



Lee Hilborne on Culture and Systems Thinking

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Key Words

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Q There is a saying that "Culture trumps strategy every time." Thinking about the healthcare culture across our diverse organizational settings, what advice would you give healthcare quality professionals as they try to improve their organizations?

A Changing the culture is probably our biggest challenge—perhaps the root cause of many of the adverse events that occur in healthcare. Those of us with a quality background might hope that we would be able to change the culture overnight—many of us have tried. With the exception of a few organizations with truly visionary leadership and a staff that's bought into the vision, the culture change will occur in an evolutionary way rather than a revolutionary fashion.

What does that mean to those of us who have committed ourselves to quality? We will win by building a cadre of individuals who see the value of embracing a culture that learns from errors and responds by changing practices and systems. This type of change will come in two ways: 1) Strong opinion leaders who embrace the philosophy; and 2) training of new healthcare professionals who enter practice having been taught from the beginning that this is the way one must approach problems. With respect to the first issue, healthcare quality professionals win by having successes with individuals and departments who then adopt the philosophy and carry the torch to their more skeptical peers. For example, through a positive experience that resulted in change and a safer environment, a service chief from a major service at UCLA has become a proponent rather than a skeptic of our quality processes. If we train a new cadre of healthcare professionals, including physicians, nurses, pharmacists and others, to believe in analyzing and solving problems, they will naturally adopt a culture of safety. Furthermore, they will encourage their clinical mentors to consider such approaches rather than maintain the status quo with respect to clinical approaches to quality assessment.

q Many of the interpretations related to confidentiality requirements, as well as concerns about potential legal action, are impacting information sharing among organizations. What systems could be put in place to allow for the rapid sharing of information that could reduce preventable injuries?

a There is no question that harm results when one organization cannot benefit from the lessons learned by others. The legal system has encouraged a culture of secrecy—or at least metered disclosure—when it comes to errors. In some respects, then, the legal system may be harming the very people that it was designed to protect. There are national and some statewide initiatives underway to provide for the ability to share analyses resulting from assessments of unsafe situations yet maintain the confidentiality needed to protect providers from legal challenges. Healthcare professionals committed to quality must strongly advocate for these initiatives. In the meantime, organizations that are part of a corporate structure should evaluate whether, at the very least, they can share findings amongst themselves since they ultimately report to a single governance structure.

q “Systems thinking” has been around for several decades, yet there is considerable variability among professionals from the various disciplines in applying those principles to every day life in healthcare settings. How would you envision changing the way we educate new practitioners to achieve the consistency and synergy possible with systems thinking?

a New professionals learn from their training experiences and interactions with colleagues already in the profession. If we train new professionals in environments that pay lip service to systems thinking but don’t actually provide it, these new healthcare professionals will adopt past, dysfunctional practices. Our challenge, then, is to ensure that organizations that have been entrusted with training the next generation of healthcare professionals actually walk the talk when it comes to systems thinking. An organization that espouses systems thinking yet terminates the next employee who commits an isolated

negligent error will never gain the trust, respect and commitment of their staff.

q Mentors can play an important role in the growth of new professionals. How could organizations formalize a mentoring process, perhaps even across disciplines?

a Mentors must actually practice systems approaches to quality—refraining from reverting to old habits even when stressed. But mentors must work in an environment that encourages collegiality when it

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comes to addressing quality and safety problems. In essence, mentors must send the message that mistakes happen. It’s the true professional that catches them and learns from them.

q What advice would you give healthcare quality professionals in organizations so that they can contribute to the growth and development of new professionals?

a There are several responses to this question. First, keep at it—don’t give up and fight the instincts to withdraw when others are slow to adopt accepted quality practices. You are among the true heroes in today’s healthcare arena. Second, plan a medium and long term strategy. Through slow change, mentoring new professionals, and converting the skeptics methodically, ultimately the race will be won. Lastly, walk the talk—even when things seem hopeless! There’s always light at the end of the tunnel. When chips are down, an organization can have no more powerful advocate than a dedicated healthcare quality professional committed to honestly identifying problems and facilitating solutions.

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