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Delivering Operational Excellence

Ninety eight thousand people die every year in US Hospitals from AIRS and 65 out of 1000 people suffer injury or illness as a consequence of treatment. What causes these alarming statistics and what can be done about it? You are listening to ReachMD XM157, the Channel for Medical Professionals. Welcome to the Clinician's Round Table. I am Susan Dolan, your host and with me is Dr. Steven Spear, senior fellow at the Institute for Health Care Improvement in Cambridge, Massachusetts, a senior lecturer at MIT and the author of the book "Chasing The Rabbit."

Dr. DOLAN:

Dr. Spear, welcome to the Clinician's Round Table.

Dr. STEVEN SPEAR:

Thank you for having me.

Dr. DOLAN:

Explain what does cause these alarming statistics.

Dr. STEVEN SPEAR:

It is an excellent question because it is really quite depressing statistics, but if you think about healthcare, on the one hand you have got this industry where the science itself is fantastic, and living in 2007, we have this opportunity to diagnose and treat diseases and other ailments, which even a generation ago people just had written off as incurable, and if you look at people who work in healthcare to a person, they are hardworking, well trained, well educated, intelligent, self-sacrificing, and so forth and so if you just took that combination of great people using great science, you would say the potential of the industry is just really extraordinary. Yet the performance of the industry is really not even un-extraordinary, that sounds boring, but it is quite depressing and dismal sometimes with rates of injury and avoidable death like you just described and then is the other stuff which we pile on; cost of care, lack of access to care and so forth, and so you ask the question, well, if the science is so good and the people are so great, what is the cause of this and really the root cause is how the delivery of care is managed and what I mean by that is that we have an industry, a sector of the economy, I guess it sounds less than answer when we say that we believe a sector of the economy upon which we all depend and is organized and managed in ways which are really quite antiquated, so what I mean by this is if you go into a typical hospital today and say I am looking for the person in charge of hip replacement, my mother, my grandmother has taken a fall and she needs to have her hip fixed or she has some arthritis and we need to do one of these miraculous hip replacements, you say, well who is in charge of hip replacements and

I will say, well, you know, we have got really the best orthopedic surgeons, it sounds great and I am really concerned that you have great surgeon, but I imagine that hip replacements in followup more surgeons is the affect of anesthesia and rehabilitation and physical therapy and say Oh, here the anesthesiologist is the great anesthesiologist, yeah but who is responsible for hip replacement everything from the initial diagnosis, workup, presurgical prep surgery, postsurgical recuperation and all that. The fellow here is the therapist and the rehabilitative specialist,it is great ,but who is in charge of hip replacements and you can push this all day and in most cases with the rare exception of the specialty hospital that is worth talking about, in most cases, you will find no one who is responsible for hip replacement or knee replacement and fixing of ankles and treatment of breast cancer and so forth. The reason as to why that exists and why is the problem has its historical antecedence, so we go back to the 50s and the 60s and ask what medicine was really capable of accomplishing. The answer is that it was capable of accomplishing very little by the standards we have today, so the example I use is that you think of a woman who gets the diagnosis of breast cancer in 1955. For most women, it is a horrible diagnosis because for most women, it is actually nothing that could be done. Then, it is the handful where the disease has been caught early enough and then in such a location and then the treatment is fairly straightforward. We say everyone gets the same treatment, which is a radical mastectomy. Then you say well what is involved in a radical mastectomy. Well, in the hospitals that are performing that procedure, there is a small group of surgeons and the surgical team which perform that procedure and a small group of nurses will help patients recover after the surgery and the science at that time is not very well advanced, so you have got the surgical teams working on the surgery and the nurses afterwards working on the postoperative nursing to push the boundaries of that. As far as pulling those two pieces together, the people are doing very similar work day in and day out. They are working together with the same people, so the range of what they are doing is fairly narrow. The variety of people they are working with is also fairly narrow, so same people all the time. So this issue of integrating piece 1 and piece 2 of the surgery and postsurgical care that they can figure out because they have got ample opportunity to practice. There are narrow set of integrate of challenges with the same people day in, day out. We assess forward 50 years. Now if a woman gets a diagnosis of breast cancer today, it is certainly not a good news, but it is much, much better news than in 1955 because over the last 4 to 5 decades, the medical community, the scientific community's understanding of the breast cancer disease has actually expanded so much that breast cancer is not even one disease; it is dozens and dozens of diseases, all of which have its own physical manifestation, all of which have its own genetic abnormality, all of which have its own environmental triggers and so on and so on, and because of there are so many diseases which manifest themselves as breast cancer, but which have always different causes, there are always different treatment plans, which are available. So, today a woman comes into a hospital and she is there because she has breast cancer, but they say well now, we may do surgery, but it is unlikely that for every patient we are going to do is a radical mastectomy, maybe partial mastectomy, maybe lumpectomy and so forth. We also may do that in combination with chemotherapy, then you will say well when the chemotherapy is going to happen? Well it may happen before or after the surgery, may some before and some after. It may be done in concert with some type of radiation therapy also which has several different types, it may be done before or after the surgery, but all of a sudden, you have these treatments, which are not simple anymore. There is this huge range of treatments and each treatment itself has so many different steps and depending on the patients, the steps may come in and out of many different orders, so now all of a sudden, it is no longer an issue of you do your work and become a master of it and I do my work and I become a master of it and integration of the two pieces will figure that as we go. You and I may not work in the same sequence in the same treatment plan ever again and so now we are in a situation where managing the process to start to finish is no longer the trivial after the thought problem it used to be. Now it is really dominates the success of the treatment or not. The big problem is most healthcare organizations when you go on and ask how they are organized, it is still around function and discipline, but it is not about the start to finish process, and when you look at what happens in terms of patients getting injured and killed and cost being high and access being denied, it is very hard to point a finger and pin it down on a failure by a person within a function. Normally what happens is it is the failure of a process to let people perform their function well or say differently and stop with this. It is not so much that it is incompetent people, but it is processes and systems that forces very competent people to look incompetent.

If you are just joining us, you are listening to ReachMD XM157, The Channel for Medical Professionals. I am Susan Dolan, your host and with me is Dr. Steven Spear from the Institute for Healthcare Improvement discussing healthcare reform.

Dr. DOLAN:

Dr. Spear, how do healthcare providers prevent being too compartmentalized?

Dr. STEVEN SPEAR:

It is a very challenging question. There are very compelling reasons why healthcare organizations, particularly the academic medical centers and the teaching hospitals organize as they are and the largest is that they have these 3 missions. One is treating patients, the second is training residents, and the third is advancing science and the thing is that treating patients is very much dependent on excellent process. This is we are discussing this whole issue of the success where it is an orthopedic procedure like a hip replacement or it is a process meant to treat cancer, like dealing with breast cancer and getting the right coordination of radiation therapy and chemotherapy and surgical therapy and rehabilitative therapy and so forth. Treating patients is very, very much a process issue, but if you think about the training of residents as opposed to treating patients, residents do not get trained and certified and boarded in process, they get trained and boarded and certified within disciplines. So there is this pressure within particularly academic medical centers to organize around disciplines because that is how people get promoted and advanced. You go to college as a premed; you are going to medical school. By your third, fourth year starting to pick electives within your clinical rotations, you apply into residencies and then the residents you are going internship, your 1, 2, 3, 4 whatever it happens to be, fellowship within a discipline

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