Opinions Letters

If we can put a man on moon ...

I read with interest “Eye of the beholder,” which is Part 1 of your series on improving healthcare productivity (April 27, p. 6). As a hospital nursing service administrator for the past 25 years, I have all but dedicated my career to figuring out how to provide the highest level of care possible at the lowest cost possible—not in response to some presidential charge but in my quest to meet my organizations' goals while being fiscally responsible.

I know you and all your readers understand that the answer to healthcare delivery efficiency is not a simple input-output ratio. Confounding variables and constraints abound on both the demand and supply side. As you stated, just looking at growth in inpatient admissions and full-time personnel is a meaningless simplification. But aren’t there other industries outside of healthcare where the productivity equation and measurement of business performance is just as complicated?

I have come to learn through my current work as a turnaround consultant that numerous complex management problems can be better solved scientifically through the application of operations research sometimes referred to as “decision analysis.” This is a mathematical capability that assists all kinds of companies (including those in transportation, manufacturing, retail and energy) to manage things such as exquisitely matching up supply and demand of any number of goods and services, and providing solutions for some of the most complicated and intricate business problems imaginable.

Operations-research capabilities are available to the healthcare industry as well, but its applications have been limited for a variety of reasons including cost, access and unfamiliarity. Although an operations research model is never sufficient unto itself, the healthcare industry can learn from other market sectors and should use all the intelligence and tools to be had in meeting its business and social imperatives. Such a revelation brings to mind the proverbial adage, “If we can put a man on the moon, then certainly we can figure out” healthcare productivity.

No waiting room

Not much progress,” (April 20, p. 8) reveals something that will, unfortunately, not be a surprise to many: We must do better when it comes to improving patient safety.

Hospitals across the nation have made enormous investments of time and money to improve safety, including striving to meet goals, like those mentioned in the article. Yet, patients are still not as safe as they should be. What is the missing link that will create real change and better outcomes for hospitals and patients?

Hospitals can and should learn from other high-risk industries that have made great strides in safety, such as the airline industry. They have shown us that all the process changes, technology improvements and measurement in the world will not make a difference unless they put to use in an organization that has a culture where safety is the top priority. How do we create that type of culture? It starts from the top of the organization, with a CEO who makes a clear and visible commitment to safety.

To demonstrate the kind of leadership and transparency that will lead to improvement, CEOs must do better. For example, as the CEO of Dublin Methodist Hospital, I am working with senior management to study the characteristics of high-reliability organizations. As our next fiscal year approaches, we will begin the high-reliability-organization journey and engage our management team and associates in this work.

I’ve also joined with nearly 125 other CEOs from across the nation who have stepped up to this critical challenge by participating in the VHA Foundation’s Health Care Safety Network. The program allows CEOs to learn from one another and from outside experts who share their knowledge of safety science with the group.

In an environment where a mistake can cost a life, we must make progress now. The CEOs of the Health Care Safety Network urge healthcare leaders across the country to provide the missing link to create cultures where safety comes first. Our patients can’t wait.

Cheryl Herbert
President
Dublin (Ohio) Methodist Hospital

Don’t overlook chaplains

I appreciate the Thomas Mone commentary in the April 20 issue (“Help us help them,” p. 21). However, he overlooks the resources that exist in hospitals and minimizes the exceptional care that hospital professional staff and physicians provide.

Board-certified professional chaplains are employed by hospitals and are part of the multidisciplinary team that cares for patients and families who face end-of-life decisions following illness or injury, including that of donation.

It is the chaplain, in partnership with the physician, nurse, social worker and other hospital staff, who identifies a plan of care for the family that includes issues of grief, shock and trauma. Professional chaplains have been board-certified through a national process that includes a graduate level (72-hour) education, a minimum of 1,600 hours of specialized clinical training, demonstration that they have met 29 competencies and engagement in regular peer review.

Chaplains are involved with such families as Mr. Mone describes from the beginning of their admission to the hospital and work closely with other members of the healthcare team to provide care. It is often the chaplain who accompanies the physician and nurse to inform the family of devastating news of their loved one’s death, and who works with the dynamics of grief and loss.

In my own employing hospital, chaplains are essential elements of the protocol for working with families facing the question of donation. Since chaplains have been involved with families from the beginning of their admission, they have the ability to assess for cultural, religious and communication needs and understanding, and to alert the other team members for needs to be met.

In our organization, as the lead chaplain working with potential donor families, I have seldom known a physician unwilling “to spend precious time further explaining brain death to the patient’s next of kin.” Because of our commitment to family care and to our protocol for a multidisciplinary approach to families facing end-of-life and donation, we are able to meet those needs in a timely, professional and compassionate manner.

I would advise administrators to become aware of the skills and contributions of professional chaplains in all areas of their organization’s work, especially that of grieving families and those facing decisions regarding donation.

Sue Wintz
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Barely enough

This is very important and barely enough (“Curing conflicts needn’t hinder research: IOM,” Daily Doce, April 28). When we