Executive Summary

▶ We don’t have time for incremental change when it comes to patient safety. What is needed is a revolutionary rethinking of how we organize our work.

▶ We must stop benchmarking ourselves against the median or average, which is mediocrity at its finest, and accept the challenge that an error-free environment is possible.

▶ With new eyes that represent diverse cognitive skills, we will overcome our blindness to defects and move from good to great.

— Most ailing organizations have developed a functional blindness to their own defects. They are not suffering because they cannot resolve their problems but because they cannot see their problems.” — James Gardner (Covey, 2004, p. 271)

The cry for a safer and more reliable health care system has been with us for several years. But are we making a difference? As we learn more about high-reliability organizations, we can be overwhelmed by the fragmented, complex, and constantly changing world of health care which is fraught with complexity and seems impossible to simplify. Morath and Turnbull (2005) characterize the health care culture as having an inadequate infrastructure that can no longer accommodate the numerous medical and technological innovations that are superimposed on this complex structure. It takes a different set of eyes to see through this complexity than was needed in the past.

How Can We Provide Safer Care?
Change What We See!

People in high-performing organizations are better able to see a potential chain of events that will lead to a crisis and take action before it happens. In retrospect, as we do root cause analysis we often find a chain of events that are allowed to happen because, in the urgency of the moment, many people miss the clues that should tell them something bad is about to happen.

In the world of business and industry, Mittelstaedt (2004) writes that many poorly managed organizations have seen tremendous destruction of their value by operational blunders and the failure to see potential disasters. In companies that failed to avoid catastrophe such as Enron, Firestone, and HealthSouth, Mittelstaedt cites three cultural factors that did not allow a true view of what was happening: myopia (failure to recognize changes), hubris (arrogant presumption that the organization and people are so much smarter), and egocen-
tricity (experienced supervisors believe they know more than employees so their ideas and feedback are not necessary) as leading to their downfall. Organizations that are well-managed such as Johnson & Johnson, IBM, Dell, Southwest Airlines, and Toyota see the world through different eyes and, according to Mittelstaedt (2004), have been able to avoid disaster by incorporating six important precepts that are embedded in their culture and management systems:

1. Create a system to detect patterns of mistakes early, and trust the data.
2. Communicate and seek candid advice through the organization and from trusted outsiders.
3. Don’t underestimate potential damage of mistakes.
4. Consider the unthinkable.
5. Protect the relationship with customers at all costs.
6. Don’t be passive; a bad situation will never go away on its own.

These successful organizations see the world differently than organizations that fail.

We don’t have time for incremental change when it comes to patient safety. What is needed is a revolutionary rethinking of how we organize our work. Covey (2004) notes that the path from effectiveness to greatness requires changing the paradigm. As noted in the introductory quote from John Gardner, we need new eyes to see our issues in order to develop new solutions.

The Eyesight of Experts Is Not the Best

Unfortunately, we like to think that the people with the most expertise have the best knowledge to see the best truth to prevent catastrophes. Unfortunately, the socialization of a professional can create rigid thought patterns that do not recognize differences and potential crisis. We like to think that if we could just find enough experts, we could solve most of our patient safety problems. However, that kind of thinking might be exactly the crux of the problem and the root cause of why we have not made greater progress. Surowiecki (2004) notes that on a survey about overconfidence, physicians, nurses, lawyers, engineers, entrepreneurs, and investment bankers all rated themselves as knowing more than they actually did. From this and many other cited studies, he concludes that the value of experts is highly overrated and that groups with a wide range of cognitive and conceptual diversity achieve the best outcomes. Consistently, a diverse group will reach better conclusions than one made up of experts.

What’s wrong with experts? One of the problems, according to Surowiecki (2004), is that the range of an expert’s thinking becomes very narrow and he/she become overconfident in their ability to reach an answer. Unfortunately, as we mature as an expert, our thinking becomes more automatic and stereotyped as we skip through information to make quick decisions. We would never want to admit as an expert we are mindlessly conforming to our historical version of the “truth,” but in fact that is true. In teams that have greater cognitive diversity, they see more possibilities and solutions than teams made up of only experts.

Surowiecki’s message is that the many are smarter than the few. The three deadly practices of myopia, hubris, and egocentricity that Mittelstaedt (2004) lists all relate to the failure of experts to recognize their limitations.

Gladwell (2005) explains the phenomenon of failing to see impending crisis as he analyzes how we “think without thinking.” He describes the theory of “thin-slicing” in which a little bit of knowledge goes a long way to filter through an overwhelming amount of information to arrive at impressions and conclusions. Some people are very adept at subconsciously going through this rapid cycle process to categorize data into understandable conclusions and others are not. The worst case scenario is the person who is unaware of how their cognitive prejudices and thinking patterns interfere with drawing accurate conclusions.

Gladwell (2005) provides an example of supposedly scientific information offered to experts to prove the authenticity of a statue that led the experts to completely overlook other clues. The experts misjudged the authenticity of the statue. Gladwell offers another example of musicians auditioning behind a curtain so the judges could concentrate only on the music to choose the perfect musician for the first trombone chair. The winner the judges chose blindly was a woman. These experts were incredulous because in their thinking it was impossible for a woman to physically play the trombone as well as a man. If there had been no curtain, the woman would not have been chosen because of a preconceived belief that women could not physically play the trombone.

The same problem applies to patient safety. We think we know the answer, and revert back to what Morath and Turnbull (2005) report as the incorrect principals that permeate our automatic thinking in the health care system. “Clinicians are supposed to be infallible, bad things happen only when people make mistakes, people who fail are bad, and blame and punishment sufficiently motivate people to be more careful, thereby avoiding future mistakes” (Morath & Turnbull, 2005, p. 72). Gladwell’s (2005) message to us is that we must take charge of this kind of cognition in order to be effective. We must have new eyes to be effective.

What Does this Mean for Patient Safety?

Morath and Turnbull (2005) note that the process of seeing patient safety with new eyes is similar to the stages of death and dying authored by Kubler-Ross.
The initial three stages of denial, anger, and bargaining result in reactions about the data being wrong, that we are within the control limits, that our patients are sicker, and that it’s someone else’s problem. In the fourth stage (depression), people become overwhelmed with the gravity of the problem and are paralyzed until the fifth stage of acceptance where hope and action predominate.

If we use the advice of Surowiecki (2004), better results would be achieved with a cross disciplinary, nonhierarchical structure of people from throughout the organization who are involved in the patient safety program. Top-down driven patient safety programs miss out on the intellect of those at the frontline who do not suffer from the same cognitive gaps as experts and leaders at the top. Thinkers who represent a wide range of cognitive diversity and experiences are the real experts to think through safety in the complex world of health care.

What’s the Solution?

Covey (2004) challenges us to move from effectiveness to greatness. This is exactly the challenge in patient safety. Covey’s message is to execute by using the four disciplines of execution. Discipline 1 is to focus on the wildly important. Morath and Turnbull (2005) state that leaders must declare patient safety urgent and a priority. This means that all leaders from the CEO to managers, educators, and staff in leadership positions must declare patient safety as urgent and the highest priority. The organization will see patient safety differently when the focus is radically changed.

Discipline 2, according to Covey (2004), is to create a compelling scorecard. Morath and Turnbull (2005) provide many measures to assess the environment and patient safety outcomes to construct a compelling scorecard such as a “Checklist for Assessing Institutional Resilience,” and the “Culture of Safety.” Scorecards can focus more eyes on the urgent issues.

Discipline 3 (Covey, 2004) is to translate lofty goals into specific actions. They offer tools such as best practices, rapid cycle techniques, model patient safety plans, and many other tools and techniques to move from concept to action. A multi-year work plan will operationalize lofty goals and will focus everyone’s vision on the long-term and short-term outcomes.

Discipline 4 (Covey, 2004) is to hold each other accountable, all of the time. Morath and Turnbull (2005) emphasize accountability before accidents happen. This means that leaders inculcate the principles of a high-reliability organization, a patient-safety plan, and evidence-based strategies as examples of measures of accountability to monitor.

Threaded throughout these four disciplines and interventions must be the recommendations of Surowiecki (2004) that the many are smarter than the few. The best results for organizations will happen when diverse groups of people — patients, families, and people from throughout the organization — are included in the processes of rethinking everything we do about patient safety and in the four disciplines of execution. Many new eyes are needed to improve patient safety.

Summary

In the words of Covey (2004), we all have the power to decide to live a great life rather than a life of mediocrity. Unfortunately, in patient safety, we in health care have chosen to live a life of mediocrity because we have not made a commitment to error-free versus an error-tolerant industry. Compared to what other industries have accomplished in safety, we must make a commitment to do better. We must stop benchmarking ourselves against the median or average, which is mediocrity at its finest, and accept the challenge that an error-free environment is possible. In the words of Collins (2001), “Good is the enemy of Great” (p. 1). With new eyes that represent diverse cognitive skills, we will overcome our blindness to defects and move from good to great.

REFERENCES