The Governance Institute's
E-Briefings

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## Welcome to The Governance Institute's E-Briefings!

This newsletter is designed to inform you about new research and expert opinions in the area of hospital and health system governance, as well as to update you on services and events at The Governance Institute. Please note that you are receiving this newsletter because you are a Governance Institute member or expressed interest at one of our conferences.

## News, Articles, and Updates

### Patient-Driven Leadership

*By Brian Wong M.D., M.P.H., The Bedside Trust, LLC*

*The night before 40-year-old Edie was scheduled for a lobectomy, she sat up in her hospital bed knowing that sleep wouldn't come to her without the help of strong drugs. Only two weeks had passed since she went in for antibiotics for what she thought was a persistent bronchial infection. The next day, she was in front of an oncologist having an almost out-of-body, real-life nightmare. After scans and more blood work, she was told she had non-small cell lung cancer and needed one of her five lobes removed as soon as possible.*

*They told her if they removed it right away, followed by chemotherapy, and the cancer hadn't metastasized, and if she avoided bleeding, infection, an air leak, or damage to her heart, lungs, or blood vessels in her chest, that she had a 60 to 70 percent chance at a normal life. Yes, she would lose lung capacity and live differently, but live nevertheless. She didn't know that the most dangerous part of the equation had gone on behind the scenes the day she left her oncologist's office in a daze.*

*Jerri had been working for the oncologist for a grand total of five days. It wasn't a fun place to be. She knew she wouldn't last long, but she really wanted to save enough for the down payment on a car, so she figured she could keep it up for a few months.*

*Dr. H, the oncologist, was old school. His nurses walked around with laptops and the diagnostic equipment was state of the art, but he was a dinosaur who only worked with pens and charts. It was Jerri's job to translate his chart notes into digital documents so they could be sent via email to a hospital or lab when necessary. His writing was stereotypically physician, but she was pretty good at deciphering his scrawl.*

*But today, she struggled. His notes said that the patient needed immediate removal of one of her lung lobes, but the description of which lobe was overly messy and smeared. She knew it was the right lung, and could make out the letters "erior" at the end of the word, but the first few letters were illegible. She Googled "lung lobe" and found an image that showed the five lobes, and she realized that it was either the "inferior" or the "superior." She showed it to a nurse who couldn't make it out and told her to ask the boss.*

*Knowing that this guy yells at everyone, she wasn't thrilled, but she had little choice if she wanted to be driving a convertible Mustang by summer. So she knocked on his door, went in, and asked if he would take a look at the chart. He didn't bother to look up when he bellowed, "Get out of here and do your job."*

*"Please Dr. H, I just need you to look at one word I am having trouble with," she said.*

*"If you can't do your job, I'll find someone who can," Dr. H replied.*

*As she walked back to her workspace she kept seeing herself headed down the coast highway*

*with the top down. She looked at the paper again and mentally flipped a coin in her head and typed in, "right inferior lobe." And that was that. She was sure someone else would check this out a number of times before surgery. Plus, there was always the CT scan to refer to before surgery. But it didn't work out that way for Edie.*

*When the surgeon (an old colleague of the oncologist) walked into Edie's surgery he didn't check the scan. One of the nurses did and mentioned that the scan and the notes didn't seem to jibe. The surgeon told the nurse to leave scan interpretation up to the physicians and (again), "Just do your job or get out." When she persisted, he said, "I'll take Dr. H's charts over a nurse, every day of the week." And he began to cut.*

*After removing a good lobe, and then a day later the cancerous lobe, Edie was left with minimal lung capacity. She finished a course of chemotherapy, began respiratory therapy, and started to marginally improve. Three weeks passed and she contracted pneumonia. It was too much for her system and she died four weeks after the surgery.*

On the surface, Edie's death is no mystery. When these "never events" happen, new initiatives usually follow. Our knee-jerk, Band-Aid reaction is to create a checklist. Though recent studies have shown the great effectiveness of using checklists, especially in surgery, this isn't a solution to the entirety of the problem and only addresses operational deficiencies. It took me a long time to realize that a key root cause of substandard patient safety and care and unnecessary deaths is cultural, not operational, deficiencies. Lately, many articles and research studies are coming up with the same conclusions.

A recent qualitative study performed by 11 hospitals (158 hospital staff members) researched, "What Distinguishes Top-Performing Hospitals in Acute Myocardial Infarction Mortality Rates?"[1] Staff in high-performing hospitals found that the definitive difference between them and lower scoring members was their ability to solve problems and learn as organizational teams. Working with a "non-punitive approach to problem solving, which focused on learning rather than blaming," made all the difference. It led them to conclude that, "High performance may require long-term investment and concerted efforts to create an organizational culture that supports full engagement in quality, strong communication and coordination among groups, and the capacity for problem solving and learning across the organization."

Dr. Pauline Chen's recent article, "What Makes a Hospital Great,"[2] also determined that the only way to become a better hospital is through relational solutions. She quoted Elizabeth H. Bradley sharing, "It's how people communicate, the level of support, and the organizational culture that trump any single intervention or any single strategy that hospitals frequently adopt." Dr. Chen also wrote, "The upside of such transparency is that hospitals all over the country are eager to improve their patient outcomes. The downside is that no one really knows how."

At The Bedside Trust, we are working with hospitals to implement a daily practice that discovers and treats the root cause of most of our problems. I started The Bedside Trust with another physician who is currently the CEO of a healthcare system in Colorado. Since 2005 we've met with over 3,500 physicians to find out what matters most to them when challenged with a difficult case. Overwhelmingly, they have yearned for true teamwork—to work beside team players who are respectful, responsive, understanding, and capable of safe conversations aimed at solving patient challenges together. They needed to be able to trust each other.

This led us back to the patients—we also asked what matters most to them. They also came back with "trust." They want to trust their physicians, trust that everyone communicates, and trust that they are going to experience a healthy outcome. They need to believe in the people taking care of them. And the best way to build patient trust is to model it by equipping physicians, nurses, administrators, and staff members to work as trusted teams.

We've learned through experience that starting with the CEO and executive team best facilitates organization-wide buy-in for building and working as trusted teams. Although it is a leadership practice, such behaviors and benefits naturally trickle down through the entire organization to create a community of patient-driven leaders.

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[1] L. A. Curry, E. Spatz, E. Cherlin et al., "What Distinguishes Top-Performing Hospitals in Acute Myocardial Infarction Mortality Rates?" *Annals of Internal Medicine*, 2011.

[2] Pauline W. Chen, M.D., "What Makes a Hospital Great," *The New York Times*, 2011.

Everyone in a hospital begins to show up as proactive leaders in their job—and more importantly, begins looking past their jobs to realize their organizational roles.

Following this practice isn't rocket science, nor does it add to a hospitals already overflowing workload. Along with saving lives, hospitals that have adopted patient-driven leadership have shown us that building trusted teams affects all aspects of an organization from the top floor to the bottom line.

How would 40-year-old Edie have fared if everyone involved in her case belonged to and embraced a trusted team? What if the oncologist and surgeon knew that one person couldn't possibly be as smart as a group of people? What if every leader, physician, and staff member trusted their co-workers and simply took a moment to listen and learn before responding to a situation? You know the answers...

*The Governance Institute thanks Brian Wong, M.D., M.P.H., CEO of The Bedside Trust, LLC, for contributing this article. He can be reached at (206) 619-8088 or visit www.patientdrivenleadership.com to learn more.*