

THE NEW YORK TIMES BESTSELLER

UNACCOUNTABLE



What Hospitals
Won't Tell You
and How
Transparency
Can Revolutionize
Health Care

"A gripping story about what's wrong with the
American healthcare system and what we might do
to make it better." —PETER PRONOVOST, MD

MARTY
MAKARY, MD

Advancing the Science of Medical Transparency



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Johns Hopkins University



How Many Die From Medical Mistakes In U.S. Hospitals?

by MARSHALL ALLEN, PROPUBLICA

September 20, 2013 4:52 PM

210,000 deaths



Sometimes the care that's supposed to help winds up hurting instead.

Causes of Death in the U.S.

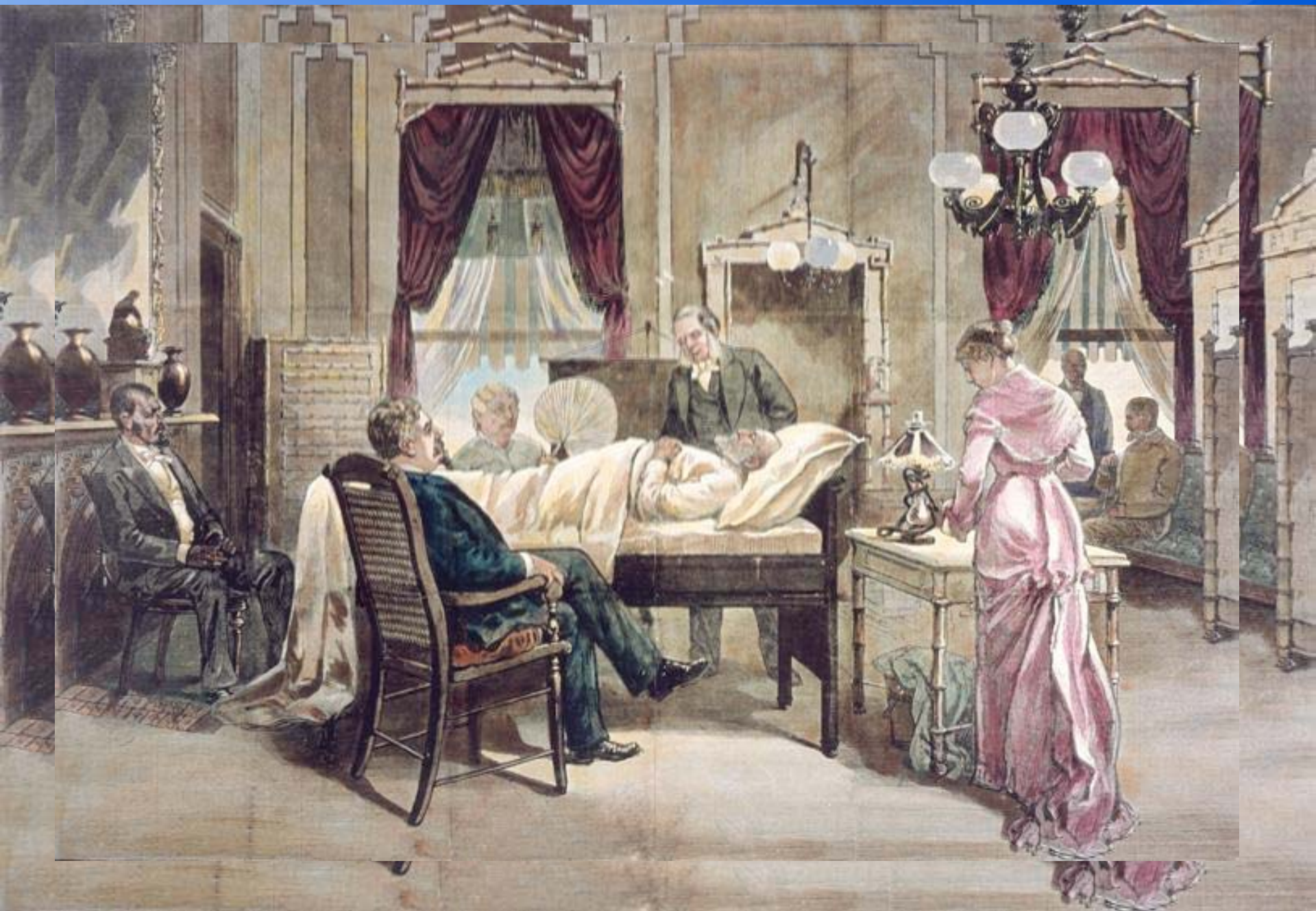
1. Heart disease: 597,689
2. Cancer: 574,743
3. Chronic lower respiratory diseases: 138,080

Source: CDC



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HBR.ORG

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OCTOBER 2013

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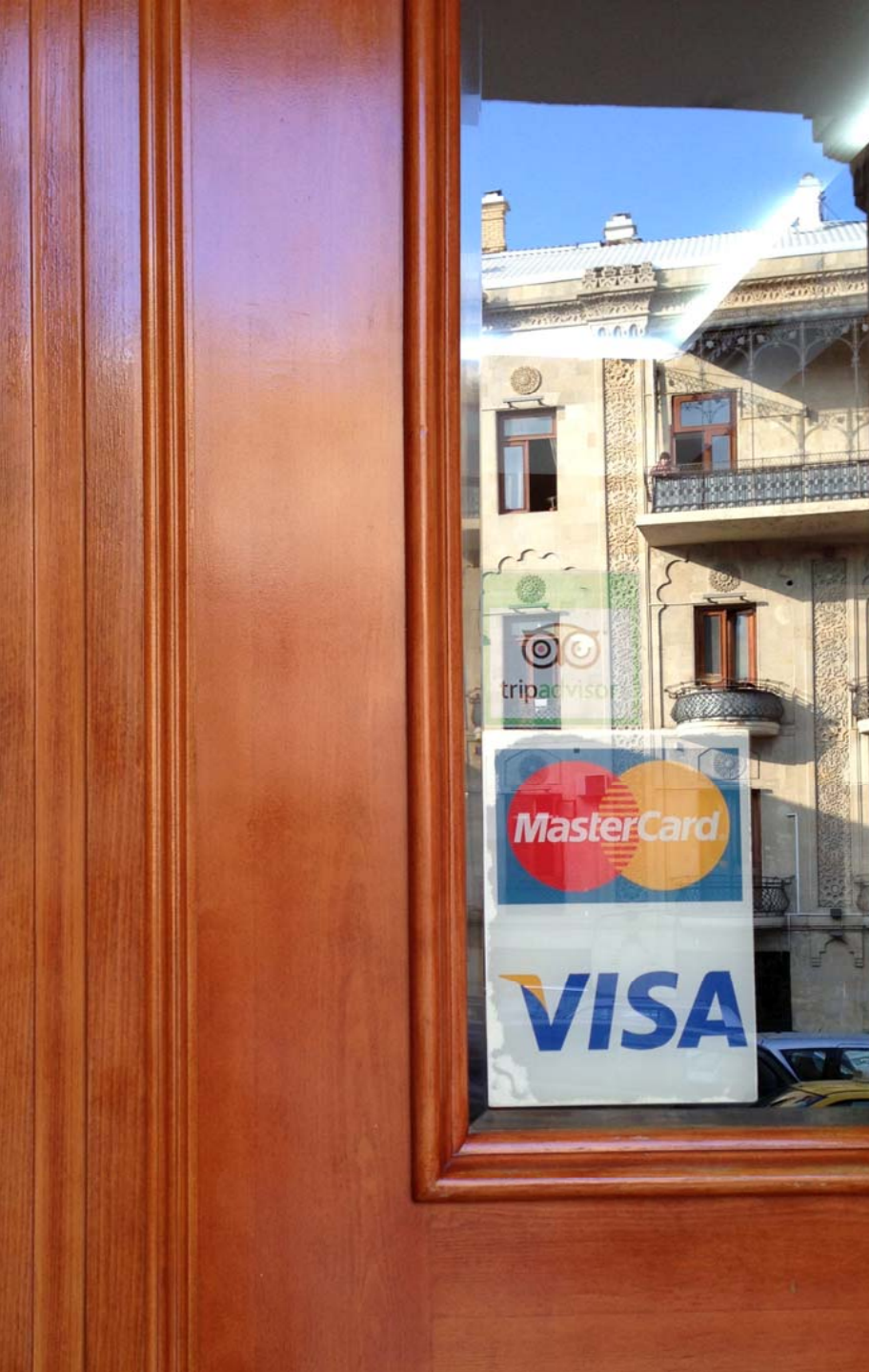
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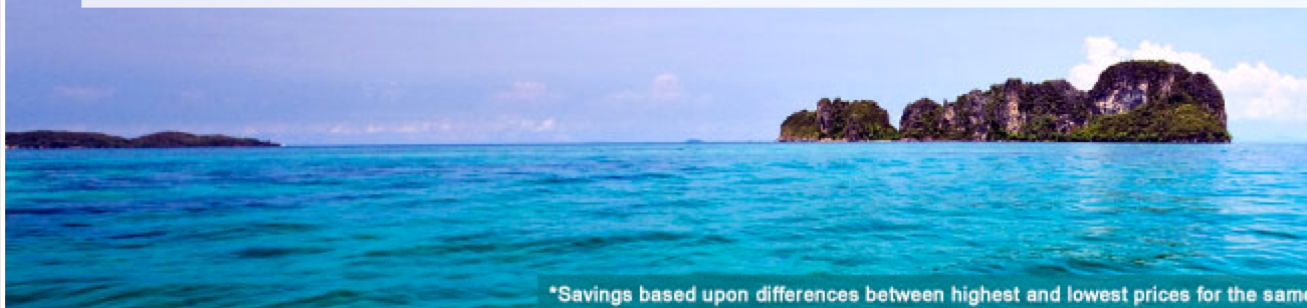
**How to engineer
breakthrough ideas**

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Plan the perfect trip & save up to 25%

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 ☐ Flights
 ☐ Vacation Rentals
 ☐ Restaurants
 ☐ Destinations



*Savings based upon differences between highest and lowest prices for the same

What travelers are saying about Baltimore

[Hotel Reviews](#)
[Photos \(4,470\)](#)
[Forums \(2,870\)](#)


timbolester

 **54 reviews**

 **41 helpful votes**

Wyndham Baltimore Peabody Court

"Changed over the years"

     yesterday



Steph003

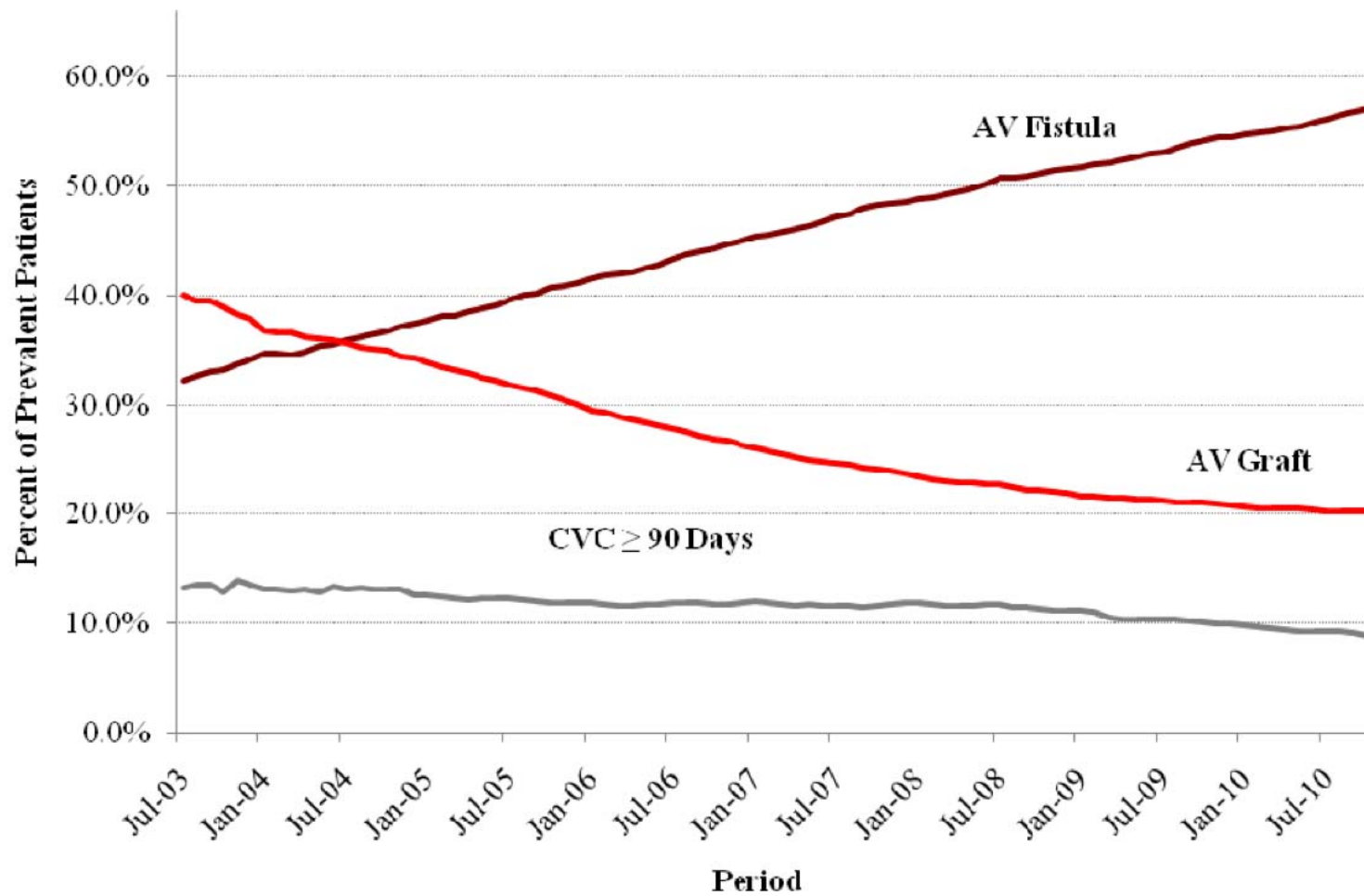
 **7 reviews**

Royal Sonesta Harbor Court Baltimore

"Excellent Location Right in the Heart of Baltimore"







ONLINE FIRST

The Power of Video Recording

Taking Quality to the Next Level

Martin A. Makary, MD, MPH

IN MEDICINE, THE PROBLEMS OF WIDE VARIATIONS IN quality and poor compliance with evidence-based care are well known. More education is not the solution for these problems. Knowledge is abundant, but implementation of knowledge often lags. This Viewpoint explores whether use of an existing technology, video recording of medical procedures, can improve quality of care.

Although the World Health Organization's hand washing declaration and aggressive global awareness campaign has been long established, behavior change among health care workers remains a persistent struggle. For instance, at Long Island's North Shore University Hospital, hand washing compliance rates were consistently low despite educational efforts. In response to these low rates, the hospital took an assertive approach to solving the problem by installing cameras to monitor hand washing rates. The out-

copy increased by 49% and quality of mucosal inspection improved by 31%,² suggesting a substantial improvement in quality because of the Hawthorne effect.

Peer review of videos can also enhance existing quality improvement efforts.³ For example, procedure videos can better inform morbidity and mortality conferences and sentinel event root-cause analyses that have traditionally relied on the notes of clinicians, which can be limited and even biased. Moreover, the exportability of video files can facilitate external review, allowing a peer reviewer removed from a local department's politics to advise on what could have improved.

In addition to reviews triggered by patient harm, video recording also offers a valuable opportunity for coaching. In the same way that athletes learn from coaches when jointly watching videos of past games, physicians can also learn from their performance by viewing with a coach. At the Brigham and Women's Hospital,⁴ a coaching program was developed in which surgeons spent 1 hour reviewing their procedure videos with an expert. The video-based peer review



Safety Attitudes Questionnaire (SAQ)

Safety Attitudes Questionnaire (ICU Version)

ICU job category: (mark only one):

- ☐ Charge Nurse
- ☐ Nurse Manager/Head Nurse
- ☐ COT Care RN
- ☐ COT Care (VNL/PL)
- ☐ COT Care Head/Registered
- ☐ COT Care Fellow/Resident
- ☐ Allied/Other Physician (Med)
- ☐ Allied/Other Physician (Surg)

Type of ICU (mark only one):

Please complete this survey with respect to your experiences at this ICU.

- ☐ Medical ICU
- ☐ Neurological ICU
- ☐ Surgical ICU
- ☐ Pediatric ICU
- ☐ Cardiac surgical ICU
- ☐ Other (specify):

MARKING INSTRUCTIONS

- Use number 2 pencil only.
- Erase cleanly any mark you wish to change.
- Correct Mark
- Incorrect Marks

Today's Date: _____

Agree Strongly **Agree Slightly** **Neutral** **Disagree Slightly** **Disagree Strongly**

PLEASE DO NOT WRITE IN THIS AREA

SERIAL 00000000000000000000

Please answer the following questions with respect to your specific ICU. Mark your response using the scale above.

- High levels of workload are common in this ICU.
- I like my job.
- Nurse input is well received in this ICU.
- I would feel safe being treated here as a patient.
- Medical errors* are handled appropriately in this ICU.
- This hospital does a good job of training new personnel.
- All the necessary information for diagnostic and therapeutic decisions is routinely available to me.
- Working in this hospital is like being part of a large family.
- The administration of this hospital is doing a good job.

It is easy to speak up if I perceive a problem in the OR

I would feel comfortable having my own care here

- In this ICU, it is difficult to speak up if I perceive a problem with patient care.
- When my workload becomes excessive, my performance is impaired.
- I am provided with adequate, timely information about events in the hospital that might affect my work.
- I have seen others make errors that had the potential to harm patients.
- I know the proper channels to direct questions regarding patient safety in this ICU.
- I am proud to work at this hospital.
- Disagreements in this ICU are resolved appropriately (i.e., not who is right but what is best for the patient).
- I am less effective at work when fatigued.
- I am more likely to make errors in tense or hostile situations.
- Stress from personal problems adversely affects my performance.
- I have the support I need from other personnel to care for patients.
- It is easy for personnel in this ICU to ask questions when there is something that they do not understand.
- Disruptions in the continuity of care (e.g., shift changes, patient transfers, etc.) can be detrimental to patient safety.
- During emergencies, I can predict what other personnel are going to do next.
- The physicians and nurses here work together as a well-coordinated team.
- I am frequently unable to express disagreement with staff physicians/intensivists in this ICU.
- Very high levels of workload stimulate and improve my performance.
- Truly professional personnel can leave personal problems behind when working.
- Morale in this ICU is high.
- Trainees in my discipline are adequately supervised.
- I know the first and last names of all the personnel I worked with during my last shift.
- *Medical error is defined as any mistake in the delivery of care, by any healthcare professional, regardless of outcome.

TURN OVER

Please answer by marking the response of your choice to the right of each item, using the letter from the scale below:

Agree Strongly **Agree Slightly** **Neutral** **Disagree Slightly** **Disagree Strongly**

- I have made errors that had the potential to harm patients.
- Staff physicians/intensivists in this ICU are doing a good job.
- Fatigue impairs my performance during emergency situations (e.g., emergency resuscitation, seizure).
- Fatigue impairs my performance during routine care (e.g., medication review, ventilator checks, transfer orders).
- If necessary, I know how to report errors that happen in this ICU.
- Patient safety is constantly reinforced as the priority in this ICU.
- Interactions in this ICU are collegial, rather than hierarchical.
- Important issues are well communicated at shift changes.
- There is widespread adherence to clinical guidelines and evidence-based criteria in this ICU.
- Personnel are not punished for errors reported through incident reports.
- Error reporting is rewarded in this ICU.
- Information obtained through incident reports is used to make patient care safer in this ICU.
- During emergency situations (e.g., emergency resuscitations), my performance is not affected by working with inexperienced or less capable personnel.
- Personnel frequently disregard rules or guidelines (e.g., handwashing, treatment protocols/clinical pathways, sterile field, etc.) that are established for this ICU.
- Communication breakdowns which lead to delays in delivery of care are common.
- Communication breakdowns which negatively affect patient care are common.
- A confidential reporting system that documents medical incidents is helpful for improving patient safety.
- I may hesitate to use a reporting system for medical incidents because I am concerned about being identified.

ICU Job Status

- ☐ Full-time
- ☐ Part-time
- ☐ Agency
- ☐ Contract

Ethnic Group:

- ☐ Hispanic
- ☐ Black (not Hispanic)
- ☐ White (not Hispanic)
- ☐ Asian/Pacific Islander
- ☐ Multi-ethnic
- ☐ Other

How many years of experience do you have in this primary specialty?

How many years have you worked in this ICU (mark 00 if less than 1 year)?

Usual Shift

- ☐ Days
- ☐ Evenings
- ☐ Nights
- ☐ Variable Shifts

CITIZENSHIP (e.g., Canadian, Filipino, USA, etc.):

Country of birth (if different):

On average, how many patients do you admit to this ICU each month?

COMMENTS: What are your top three recommendations for improving patient safety in this ICU?

-
-
-

If more room for comments is needed, please provide your response on a separate sheet of paper.

Thank you for completing the questionnaire - Your time and participation are greatly appreciated

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Operating Room Teamwork among Physicians and Nurses: Teamwork in the Eye of the Beholder

Martin A Makary, MD, MPH, J Bryan Sexton, PhD, Julie A Freischlag, MD, FACS
Christine G Holzmueller

BACKGROUND: Teamwork is the most important factor in improving patient safety.

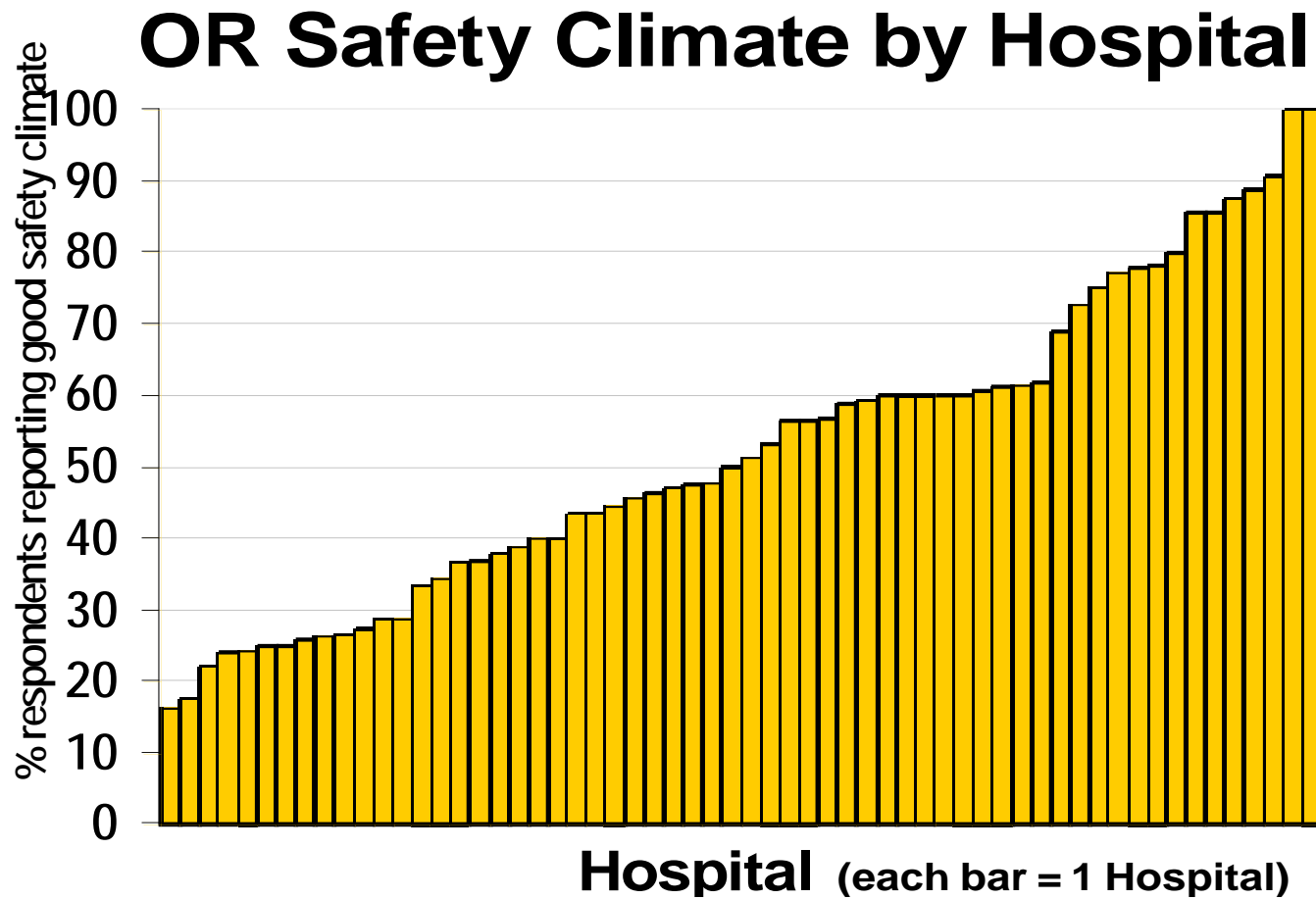
STUDY DESIGN: Operative room teamwork was rated by observers.

RESULTS: Over 100 cases were observed by 10 observers. The mean rating was 70.

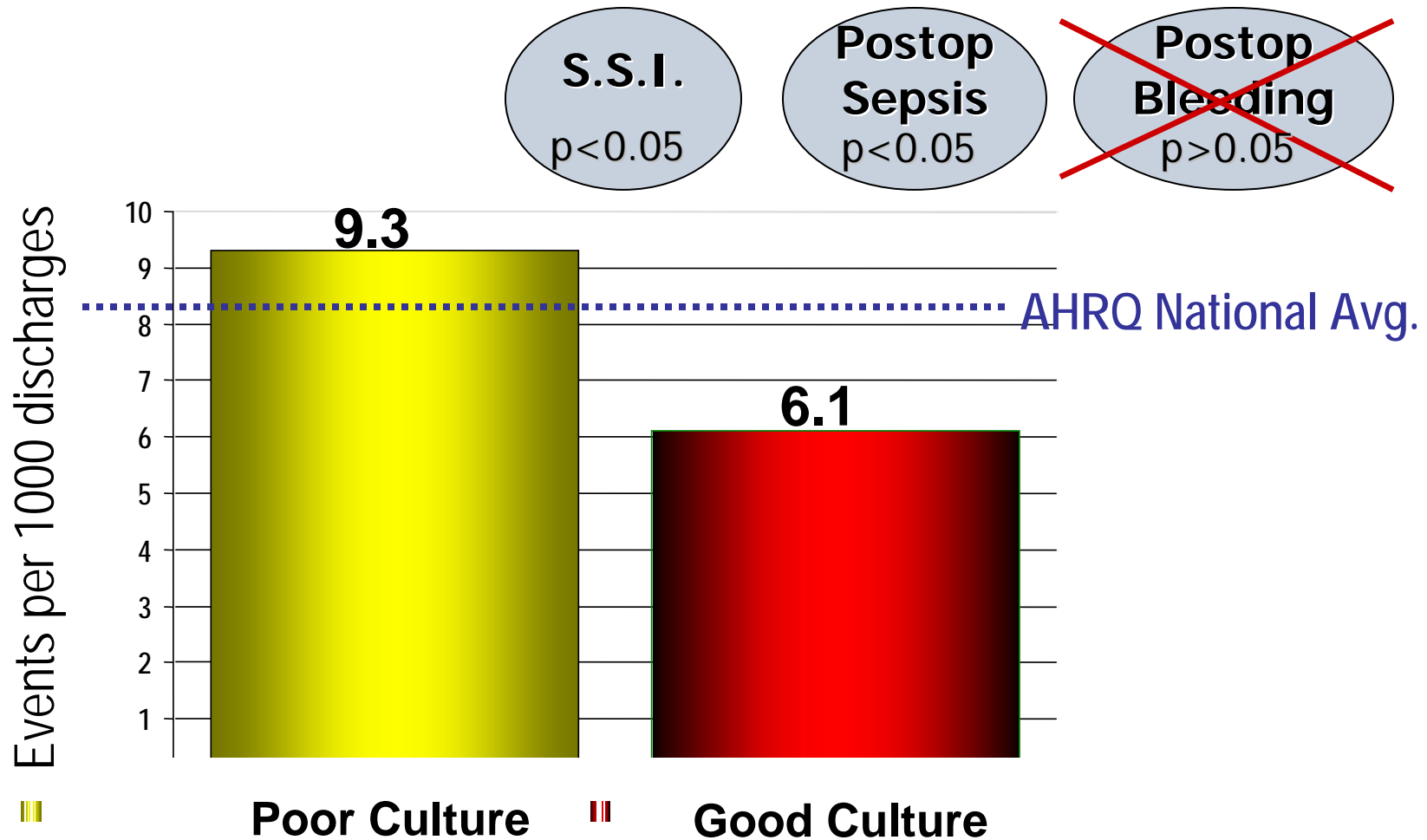
CONCLUSIONS: Consistent teamwork was observed in all cases. Safety was not compromised.

Caregiver Position Being Rated				
	Surgeon	Anesthesiologist	Nurse	CRNA
Surgeon	85	84	88	87
Anesthesiologist	70	96	89	92
Nurse	48	63	81	68
CRNA	58	75	76	93

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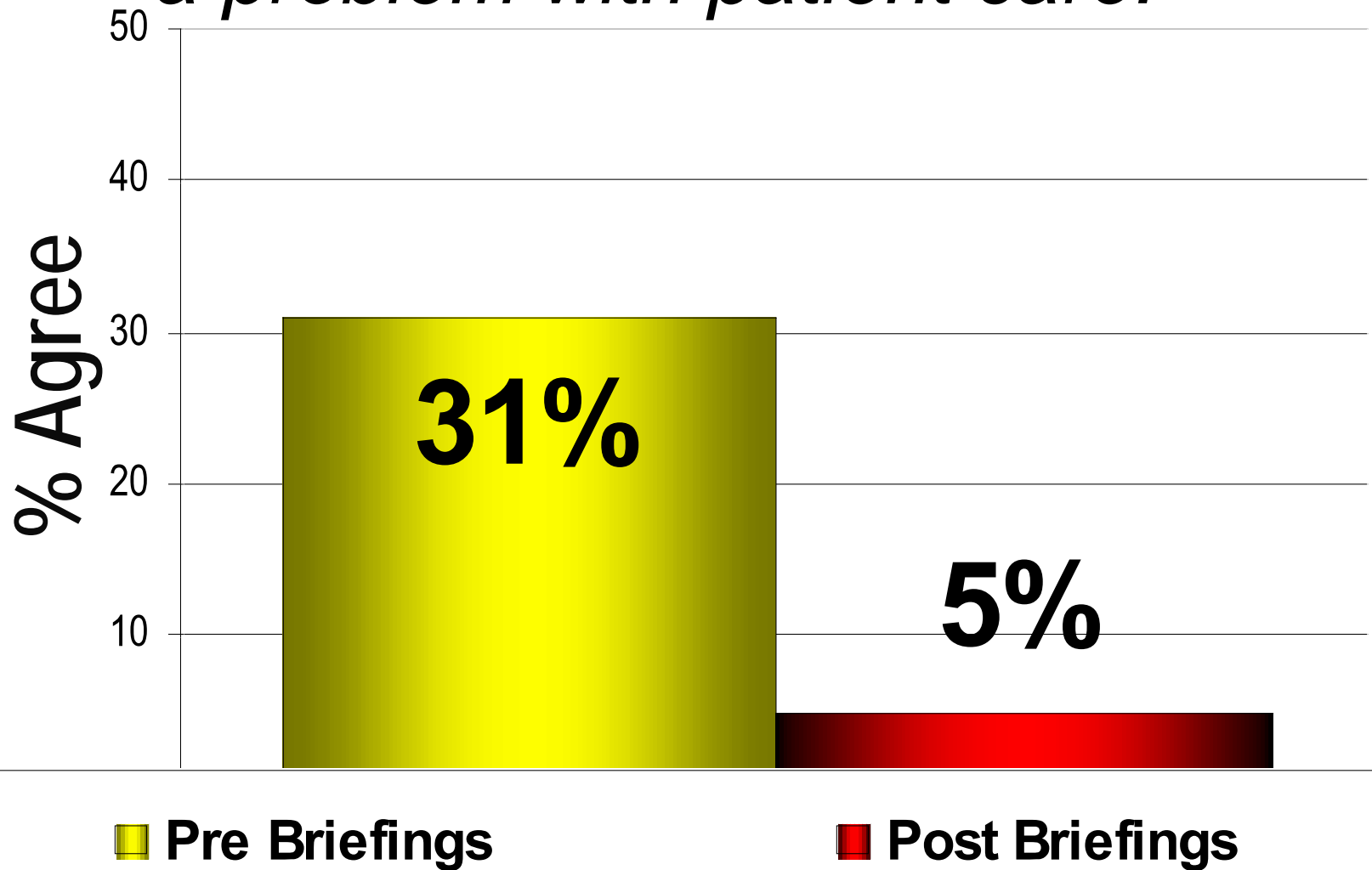


Rates of PE/DVT

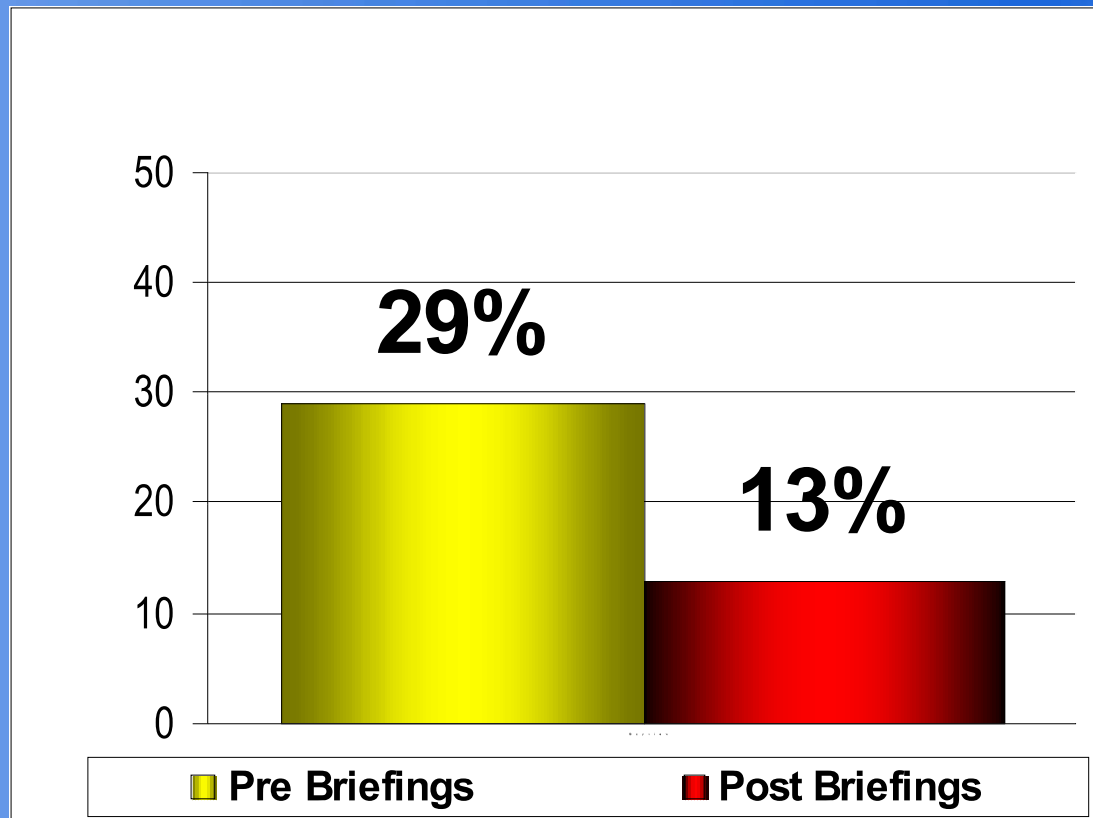


Unpublished data

“It was difficult to speak up if I perceived a problem with patient care.”



**“There was an unexpected delay
related to the case.”**



Nundy S, et al. Impact of Preoperative Briefings on Operating Room Delays *Archives of Surgery*, 2008;143:1068-72.



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