PATIENT SAFETY:

Engaging Medical Staff

Toward a Common Goal

by Joyce Sherman

Working together with physicians in a systematic—but not mechanistic—way to achieve patient safety and eliminate clinical errors is a challenge that hospitals across the country are facing. Healthcare executives should be empowered to engage physicians in patient safety efforts to develop a flexible structure in which to provide high quality patient care. Once a hospital is committed to a patient safety initiative, it is important to establish standards of care, recognize and validate physicians' self-interests and encourage interdependence rather than independence among caregivers.

Physician Involvement

Healthcare executives are becoming more aware that to pursue patient safety goals, physician involvement in the organization is crucial. Bruce P. Hagen, FACHE, president of Riverside Methodist Hospital, Columbus, Ohio, says that when he became president, physicians were starting to develop a structure designed to help them get more involved in the hospital's operations. The structure was formally put in place soon after Hagen took the helm, and he welcomed the physician involvement and the loyalty that it represented. Hagen says, "Physician involvement is now hardwired in most of the medical staff. They want to see the hospital do well for all the right reasons."

When promoting alignment between hospitals and physicians, Kenneth H. Cohn, M.D., director at Cambridge Management Group and Health Administration Press author, agrees that engaging physicians in the operational side of the organization is important. "Involving medical staff in planning the building of a new facility, for example, helps ensure that the organization keeps patient safety as a priority in the planning," he says. "Physicians and nurses work with the patients and equipment, and they work within clinical policies and procedures, which executives may not have direct knowledge of." They know what kind of physical structure will facilitate the safe hand-off of patients from the medical-surgical floor to the X-ray department, for instance. Their involvement in the planning allows them to take ownership and increases their stake in the patient safety effort.

At Riverside Methodist Hospital, the physicians actively engaged the hospital's leadership to become more involved in its operations. Together they developed a series of clinical operating councils. Mark Vary, M.D., chief medical officer of Riverside Methodist, says patient safety, as well as patient satisfaction and physician satisfaction, has improved significantly as a result of the work of the councils. For example, the Primary Care Council, which was created to provide a forum for the needs and interests of the ambulatory medical staff, identified as its number one issue how to get prompt, thorough communications about the treatment of emergency department (ED) patients out of the ED and to the patients' primary care physician. The council created an autofax system whereby all the information available at the time of the patient's discharge—discharge medications, course of treatment, lab work ordered, and so forth—is sent automatically to the primary care physician of record. By the next day, that physician has medical updates on all of his or her patients who visited the ED the previous day.

Before the autofax system was put in place, primary care physicians may not have known for days that a patient had been to the ED with a complaint, let alone what diagnosis was made. The autofax system alerts the physicians almost immediately about the details of the patient's emergency visit, rather than having them stumble upon the information later if the patient happened to come into the office for a follow-up visit. Vary says, "The implementation of this system is significant for patient safety because it helps the physician provide better follow-up care to the patient. It helps ensure patient compliance to prescribed medications; the primary care physician is alerted to the course of treatment and can readily answer questions about it that, if unanswered, might result in the patient dropping the treatment."

Shared Goals

Physicians and executive management share the goal of providing the best possible patient care. However, their specific interests may diverge in the process. To be successful, patient safety efforts must engage medical staff in a way that complements their specific objectives and interests. Joseph S. Bujak, M.D., vice president of Medical Affairs at Kootenai Medical Center in Coeur d'Alene, Idaho, says, "A physician defines quality as 'the way I take care of patients,' which is why they inherently resist intrusions into their routines." Understanding this mind-set is a key to administrators effectively implementing a patient safety effort.

An important objective for physicians is that their time be valued. More and more, physicians are sticking to work hours more typical of businesspeople. This trend is described by Bujak, who says, "One force that will drive change toward alignment is the Generation X physicians. These younger professionals really do not want to put in long hours; they want to leave at 5:00 p.m. With this trend the hospital environment evolves to one in which physicians let the pharmacists, nurses

and other component caregivers do their job so that the physicians can leave to attend to other aspects of their life." Bujak emphasizes that you cannot get home at 5:00 p.m. if you are unwilling to delegate.

Cohn suggests that "virtual gain sharing" can be effective in aligning physicians to hospital patient safety initiatives. The Office of Inspector General's rules barring physicians from gaining financially from cost savings achieved by hospitals are in their legal infancy and are applied case by case. Even though their application is not widespread, physicians are advised to avoid the taint of "toxicity of rewards." To help physicians avoid dilemmas related to financial gain, Cohn recommends that hospitals motivate physicians to provide the highest quality and most cost-effective care by offering to reinvest the savings back into the physician's department or service line. For example, one hospital challenged its orthopedic surgeons to reduce the number of vendors the department was using from eight to two. Such a change would enhance patient safety by reducing variation in equipment and would increase savings by limiting the vast differences in prices. At first, the surgeons dismissed the idea, saying it would compromise their freedom to practice medicine on their own terms. Then a cardiologist and an orthopedic surgeon who were members of the hospital's medical advisory panel took on the initiative as their own personal challenge. Through a process known as "cross-talk" among the orthopedic surgeons in the department, they accomplished the goal of whittling the vendors used down to two. The hospital saved $1.2 million in the first year as a result. This savings was, as promised, reinvested in the Orthopedics department, creating a safer environment and providing more advanced treatment for its patients and allowing the surgeons to gain a reward for their efforts.

Establishing and Enforcing Standards of Care

Regardless of who takes the first step to strengthen alignment, the key is for the medical staff and hospital leadership to aggressively work toward alignment on patient safety strategies and implementation. One main component of patient safety strategies is developing processes and clinical guidelines or protocols that reduce inappropriate variation and enhance patient safety while recognizing the inherent unpredictability and uniqueness of each case.

Bujak says that while you cannot completely standardize work based in biology because of the inherent variabilities in a patient's biological makeup, variation-reducing protocols are effective in increasing patient safety. "Attaining a safe patient care environment is non-negotiable. How that end is achieved is open to the creative input of clinicians," he says. Administrators can develop safety initiatives that accommodate this essential input. In doing so, they should take a proactive approach to physicians that "this is going to happen." Such a stance empowers the administration to go to the medical executive committee with variation-reduction policies with the confidence that the committee will work with them and sanction the guidelines. The organization then is allowed and expected to enforce compliance.

Independence Versus Interdependence

The tendency among physicians to work independently is a hallmark of the medical profession. Bujak advises that the physician community must abandon its over-riding commitment to individual physician autonomy. "The complexity of healthcare delivery has outstripped the capacity of the human mind to manage all variables. Optimum outcomes require the orchestrated input of others who contribute their expertise. For example, a clinical pharmacy presence is essential to maximizing safe prescribing practices. Unless physicians come together with all the other players in the delivery of care, they risk losing everything, including their professional status as an elite occupation. The medical profession will become just a trade, and the care factor will be completely gone." Bujak adds that, for their part, "organizations must have a vision that touches people in such a way that they subjugate their self-interests and pursue a greater interest by working interdependently with others in the care process."

One way hospitals can do this, Bujak suggests, is to change the structure of the organization. "Employ hospitalists in a contractual relationship in which they are obligated to comply with deviation-reduction standards. Also, move to a service line structure rather than a departmental one. Develop a dual management responsibility structure with one physician manager and one nonphysician manager. This creates dual accountability for both managers in both clinical and operational outcomes." In changing the hospital's structure, Bujak

cautions that managers should know how to budget for service lines. Further, employee incentives should not be set up so that the staff in different departments are competing with each other for bonuses, especially if they work together in the care process. He also emphasizes the importance of investing in the physician managers' ability to lead by providing relevant education opportunities, understanding the skills needed to manage and helping them sharpen those skills.

Presenting a different perspective, Cohn emphasizes interdependence as a key to achieving patient safety and quality improvement. One way to promote physician interdependence and enhance patient safety, Cohn says, is to create crew resource management (CRM) teams. CRM (originally called cockpit resource management) was developed by NASA to improve air safety by identifying those aspects of human error that cause the majority of air crashes: failures of interpersonal communications, decision making and leadership. In healthcare, CRM is a method to improve safety by enhancing caregivers' understanding of the role that human factors play in errors, including how attitudes and behaviors affect safety.

One main feature of CRM training, Cohn says, is that each team member, whether physician, nurse, social worker or pharmacist, becomes comfortable speaking up and engaging with the team regardless of status. Cohn knows one audiologist who was part of a CRM team at an ear, nose and throat surgery department in New England who overheard two anesthesiologists discussing the treatment of an infant during an upcoming surgery. She knew the dosage of anesthesia they were planning to use could result in the child's death. As a result of her CRM training, she recognized the pattern of human error and had the confidence to speak up. The anesthesiologists realized their error, and the audiologist believed she saved the infant's life.

For CRM team members to proactively assume a leadership role on the team, according to Cohn, the training includes "changing an organization's culture from blame to a shared sense of responsibility, which occurs by enhancing skills in several areas related to CRM." These areas include decision making, performance feedback, cross-checking, communication, creating and managing teams, recognizing adverse situations (red flags) and managing fatigue. Physicians are more inclined to engage in CRM training and participate on teams when they see that the hospital's leadership is committed to the process and they feel the enthusiasm generated by the training. They recognize that they would feel safe being treated at a facility that uses CRM teams.

CRM provides a structure for exercising interdependency, but, Cohn cautions, independence and interdependence is not like an on/off switch. He suggests organizations talk about working *more* interdependently, reflecting the idea that interdependence is an ongoing journey.

A New Era

Many factors are involved in creating a culture of alignment between the hospital leadership and medical staff. The huge divide that remains in many hospitals is rooted in historical, cultural and legal precedents that, according to Bujak, support the traditional covenant of hospitals to remain neutral in physicians' practices and consider the hospital the physician's workshop. To be successful, the next era of hospital/physician relationships needs to adopt the emerging models based on interdependence and bring all staff together toward the goal of achieving patient safety.

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To learn more about hospital/physician relations attend Joseph S. Bujak's seminar "Understanding Physician Behavior: Creating Successful Executive-Physician Relationships," Kenneth H. Cohn's seminar "The Pulse of Physician/ Hospital Relations, 2006" or Bruce P. Hagen's seminar "Tearing Down and Building Back Up: New Business Models for Physician/ Hospital Relationships." Go to the Education area of **ache.org** for information on these seminars and others offered by these sources. Other resources are Bujak's book *Leading Transformational Change: The Physician-Executive Partnership,* co-authored by Tom Atchison, Ed.D., and Cohn's book *Better Communication for Better Care: Mastering Physician-Administrator Collaboration,* both published by Health Administration Press.