Support a Culture of Safety

The universal requirement for achieving a culture of safety in healthcare is the understanding that zero unintended harm is not only attainable but also, in terms of ethics, the only acceptable goal. However, when the attitude prevails in an organization that zero harm will never be achieved, the underlying corrosive cynicism supports the status quo as effectively as it eats away and dissolves the best efforts and programs thrown at the problem.

People tend to cling to established methods if they do not believe that change can produce improvement. When an American hospital maintains that its true client is the physician and its physicians have been trained as autonomous scientists whose ethos requires rejection of methods or procedures “not invented here,” little change, and even less improvement, results. When, however, physicians challenge the status quo and lead the process of revolutionary improvement, the entire medical staff can catch fire with the same deeply felt determination. Indeed, nothing short of that fervor works. But with an average of 22 to 30 patients per hour perishing from avoidable medical mistakes and infections in US hospitals, how can any physician justify not demanding better?

Physicians are led by a critical mass and not by consensus, which means that only a small group of physicians determined to improve safety rates can form the nexus of a revolution. Moreover, when physicians on the front line—not their chief medical officer or CEO—are the change agents, who accept the opportunity to inspire belief in zero harm, the rest of the clinical team tends to follow. Is it any wonder that the philosophical effectiveness of physicians determined to embrace true improvement in patient safety is at least an order of magnitude higher than the impact of top-down directives and endless programs originating from the C-suite?

This is exactly how clinical bundles took root and began saving thousands of lives a few years ago. Physicians drove the belief that central line infection disasters could be completely eliminated. This willingness was echoed by staff members who did what was necessary, accepting standardization of best practices over maverick autonomy. In other words, first comes the belief in the shared vision; then comes the achievement. This sequence was also seen in the airline industry's approach to striving for zero fatal accidents in US commercial aviation. Until the airline industry embraced the philosophy that zero accidents was possible, and until the airline captains and CEOs signed on and led the charge, little improvement was made. Even as late as 1988, an airline industry–generated cynicism was pervasive, such that the occasional fatal accident was seen as just a cost of doing business. When, in 1989, the concept of zero accidents as an achievable goal gained ground, the performance of the industry began to improve markedly, and through July 2014, 12 years passed with only six major airline accidents occurring in the United States.

Furthermore, 2011 marked the first year in aviation history with no fatalities from a commercial airline flight anywhere in the world. Thus, zero believed can lead to zero achieved. All the noble efforts to eliminate inadvertent medical harm will continue to fall short until we truly believe in zero harm and until the natural leaders of healthcare—our physicians—accept their pivotal role in leading the charge. Simply put, no other approach will work."