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The Value of Interdisciplinary Education: Learning Together Helps Make Care Safer

The Need for Change

It has been more than a decade since the landmark Institute of Medicine (IOM) report, *To Err Is Human,* raised awareness of the need to improve the safety of health care. Many national agencies and organizations have devoted considerable energy to supporting quality improvement efforts. Evidence suggests that the effectiveness of these efforts has been variable. The Consumers Union gave the US healthcare system a failing grade on creating a system that prevents harm and reliably tracks progress[1] and Robert Wachter, a professor at the University of California, San Francisco, offered a grade of B minus in a recent *Health Affairs* article.[2,3] While there is disagreement on how much progress has been made, one message is clear: movement toward improving safety – and tracking success to that end – has been slow, and we are still experiencing alarming rates of error and finding deficiencies in our healthcare system.

A number of key thought leaders involved in the development of the IOM report attributed the lack of progress to "the persistence of medical ethos, institutionalized in the hierarchical structure of academic medicine and healthcare organizations, that discourage teamwork and transparency and undermines the establishment of clear systems of accountability for safe care."[4]

To overcome these challenges, the Lucian Leape Institute of the National Patient Safety Foundation developed a vision for meaningful improvement in patient safety around five core concepts: transparency, care integration, patient/consumer engagement, restoration of joy and meaning in work, and medical education reform. Teamwork was a recurrent theme that emerged across all five of these core concepts. It became obvious that meaningful medical education should incorporate development of skills, behaviors and attitudes that foster teamwork and communication to improve safety. "Physicians, managers, nurses and others should work together in teams to redesign flawed processes to prevent harm. One reason this has not happened faster is that physicians have not been educated to carry out this critically important work."[4]

Moving Toward Transformational Change

With health and medical education reform high on the national agenda, we must consider the three Cs that are necessary components for an interdisciplinary team that works well together – cooperate, coordinate and communicate.[5]

Teamwork is not an exact science; it is learned in practice. All team members bring unique skills and experience to their work. The fundamental principles that lead to winning or successful performances are good communication, clear definition of roles and mutual respect in coordinating a strategy, and a leader who recognizes the importance of these values.

The same principles apply to health care. Most physicians are not trained to be leaders, but their decisions influence the care provided by other healthcare professionals (the clinical team).[4] Physician leaders must recognize and respect the role of the other team members because the collective efforts of a group are much more successful than those of an individual in achieving safety improvement.

The concept of mutual respect and strategies to incorporate the three Cs into practice must be established from the first day of medical school and be apparent throughout the educational continuum. Healthcare providers in practice must have these concepts reaffirmed through team training and continuing education opportunities. Even the process of making these opportunities available requires collaboration between educators, quality and safety improvement officers, risk managers and healthcare professionals. Some organizations have successfully created interdisciplinary educational opportunities for students and healthcare professionals; however, they remain the exception rather than the rule. It's time to make interdisciplinary opportunities the standard in healthcare education to facilitate their use in healthcare delivery.

Patient safety leader Lucian Leape and his colleagues indicated that medical education reform was a core component of safety improvement, and that teamwork and communication strategies should be part of the curriculum. Continuing education in the form of lectures, seminars, and fellowships are well-recognized mechanisms of delivering content to practicing health professionals and can help fill a critical knowledge gap.

One example is the collaboration between the American Hospital Association (AHA) and the National Patient Safety Foundation (NPSF). Together they sponsor a Patient Safety Leadership Fellowship (PSLF) that offers an interdisciplinary environment for learners from medicine, nursing, risk management, research and administration, in both clinical and non-clinical settings. Geared toward mid-career professionals, the Fellowship delivers key concepts in patient safety from the nationally recognized faculty and successful strategies for implementation from fellow classmates. Through leadership retreats and virtual self-study modules focused on creating a culture of safety, reliable design, leadership and complexity science, as well as disclosure, reporting and transparency, Fellows are prepared to lead improvement initiatives that have the potential to create lasting organizational change.[6]

The learning environment where the Fellows convene is a "gracious space," where they feel welcomed and encouraged to learn,[7] affording opportunities to discuss common challenges. Through my personal experience as a member of the 2008-2009 class, I learned about the power of teamwork. The interaction with the members of my cohort allowed me to view patient safety from a variety of perspectives. The open, collaborative learning environment fostered a climate of mutual trust and respect that has helped us maintain lasting relationships as colleagues working to improve patient safety. Healthcare organizations and institutions must learn to foster this type of organizational culture in order to create an environment conducive to learning and practicing safely.

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Implications for the Future

As we work to create transformational change through interdisciplinary education, communication and coordination between educational societies, quality and safety improvement organizations, educators and health professionals will be critical to success. By committing to the core values of "cooperate, coordinate and communicate," we will begin to make the improvements in health care we so urgently need. ■

Valerie P. Pracilio, MPH
Project Manager for Quality Improvement
Jefferson School of Population Health
valerie.pracilio@jefferson.edu.

REFERENCES

1. Consumers Union. Safe Patient Project. To Err is Human-To Delay is Deadly.Executive summary. http://cu.convio.net/site/PageServer?pagename=spp_To_Delay_Is_Deadly_Executive_Summary. Accessed June 9, 2009.
2. O'Reilly K. Patient safety improving slightly, 10 years after IOM report on errors. *amednews.com.* http://www.ama-assn.org/amednews/2009/12/28/prsb1228.htm. December 28, 2009. Accessed February 4, 2010.
3. Wachter RM. Patient safety at ten: Unmistakable progress, troubling gaps. *Health Aff.* 2010;29:165-173.
4. Leape L, Berwick D, Clancy C, et al. Transforming healthcare: A safety imperative. *Quality and Safety in Health Care.* 2009;18:424-428.
5. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, D.C.: National Academy Press; 2001.
6. Hospitals in Pursuit of Excellence. Patient safety leadership fellowship. http://www.hpoe.org/hpoe/PSLF/pslf-landing-page.shtml. Accessed February 4, 2010.
7. Hughes PM. *Gracious Space.* Seattle, WA: Center for Ethical Leadership; 2004.