

Effective Leadership Is Needed to Ensure Quality and Safety in the Workplace

This is the last in a series of roundtable discussions from a September 2017 meeting of the AAOS Patient Safety Committee. In this article, David C. Ring, MD, PhD, chair; and committee members Michael S. Pinzur, MD; Michael R. Marks, MD, MBA; Dwight W. Burney III, MD; Andrew W. Grose, MD; and Alan M. Reznik, MD, MBA, address the importance of leadership in establishing a culture of safety.

Dr. Ring: What is the role of leadership, and how does leadership advance quality and safety? Most people say a culture of safety is established by leaders modeling humility, the understanding that to err is human, and championing systems designed to catch errors before they cause harm.

Dr. Pinzur: You must have enlightened leadership to understand that quality, which may be expensive to implement, decreases complications, reduces costs, and improves outcomes—in the long run. If your leadership understands that, they will provide the appropriate resources. If they don't understand, you face the challenge of educating them.

Dr. Marks: You need leadership that wants to be collaborative and understands that bottom-up can work just as well as top-down. For instance, with lean processes, you're getting all the people on the front lines to help identify the opportunities to create the improvements.

Dr. Ring: Everybody plays a leadership role in the sense that they can speak up and make a difference. In quality and safety, each surgeon can say, "I could screw this up, so please help me." Everyone can create an environment in which people want to do their best, contribute, and help.

Dr. Burney: It's similar to what Google found: The best functioning teams had leaders who were willing to exhibit vulnerability.

Dr. Ring: Leadership is about creating a culture that encourages

people to speak up. When they speak up, you take it seriously. When somebody's uneasy, you say, "Let me think about this."

Dr. Grose: Speaking up is not that simple. It is extraordinarily difficult to speak up when you feel ignorant or inexperienced and don't know enough to be confident in your question. Or if the person has the power of position or expertise over you—for instance, a prominent professor.

We forget how much we don't know as a post-graduate year-3 resident or third-year medical student and how hard it is to speak up as a student. From that perspective, the overwhelming assumption is, "I'm probably wrong." It's inhumane to ask them to speak up. That's a particular tension in residency training that we tend to sweep under the rug.

Dr. Pinzur: You can create an environment with both verbal and nonverbal communication. Some surgeons create an environment that encourages residents to ask questions.

When we have a new person in the room and they question something, I say, "That's great; we need you to ask questions because" If you support that behavior and people know it, they will speak up. You create the environment, because you are the leader in the operating room.

Dr. Ring: I was taking plates and screws out of a distal radius. I took the volar plate out. On the radial plate, the screws were stripped, and it was really hard to get the last screw out. Once I finally got it out, the skin flap covered the plate. I was feeling relieved and started to close—I would have left in the plate. The resident asked, "What about that plate?" I stopped everything and said, "Thank you," and then called it to the attention of everyone in the room: "Did you see that? It's not easy to speak up, but I really appreciate it. You saved this patient another surgery." That's leadership, when you say, "I'm vulnerable. I need your help, and speaking up is the right thing to do."


Dr. Reznik: The timeout often ends with the question, "Are there any concerns?" Instead of the usual, "No concerns," I say,

"I'm always concerned." Everyone laughs for a second. But it gives them permission to understand that I'm worried that things may not go well. When things happen that were not planned, everyone knows I am concerned. They also know I never yell at anyone when anything goes wrong. The minute you yell or get visibly upset in a crisis, your team is paralyzed, and they can't help you. More importantly, if you stay calm, while expressing your concerns, they feel comfortable piping up and saying something helpful.

Dr. Pinzur: We had one senior surgeon who was incredibly abusive. I walked into the operating room one day, and I looked at the nurses and I said, "I have a question for you. If I was going to do something wrong, would you stop me?" They all said, "Of course, because you listen." Then I asked, "If Dr. X was going to make a mistake, would you stop him?" They all replied that they would not. It's not just the way you ask the question; it's your persona and the way you treat people.

Dr. Reznik: To echo that point, many years ago, as a visiting fellow at the Nuffield Orthopaedic Centre in Oxford, England, a well-known surgeon nicked the circumflex artery doing a total hip replacement through an anterior lateral approach. It retracted away. We were all standing there watching the blood well up in the field. What do you do next? I learned a very important lesson. The surgeon calmly asked for some packing and put it in. He then asked for a list of the things he needed to be placed on a clean towel on a tray next to us. He carefully lined up all his instruments in the exact order he would need them. Then he said, "I want everyone to change their gloves." I was mystified at this point—why was he doing this? He seemed so ready to go. Then, after everyone changed their gloves, he finds the artery, ties it off, and it's perfect.

Later that day when I asked him why he had everyone change their gloves, he said, "I needed a minute to think."

The discipline he demonstrated in taking control and creating time to think before acting in a crisis always stuck with me. Just in the simple way he aligned the instruments, his behavior calmed the team, and we all knew the plan. 

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David C. Ring, MD, PhD