and that the payers should trust in our professionalism and good intentions. Concern over this variation was more recently amplified by a study that showed that in an ambulatory setting only 60% of patients received appropriate evidence -- based interventions. Failure of the health care
profession to step up and take ownership for quality and safety has created a void filled by regulators, judges, legislators, payers, and malpractice attorneys.

A watershed event was the publication of the Institute of Medicine’s report "To Err Is Human." This report estimated that from 44,000 to 98,000 deaths occur each year due to medical errors. The physician response to this report was one of disbelief. They were incredulous that that many patients were being seriously harmed and challenged the validity of the data. The reason for this response is that complications of care are given a medical diagnosis. For example, when patients are admitted with venous thromboembolism they are treated with anticoagulants. There are nomograms and algorithms available to guide the dosing of these medications. Failure to follow these guidelines can lead to either inadequate anticoagulation, which leaves the patient at risk for further clotting and potential pulmonary embolism, or an overdosing that leaves the patient at risk for hemorrhage. When either of these adverse outcomes occurs we don't say that it is result of failing to follow best practice but rather we make a diagnosis of pulmonary embolism, stroke or G.I. bleeding and ascribe it to "bad luck." The same could be said for an elderly patient who is over sedated at night, crawls out of bed to go to the bathroom, and falls and breaks her hip. The diagnosis isn't one of over-sedation but rather one of a hip fracture requiring additional therapy.

Healthcare organization attempts to improve patient safety and clinical quality require physician engagement. These efforts demand a redesign of the processes of care. But in the physician community, where individual physician autonomy is paramount, vigilance and memory are presumed to be what is required to avoid medical errors. Each physician defines quality as "the way I take care of patients." A physician must believe that everything he or she does is as perfect as it can be. How could a physician live with himself if they knowingly made decisions that harm their patients?

Most would agree that data is essential to managing the clinical improvement process. It is also assumed that physicians are data-driven. But probably every healthcare organization has at some point along this journey been held hostage to physician demands for valid data. If a physician must believe that everything he does is perfect and the data demonstrates that his performance is less than perfect he must conclude that the data is bad. In fact the data is bad! To a physician data is something used to guide pursuit of absolute truth. The gold standard of medical research is the prospective, double blinded, randomized, single variable trial with a significant N and a P value greater than .05. Anything else is not data. The data used to guide performance improvement is much more qualitative and when it fails to match expectations it is denied.

If in fact the data is irrefutable, the physician’s next response is to justify the data. In some way her patient population is unique. If that too fails, the last resort is to "shoot the messenger." In effect a physician says to the non-physician, "tell me again, when was it that you graduated from medical school?"
There are significant elements in the healthcare culture that perpetuate the status quo and contribute to the inertia that surrounds healthcare improvement initiatives. The healthcare organization is a culture of orders. Nothing can happen to a patient without a physician’s order. Standardizing care would require every physician to agree to a pre-determined approach. Given the primacy of individual physician autonomy the default is to individual physician preference. In the course of medical training physicians are not taught to focus on processes of care. Individual competency and individual excellence are held up as the ideal. Medical mistakes are consequent to failures in vigilance or memory.

Physicians don't communicate well. The Joint Commission in reviewing sentinel events has noted that failures in communication are almost always a significant element. Physician handwriting is notoriously illegible. As the author of the diagnostic and therapeutic plan, the physician has an obligation to communicate that plan clearly. Unreadable handwriting is the equivalent of speaking in a foreign language and a failure to adequately communicate with other caregivers. There is a growing intolerance of disruptive physician behavior often manifest as a disrespectful response to the inquiries of other healthcare professionals. An attitude of arrogance or intolerance intimidates others who then often avoid contacting that physician, potentially leading to patient harm. Physicians who behave in an intimidating fashion can significantly create an environment that compromises patient safety and clinical quality. Governing boards must insist that medical staff leadership accept the responsibility of eliminating this kind of behavior.

Physicians approach decision-making very differently from others who work in the hospital environment. Physicians are guided by the principle of distributive justice. In essence, the end justifies the means. What matters most is how things turned out, and how you got there is irrelevant. Physicians don't hesitate to violate established policies and procedures in an attempt quickly resolve issues. Other healthcare workers, especially nurses, operate on the basis of procedural justice. To them how you get there is paramount. There is a need to feel included and to have a voice and if these essentials are bypassed they often reject the conclusion.

The way physicians are acculturated predisposes them to reject performance improvement initiatives. As mentioned, to the physician the clinical outcome is the most important metric not balanced accountability. In addition, physicians are taught that it is their ethical responsibility to serve as the patient's advocate (apostrophe S). That is, short of doing harm, a physician must do anything he might that could conceivably benefit his patient irrespective of the patient's ability to pay. That is the essence of the Hippocratic oath. Hospital administrators on the other hand have an ethical responsibility to serve as the patients’ advocate (S apostrophe). As stewards of a community resource they are constantly challenged to create the greatest good for the greatest number. They realize that when they decide to allocate resources in one place that those resources are no longer available to allocate elsewhere. Each of these perspectives is accompanied by an equally valid but totally separate set of ethics and no one can work simultaneously in both. Looking at the same set of circumstances, each perspective drives a different conclusion. Because the answer to each is so very clear, when the other doesn’t come to the same
conclusion, they conclude that the other is either incompetent or self-serving. In any case he isn’t to be trusted.

Most physicians don’t have a good understanding of medical economics. Many act in ways that would suggest that the hospital “prints money in the basement.” Managing a hospital is an incredibly complicated challenge requiring a systems perspective. The physician’s daily work is much more linear and focused on the immediate needs of one patient at a time. Moreover, the reimbursement incentives are misaligned.

Finally, physicians are primarily fixers. They are presumed to have all of the answers, are quick to judge, can’t understand delays between deciding and acting, and are very time conscious and impatient. Now to a physician means immediately. Now to a hospital administrator may mean the next budget cycle if the subject in question relates to capital equipment. Physicians, who often have to make clinical judgments quickly, and who are autonomous captains of the ship, don’t understand the delay in decision-making that is the rule in healthcare organizations. These delays drive physicians crazy.

In the healthcare setting there are four cultural barriers to quality improvement. The first is the presumption that knowing equals doing. The invariable response to a necessary initiative is to distribute the information that justifies the change. The presumption here is that good people given access to good information will change their behavior. This, of course, is not true. Knowing is an essential but far from sufficient element in the behavioral change process. In addition you must have at least the capacity to change and the motivation to do so.

Second, there is acceptance of a no harm no foul attitude. It has been traditional when evaluating adverse events to grade those events on a scale of one to five. One means nothing adverse happened and five means the patient died. Unless an event is graded at least a three it is ignored. This approach ignores the inverse power curve relationship. If you plot frequency squared against magnitude squared and achieve a down sloping straight line you define common cause. Think earthquakes. Only a seismograph senses the magnitudes of the most frequent movements around the San Andreas Fault. Once every 100 years San Francisco Falls down. That which occurs at the greatest frequency occurs at the lowest magnitude. That which occurs at the lowest frequency occurs at the greatest magnitude. Think penicillin allergy. If a patient states allergy to penicillin but inadvertently receives the drug the most common consequence is that nothing happens. Once every four or five years a patient will die of anaphylaxis. The process failure that would allow this patient to receive penicillin is identical, but because of the no harm no foul attitude those high-frequency low magnitude events are ignored. The current emphasis on near misses is a reflection of the importance of the inverse power curve and an attempt to overcome this attitude.

The third cultural imperative is that errors are consequence of personal failure. When an adverse event occurs the chart is reviewed and circumstances assessed in order to answer the question why. In retrospectively reviewing any adverse outcome it is always apparent that if only one or more individuals would have been awake this would never have
happened. Then blame is assigned and additional training mandated. In this regard, failure to follow policy is never at the root cause of an adverse outcome. That is why narrative is so important. One needs to understand the context within which error is made in order to identify other factors that can predispose individuals to either bypass those policies, forget to apply those policies, or apply them incorrectly. In each of those circumstances remedial education is neither warranted nor appreciated. The individual knows the policy, but something about the work environment has interfered with their ability to comply. By altering those factors one can make a huge difference.

Lastly, as mentioned above, nothing happens without a physician’s order. This reinforces an ingrained sense of personal responsibility and personal accountability and diminishes the contribution of process standardization towards improving patient safety and clinical quality.

Why do physicians resist change? Rick Maurer describes three levels of resistance to change. The first level of resistance is at a factual level. The individual just doesn't understand the rationale for changing the behavior. When presented with information that would justify a change she can then make a conscious decision about whether she finds that rationale convincing or not. The second level of resistance is emotional. The individual understands the rationale, but doesn't like the implications. I would suggest that most physician resistance to performance improvement initiatives exists at this level. Almost all meaningful change that involves physicians requires a change in orders. The standardization of order sets is one of the most effective ways of reducing variation and improving outcomes of care. What are the implications of a preprinted order set? Who can apply a preprinted set of orders? The answers are obvious. The presumption is that the physician's role is demeaned by a preprinted set of orders that would appear to exclude the craftsman like elements of individual physician judgment. At this level the physician gets it, but doesn't like it. The highest level of resistance is prejudicial. This is a categorical reluctance to participate rooted in entrenched attitudes. "No hospital administrator is going to tell me how to practice medicine." “No pharmacist is going to treat my patient.” Prejudicial resistance is the most difficult to overcome and represents an absence of trust. In summary, the levels of resistance reflect in order: “I don’t get it;” “I don’t like it;” and “I don’t like you.”

It is important to appreciate that you cannot overcome emotional resistance to change by continuing to present factual justification. You must address it at the emotional level in order to achieve acceptance. The tendency, however, is to continue to present additional data in hopes of convincing the resistor.

Change is awkward, clumsy, and always takes more time than the historical way of behaving. The change sequence progresses as follows: An organization is behaving in a way that is unconsciously incompetent. It then learns that a different approach is either required and/or more effective. At this point it enters into the zone of conscious incompetence. This creates some anxiety and a desire to achieve improved performance. It is at this point that new initiatives or new programs become identified and the results to be achieved create a sense of willing enthusiasm among the participants. As the change
The initiative unfolds. People are now required to adopt new behaviors. This represents the zone of conscious competence. But it requires paying attention to unfamiliar behaviors that are awkward and always require more time than the rote behaviors to which they had become accustomed. It is at this point that most change initiatives fail. Especially at times of stress people are likely to revert to old habits because they are comfortable, familiar, and take less time. If the organization can persist through the zone of conscious competence gradually the new behaviors will become comfortably familiar. At this point the organization moves into the zone of unconscious competence. Remember when the electronic order entry systems were first introduced? Everyone feared the loss of the paper-based system. The transition was awkward and clumsy and slow but as you look back no one can imagine returning to a paper-based system.

The focus on maintaining individual physician autonomy is sacrificing physician group autonomy. Every level of enhancement in patient safety as you approach six Sigma levels of significance represents a progressive encroachment on individual physician autonomy. The current practice of medicine in which each doctor writes individual orders generates an adverse event at a frequency of about one in ten. The processes are largely custom crafted each time. A system in which the physician uses standing orders and reminders creates a serious adverse outcome at a frequency of one per hundred. This is a system of defined standard processes and teamwork. When, in addition, the system requires an external approval for certain orders serious adverse events are reduced to a frequency of one in one thousand. This represents the removal of discretion in a high reliability culture. In a system where all patients received evidence-based medicine without orders the frequency of serious adverse events becomes one in ten thousand. This represents a loss of autonomy. Finally one can approach six Sigma levels of perfection when performance is totally independent of a specific physician, a true loss of identity. This is referred to as having equivalent actors. The care is standardized no matter who the individual physician may be. You can appreciate in this sequence that at each level the primacy of the individual physician is progressively challenged to the point where the processes of care occur totally independent of the specific physician.

The important points related to physician resistance to engaging in initiatives designed to improve patient safety and clinical quality are these: 1. Standardization directly challenges individual physician autonomy and autonomy is the transcendent value within the physician culture. 2. Traditionalist and boomer physicians, generally born before 1965, have strong needs for control. Because in their mind the quality of medical outcome is primarily dependent on vigilance and memory and directly reflects upon individual competency, older physicians are reluctant to cede control to others when in fact they are held to be primarily accountable. (Generation X physicians, on the other hand, are much more willing to delegate and work in teams.) 3. The standardization of care represents an erosion of physician authority and creates a sense of diminished importance. This generates an emotional resistance to change. They do not like it. 4. Finally, the change process itself tends to slow the pace of work. Physicians, who are very time conscious, are reluctant to accept new behaviors that in their mind tend to slow them down.
A call to action

What would happen if a layperson curious about the details of surgery were to attempt to barge into an active operating suite? You can only imagine how angry all the personnel would be to witness someone violating sterile technique. Anyone and everyone in that room would feel authorized to quickly chastised that individual and remove them from the premises. No one denies the appropriateness of sterile operating room technique and everyone willingly complies with the policies designed to ensure compliance. How can we get to the status of operating room sterile technique as relates to the application of other evidence-based interventions designed to improve patient safety and clinical quality? Answer, we need to demonstrate the will. Issues of patient safety must be nonnegotiable!

As scientists why can't physicians apply science to the journey towards achieving perfect care? Why are demonstrably better approaches to patient care so slowly adopted? More importantly, bad clinical process will overcome physician vigilance every time. No one shows up for work intending to participate in an adverse outcome. Well intended clinicians are all too frequently victimized by bad clinical processes. Conversely, well-engineered clinical processes that standardize care by reducing variation predictably lead to better-aggregated outcomes.

What would the response be on the part of hospital governance if they were to learn that the chief financial officer failed to send a bill 15% of the time? Yet governance seems willing to accept the publicly reported data suggesting that members of their medical staff failed to appropriately apply evidence-based interventions more frequently than that? Where is the outrage?

Safety is the foundation on which quality is built. The journey toward enhanced patient safety and clinical quality should rest on an absolute commitment to creating the safest patient care environment possible. Safety represents the moral high ground. There's no one in a public forum that would stand up and suggest that initiatives designed to improve patient safety are unacceptable. Moreover you can't have quality without safety.

Here are some suggestions for how to move the safety and quality agendas forward.

1. Seek to make good better. Too often better is held hostage to perfect. Since the physician point of beginning is that her current approach to patient care is perfect, imperfections that exist within any proposed change are reason enough to reject the proposal in its entirety. This is an example of how misidentifying a polarity as a problem can paralyze improvement initiatives. Problems have solutions, they are issues of an either/or nature. If the use of guidelines is framed as a problem to be either accepted or rejected, the fact that they are not applicable 100% of the time means that they will be rejected in deference to individual physician preference. The use of guidelines is not an either/or issue, but rather a polarity. Polarities represent both/and issues. Following guidelines creates in the aggregate outcomes that are superior to the individualized physician craftsman approach. But they are not perfect. They work approximately 85
percent of the time. 15% of the time it is appropriate to deviate from those guidelines. If the physician frames a proposal to apply patient care guidelines as a problem, he is quick to point out its inadequacies in very specific situations and thereby rejects the proposal out of hand. What is essential is accepting the appropriate application of guidelines most of the time with a willingness to deviate from those guidelines when circumstances justify. Then, by following outcome data, one can seek to further improve the guideline going forward.

2. Focus first on the key elements that disproportionately impact patient outcomes. This represents an application of the Pareto principle or 80/20 rule. It is easier to create change if you alter a few critical elements then to create an inclusive proposal acceptable to everyone.

3. Start from points of agreement. This point seems obvious, but it is amazing how often discussions focus on points of difference, rather than points of agreement. It seems of greater importance to be right, usually in direct proportion to the amount of testosterone in the room! By starting from points of agreement, progress can be made, trust can be built, a “can do” attitude is developed and momentum built towards future success.

4. It is important to appropriately frame improvement initiatives. Proposals to make change must be seen as serving specific physician self interest. Answering the question, "what's in it for me," is essential to achieving acceptance. For some, it will be enough to know that the changes will improve patient care. For others you may be able to allow them to see that guidelines can reduce their liability exposure by preventing errors of omission. Guidelines save time, reduce variation, simplify the approach to patient care, and can free the physician to focus on those elements of patient care that can uniquely be performed only by her. Standardizing care can lead to fewer misunderstandings, and fewer telephone calls. Whatever the circumstance, identify a specific deliverable that the physician will personally value.

5. Think slinky! Significant change initiatives always meet resistance. All groups act to defend the status quo. If as a leader you seek to initiate a transformational change it is only somewhere between 10 and 15% of individuals who can see excitement and possibilities in true novelty. Since most group decisions are made by attempts to manage for consensus, the larger group will reject all truly new ideas. See those 10 or 15% of individuals as the front rings of a slinky. You move a slinky by pulling on that front rings and the tension that exists between those rings and the body of the slinky gradually causes the lagging rings to catch up in their own time. To manage by consensus would be the equivalent of getting behind the slinky and trying to push the entire mass forward. The positive news is that most transformational change initiatives are achievable by managing to critical mass which has been empirically defined as the square root of N. “Only heretics create change.”

In this context it is important to appreciate the approach of physician skeptics. Skeptics are persons who make positive contribution by pointing out the negative. Physicians are particularly good at rapidly identifying deficiencies in any proposal. They can quickly
point out all the circumstances where the proposed change won’t work. Sponsors of the initiative are then quick to conclude that the physician is being hypercritical, non-supportive, a naysayer or worse, a saboteur of the initiative. It is important when engaging a skeptic to ask them for an overview assessment of the proposal. For example, “on a scale of 1 to 10 how would you rate this proposal?” Or, “If we can adjust the proposal in response to your criticism, what would your assessment be?” In this way you avoid making a fundamental attribution error. Moreover, if proposals are modified to overcome the objectives of a skeptic, he often will be willing to become a proactive champion of the effort.

6. Change nothing, pilot everything. Most individuals resist change, especially when they don’t understand it, don’t control it, or don’t want it. When an initiative is framed as a change, the immediate response tends to be one of anxiety. Pilots on the other hand are readily accepted. A pilot can include the early adopters of change (the front rings of the slinky). When these individuals are given the time, space, and resources to experiment with the idea, they can make the necessary modifications that will enhance its effectiveness. If the change has positive consequences, others will observe the value and begin to copy the initiative. This approach allows leadership to diffuse some of the political pushback that occurs when select initiatives are put into play with a minority of the group. When some of the majority complain, you can invite them to be a part of the pilot. This would expand the number of participants. Most will refuse, preferring to continue business as usual. In addition, not all ideas are good ones. If a given project fails, no one’s ego is at stake, since, after all, it was only a pilot!

7. Appreciate the essential value of dialogue. You can’t teach a person anything; you can only help him discover it for himself. No individual, much less physicians who have intrinsic needs to be in control and are presumed to be both omniscient and omnipotent, wants to be told what to do. Individuals need to discover for themselves, and that discovery comes in the form of aha moments. That is why dialogue and the Socratic approach are preferred ways for engaging physicians.

The answer to most challenging questions lies in the collective wisdom of the group assembled. Margaret Wheatley has said that when individuals who are interdependent for creating an outcome in which they are vested are given access to all the necessary information and allowed to engage in “soulful dialogue,” magic happens. Facilitated dialogue is a self-organizing, non-linear, and emergent process that improves communication, builds mutual understanding, enhances trust, and unleashes creative thought. The process actually transforms the conversation.

Contrast that approach with the typical Board or Physician meeting. Agendas are most often rote, opposing propositions are debated, and the views of the most powerful coalition are adopted. It is a convergent process. Dialogue on the other hand is divergent. Hearing the viewpoint of others expands perspective, and enlarges the range of possible solutions. By practicing attentive listening and suspending judgment, you come to appreciate the individuals in the room. That builds trust.
8. How you frame an issue is all-important. All individuals behave in ways that they believe will serve to enhance what it is that they personally value. In order to get individuals to change their behavior you must allow them to appreciate that adopting the new behavior will actually enhance what it is that they care most about. To get physicians to adopt new behaviors in support of enhanced safety and quality, you have to allow them to see how the new behavior will get them more of what it is that they care significantly about.

9. Changing structure can have a major impact on moving the safety and quality initiative forward. The presence of intensivists and hospitalists has simplified the approach to engaging physicians in performance improvement. Physician employment and preferred contracting relationships with specialties intrinsically hospital-based create an opportunity to align incentives. When dealing with a voluntary medical staff it is only through leveraging credentialing and privileging that governance can ensure compliance with safety and quality initiatives.

All changes that apply to patient care are initiated through a physician's order. To standardize the approach involves creating preprinted order sets. When physician electronic order entry becomes a reality preprinted order sets that seek to apply evidence-based interventions will be facilitated. Case management functions can go a long way towards assuring the standardization of appropriate interventions. Case managers provide an additional pair of eyes for evaluating the appropriateness of documentation and coding as well as compliance with the appropriate application of elements of evidence-based care. They also can provide real-time feedback to the ordering physician.

Lastly, Generation X physicians are far more comfortable working in teams. Teams of clinical professionals are far more suited to addressing the complexities that attend care of the hospitalized patient. Drawing on the expertise of pharmacists, nutritionists, social workers, respiratory and physical therapists, and case managers can assure a systems perspective and enhance both the efficiency in the efficacy of care.

10. Understand the creative process and the importance of vision, especially to an expert culture. Creative tension is produced when you can simultaneously hold in mind a vision of what could be and an honest assessment of current reality. Absent vision there is no creativity. Failing to honestly confront current reality reduces the tension. Creating that tension actually pulls the organization toward the vision. Authoring, communicating, promoting, and modeling the vision is the primary responsibility of leadership.

Physicians comprise an expert culture. Experts are primarily vision driven. Think goal alignment. Healthcare organizations are primarily mission driven. Don’t confuse the two. Trying to leverage physician behavior in service of the organization’s mission is rarely effective. When the physician can see that his most important goals can be better achieved by working together within the organization, then alignment occurs.

Vision is of pivotal importance in another context. When circumstances challenge the organization it matters whether you view the challenge as problem to be solved, or a
purpose to be found. Problem solvers want to make the problem go away. Framing the
challenge as an opportunity to redesign the response in ways more consistent with
achieving the vision is an architect function and fundamentally transforms the mindset. A
problem has become an opportunity; a victim has become an architect of her own future.

Dr. Jim Bagian has listed these guiding principles for a patient safety system. 1. It should
be a learning and not an accountability system. 2. The reporting characteristics should be
confidential, de-identified, and non-punitive. 3. There should be an emphasis on the
importance of close calls or near misses and reports should emphasize narratives. 4.
There should be interdisciplinary review teams. 5. Feedback should be prompt. The
system is about identifying vulnerabilities and not about producing statistics.

There is some intrinsic tension that exists between on the one hand trying to achieve
efficient patient care and on the other hand building in redundancies which are essential
to designing safety into the system. Industries that focus on engineering safety accept
that humans are fallible and will make mistakes. In order to interdict those mistakes they
build redundancies into the system. Those redundancies of course add cost to the system.
There is a tension that exists between adding in redundancy and streamlining care to
control cost. In healthcare informatics the use of prompts and edits are one-way to help
guide and improve patient care.

What are the consequences of failing to aggressively commit to the creation of safe
patient care environments and to pursuing "perfect care." The first consequence is a
migration towards the mean. It is an almost universal observation that human behavior
predisposes to a migration towards the mean. Those individuals who perform beyond the
average are gradually sucked back towards the mean. In an environment of mediocrity
you risk losing your best people, those who aspire towards excellence. In fact, excellence
is a form of deviant behavior. This is a statistical fact. For any observation to be a
manifestation of something outside variation from the norm it must occur outside of two
standard deviations. You get what you accept and that what you accept sets the standard.
That is why it is essential that governing boards set the tone and the timetable for the
pursuit of excellence.

Does productivity drive morale or does morale drive productivity? The answer is
counterintuitive. Whenever studied, it is productivity that drives morale and not vice
versa. When people work together to accomplish important objectives in which they are
vested they feel a sense of pride, and it is that pride which drives morale. Achieving high
degrees of patient safety and the pursuit of perfect care are in the final analysis a matter
of will.

What can you do right now? Jim Bagian makes the following recommendations.1.
Encourage open, clear and respectful communication both verbal and written. 2. Pre---
brief and de—brief. Pre-procedure "time out" has proven to be a valuable addition to
preventing wrong patient and wrong site procedures. 3. Place an important emphasis on
close calls. Reporting close calls alters the dynamics for identifying potential adverse
events. Historically, adverse events were reported utilizing incident reports. Incident
reports which occur after the fact were often seen as an indictment of failed professional responsibility. Reporting close calls on the other hand identifies the reporting individual as a vigilant observer who in recognizing the potential threat becomes a heroine for identifying needed clinical process improvements. 4. In a similar way failure mode event analyses or FMEAs represent a way of identifying and correcting potential breakdowns that can compromise patient safety. 5. Utilize cognitive AIDS and checklists. This is analogous to the preflight checklist that pilots use in commercial aviation. They are not too proud to ritualize a procedure designed to ensure that they not overlook elements critical to safe flight. 6. Eliminate the "who is at fault" question as an initial response. It is important to adopt a blameless approach and to see identification of actual or potential failures as an opportunity for improvement and not as an indictment of individual performance.7. Leadership must take responsibility. This must begin at the governance level and move through the administrative hierarchy and critically incorporate the medical executive committee.

In larger institutions movement towards a service line orientation with employed physicians serving as directors and managers of the clinical side of the operation will become an ever-increasing reality. Physician service line directors will accept responsibility for balanced accountability that includes not only the efficacy of care but also the efficiency and appropriateness of the care provided. How patients experience that care will be an additionally important metric. When physicians accept the design responsibility for care, and when the performance can be aligned with organizational needs significant integration will occur.

The movement towards employing physicians represents a unique opportunity to transform the physician culture. Physicians currently exist as an I wherein individual autonomy is the transcendent value. There is no collective identity within the physician culture. The I must be transformed into a We wherein the physicians accept a collective identity and a willingness to allow representatives to act on their behalf in pursuit of the greater good. Ultimately, when true integration occurs, the We will transform into an Us.

The current rhetoric of healthcare reform is mandating that the provider community provide higher quality care to more people for less cost. This is an impossible challenge. Choose two, you cannot achieve all three. In this regard the only available profit margin lies in the identification and elimination of waste. This waste occurs in the form of preventable adverse patient events as well as in the identification of the overuse, under use, and misuse of resources. It is estimated that between 30 and 40% of costs incurred in the diagnostic and therapeutic process represent waste. Physicians are best positioned to identify and eliminate that waste. The economic margin that is created can allow the healthcare organization to meet the physician expectation for economic security and create the US that is required to sustain mutual success. The US has a vested interest, both professional and economic in assuring a safe patient care environment and the pursuit of perfect care.