Anesthesia Patient Safety Foundation

Patient Safety at Risk: A Call for Leadership

Jeffery S. Vender, MD, MCCM, FCCP, MBA

What is the most important ingredient for sustaining past achievements, while promoting future efforts at improving patient safety?

There are many reasons for faltering success or failure. The key is to identify those "vital few" things that most account for the problem. In my experience, as it relates to patient safety, there are two key factors that drive results – *culture* and *leadership*. *Culture* reflects the values, beliefs, and behaviors of an organization, or more simply put, how things are done here *on a daily and consistent basis*. *Leadership* establishes and supports the culture, addresses complex issues, and sustains past success, while pursuing necessary change for a better tomorrow.

The author will describe how culture and effective leadership can enhance patient safety and quality of delivered health care based on more than four decades of study, observation, and passion for this particular topic.

The beginning

Anesthesiology was considered a high-risk, high-liability specialty when I entered the field over 40 years ago. Halothane and copper kettles were still employed, as enflurane and vaporizers were replacing them. In the 1970s and '80s, a number of significant medical advances occurred with the introduction of new pharmaceuticals and better intraoperative monitoring. By the mid 1980s, patient safety was taking center stage in the field of anesthesiology. In 1984, the Closed Claims Database was started, and in 1985 the independent, non-profit Anesthesia Patient Safety Foundation (APSF) was founded, in large part due to the leadership of Dr. Ellison C. ("Jeep") Pierce, whose vision was that "*no patient shall be harmed by anesthesia*."

Then, in 1986, ASA adopted its first mandated standard – Standards for Basic Intraoperative Monitoring. As a result of these and other bold initiatives, the specialty demonstrated its awareness, support, and leadership for patient safety.

By the 1990s, anesthesia was reporting reductions in anesthesia morbidity and mortality. The surrogate marker of success was a significant reduction in medical liability associated with adverse anesthetic events, although there is a widespread variation in the literature as to the statistical magnitude. *Something had changed!* These results could only have been achieved by forward thinking, committed leadership, and industry partners with a dedicated focus on patient safety. *Congratulations!*

Not so fast...

My concerns for patient safety and health care quality begin, not end, with our past recognition – as past performance is no guarantee of future success.

By the 21st century, patient safety had become a ubiquitous term in the health care industry. Then came a "shot across the bow" that rocked the patient safety boat. In 1999, the Institute of Medicine (IOM) published "To Err Is Human: Building a Safer Health System." This report suggested as many as 98,000 patients died per year from medical errors (asamonitor.pub/3tof93o; To Err Is Human: Building a Safer Health System. 2000). Interestingly, anesthesia was highlighted in the document, stating the specialty had made very impressive improvements in patient safety.

In 2005, Leape and Berwick looked to see what was learned from the 1999 IOM report. I have excerpted several of their comments: "*building a* ***culture of safety*** *is proving to be an immense task; the answers are to be found… in the culture;* ***lack of leadership*** *… impedes progress* [author emphasis]" (JAMA 2005;293:2384-90). What was clear from their report is that leaders can't be sure their message will be heard, understood, or followed by just screaming from a mountain top.

Numerous strides had been made to address patient safety through attention to systems, processes, and development of outcome measures. Despite these efforts to increase awareness, patient safety remains an issue. In anesthesia, we still see OR fires, wrong-side procedures (never events), medication errors, awareness, and other preventable errors.

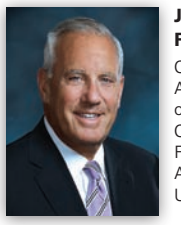
Over the past 20 years, numerous guidelines, practice parameters, and even standards have been introduced in an effort to standardize care, reduce variability, and implement best practices in anesthesia. Although these efforts are laudable and important, there still is a significant incidence of non-compliance for a multitude of reasons and reported adverse events.

We have improved, but what will take us to the next level of patient safety to reduce preventable adverse events? From my perspective, a missing link is the absence of a sustained culture (of safety) and the leadership to support it as well as the implementation, adoption, and sustained change necessary for patient safety.

Our environment unmasked

Despite all of the efforts to improve patient safety, there have been a growing number of internal and external factors that challenge and even endanger our accomplishments. Over the past two decades, we have witnessed an explosion of mergers and acquisitions of hospitals, systems, and physician practices. Aside from these consolidations, we have seen the fragmentation (and the eventual consolidation) of various health care services to freestanding centers – ASCs, urgent care, physical therapy, endoscopy, radiology…. Does anyone really believe *the primary motivation* for these mergers and acquisitions was directed to improve patient safety and outcomes, or the proliferation of freestanding centers designed to improve safety? *I DON'T!* As health care delivery continues to evolve, are we taking any steps to build a culture with a long-term perspective toward safety or value-based health care?

"And then along came"… COVID. Caregiver burnout had already been recognized as an industry issue. The impact of burnout on caregiver well-being and patient safety had become a featured topic of discussion and concern. Employee engagement was on the downslide. The COVID-19 pandemic further exposed and accelerated this underappreciated issue and has now contributed to what is currently being referred to as "The Great Resignation" (asamonitor.pub/3GDIo60). This has resulted in sudden and significant staff/labor shortages, supply-demand imbalances, and production pressure, all contributing to more burnout and disengagement, all at a significant cost. *Can any of this be positive for patient safety?*



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Leaders in Patient Safety

Can you walk the talk?

Most institutions have a stated mission and set of values that include patient safety and quality. To deliver on the promise, it takes more than words on a wall or piece of paper. It takes action. If we don't actively live our values, we have failed in "walking the talk." If we want safety, it cannot be attained just through more guidelines, standards, or documents acknowledging the need to change. If we want safety, it must be in the fabric of the culture we build and our ability to attain, implement, and sustain our stated values and goals throughout the organization. Herein lies the role and importance of leadership.

Unfortunately, organizational awareness and *self-awareness* are only as good as our abilities to objectively measure them. *Has anyone ever seen a hospital that*

says their quality and safety isn't "good" to "excellent"? How frequently, if ever, have you met a physician, care provider, or administrator who said they were less than average? (In every finite set, 50% of individuals are below average, even in anesthesiology.)

A tipping point?

Remember Space Shuttle Challenger (1986), Space Shuttle Columbia (2003), or the recent catastrophes associated with the 737 Max (2018, 2019)? Upon initial review, a technical explanation existed for each incident – the "O" ring, the "foam shield," and the "software" dysfunction (The Challenger Launch Decision. 1996; Bringing Columbia Home. 2018; Flying Blind: The 737 MAX Tragedy and the Fall of Boeing. 2021). Upon deeper review and analysis, a different set of issues has been suggested to explain the real issue: *broken corporate culture, production pressures, cost-cutting, profit versus quality, and disconnected leadership.*

Based on the current situation in health care with burnout, disengagement, labor shortages, production pressure, supply-demand imbalances, increasing costs, and societal affordability, I believe quality and patient safety are at a tipping point.

The true culture of safety

Understanding and addressing human factors that contribute to adverse events and provider error and effectively implementing system engineering redesigns are necessary to standardize care and reduce variability, but is that enough?

If we really want patients to be safe, we must develop a true "*culture of safety.*" These shared beliefs and values must be adapted to the current situation and aligned with our key objective of avoiding patient harm. A true culture of safety must be supported by several subcultures: *a just culture (non-blame), a reporting culture, and a learning/sharing culture.* Subcultures that encourage speaking up, holding each other individually accountable (at any level), disclosing errors and near-misses, and establishing transparency in a non-threatening environment are crucial. We need a culture that proactively anticipates safety issues. We cannot afford only to learn our lessons through post hoc analysis of catastrophic errors. We must have a learning culture that has a preoccupation with identifying near-misses or simple failures and that seeks to sort out the real cause(s), not the expediently obvious answers. We must seek to recognize and eliminate normalization of deviance, where individuals become insensitive to a practice that deviates from their own rules of safety, as it is a behavior that can harm both our culture and our patients (*Anesth Analg* 2010;110:1499-502).

A call to (and for) leadership

Leadership for this discussion is defined as any individual, at any level of an organization, department, or team, who puts our cultural values and safety goals to action (verb).

Simply stated, leaders inspire others, influence their behavior, and positively impact a desired outcome or change. Teachers with students, coaches with athletes, and parents with children all function in leadership roles. It is not just about titled positions of authority – it is how one leads that matters. Too many individuals assume the title, but do not fulfill the role of bringing our values to action and making patient safety and quality a reality, not a video, buzzword, slogan, or hammer. *As important as leadership is to a culture of safety and quality, its absence or inadequacy can be even more deleterious to organizational success.*

We need effective leadership to enhance the culture of safety, especially during this unprecedented pandemic, where situations have become more complex and uncertain, answers are not easy, rapid change is needed, the risks are higher, and it is clear the status quo will not work.

If we want a *culture of safety,* based on actions and not words, the leadership I am referring to cannot be a single individual at the top of a hierarchal organization. Health care is too complex; the hero leader cannot do this alone.

The leadership we need:

- At the top – *Is responsible for and owns the culture*
- Identifies, develops, and engages other leadership, *at every level,* creating an aligned organization
- Values *people and purpose,* not just profit
- Continually communicates and reinforces the purpose (*the why*) for the how and what we are doing. It is that shared purpose that engages and connects people to go "above the bar"
- Is present, mindful, asks questions, and promotes (not suppresses) diversity of thought
- *Listens* so to better understand, learn, and lead
- Inspires trust, not control, to instill *collaboration* between interdependent individuals and teams for enhanced performance
- Seeks individuals who are committed to patient safety and the culture of the organization, not just competency
- Strives to make changes *objective and measurable* and *then holds themselves* and others *accountable for the results*
- Recognizes the very important difference and complementary relationship of "*doing the right thing*" *(and courage to go do it) versus "doing things right!"* As said by esteemed management educator Peter Drucker, "There is nothing worse than doing the wrong thing well." (asamonitor.pub/3Fq3gwm)
- Is *all of us (you), irrespective of title, with a commitment to a better way, who are willing to speak up and go beyond defined boundaries!*

The future challenges of health care and patient safety will not be easy. I truly believe with the *right leaders* we can do better. *Are you that leader?* ■

Resident Research Award Guidelines

Deadline for receipt of entries: ***April 4, 2022***

The purpose of the ASA Resident Research Award is to encourage resident and fellow engagement in research and to recognize and reward excellence in original basic, clinical, or population research, as reported in an original, unpublished manuscript.

Eligibility

1. The entrant must be an ASA member at the time of submission. Entries submitted by a principal author who is not an ASA member will not be reviewed. Any co-entrant(s) is not required to be an ASA member.
2. The work reported should have been completed during residency or research fellowship training. Research performed as a student may be considered.
3. Papers should be submitted during or within one year following completion of the training.
4. A previous entry or award does not preclude eligibility.

Submission of entry

1. The entry should be a manuscript describing original basic, clinical, or population research. Case reports, case series, literature reviews, or chapters will not be accepted.
2. The original entry should follow the format (title page, abstract, text, references) of the journal *Anesthesiology* (anesthesiology.pubs.asahq.org/public/InstructionsforAuthors.aspx). Collaborators and co-authors should be listed on the title page. Entries that do not follow this format will be returned.
3. A limit of 25 double-spaced pages (excluding letters of verification but including all figures, tables, and references) will be enforced; manuscripts that exceed the page limit will not be reviewed.
4. Concurrent online submission of an abstract of the work for presentation as a regular scientific paper at the ASA ANESTHESIOLOGY® annual meeting is required (go to asahq.org/annualmeeting/education/submissions. You will be able to access the submission site on this page). Your submission should be prepared in accordance with the rules and deadlines for submission of regular abstracts and submitted independently via the submission link on the ASA website.
5. The work should not have been presented, published, or submitted at any other national meeting, national residents' research or essay contest, or journal prior to this submission. The essay can be presented to local/regional residents' research or essay contests (e.g., Midwest or Western Anesthesia Residents Conference).
6. The manuscript must be accompanied by a letter, signed by the entrant, stating that the research and writing were predominantly performed by the entrant during residency or research fellowship training and that the work has not been presented, published, or submitted to any other national meeting, national residents' research or essay contest, or journal prior to this submission.
7. The manuscript must be accompanied by a letter from the residency program director confirming the eligibility of the entrant and stating that the work was performed predominantly by the entrant and during residency or research fellowship.
8. Only one submission will be accepted per entrant.
9. Manuscripts and the two letters should be sent electronically as a single, collated, searchable PDF or Word document file to the chair of the Committee on Research, Y.S. Prakash, MD, at prakash.ys@mayo.edu by April 4, 2022 at 11:59 p.m. CT.
10. Winners will receive their awards at the Celebration of Research session at the ANESTHESIOLOGY 2022 annual meeting in New Orleans.

Questions may be submitted to Rachel Gutterman, ASA Education Department, at **r.gutterman@asahq.org**. ■