EDITORIAL

Creating a New Tipping Point in Intensive Care

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Hospital work is unique. It is altruistic in nature, intellectually challenging, and important. The people drawn to it want to make a difference in the lives of patients who are increasingly vulnerable and frail. But there are few nurses or physicians who don't find themselves quickening their pace when they walk into the hospital to begin a work shift. Increasingly, hospitals have become difficult places to work.

As institutions, hospitals are traditional, bureaucratic, and hierarchical. The regulatory burden has grown exponentially, and few hospitals have figured out how to use information technology to reduce that burden. The "reengineering" (a code word for layoffs) of the 1990s, combined with current shortages in the healthcare workforce, has left many nurses and physicians—as well as other members of the team—with impossible workloads and a residual suspicion of hospital administration. Many healthcare professionals working in the hospital feel frustrated by the lack of interdisciplinary teamwork, stymied by the disciplinary silos and rigid roles, and exhausted by the daily workload.

Regulation around the work hours of medical residents and clinical nurses, though welcomed by many as safer for patients and more humane for staff, has led to increasing fragmentation. Reduced hospital lengths of stay (with the national average being 4 days[1]) means that, for nurses working outside the intensive care unit (ICU), 25% of patients are discharged every day and replaced by new patients—a turnover rate that may be only 25%, but one that feels like 50%. For nurses working in the ICU, the turnover may be even greater depending on the nature of the ICU. A culture of low expectations has evolved in many hospitals: everyone on the team comes to *expect* and *accept* impossible workloads, poor interdisciplinary collaboration, ineffective communication, and treatment errors.

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The Tipping Point

According to Malcolm Gladwell, change is possible; people or social institutions can radically transform their behavior in the face of the right kind of impetus. He terms this impetus "the tipping point."[2] In his book of that name, he provides compelling examples of a number of forces coming together—many of them appearing small or inconsequential—that result in a large-scale change.

One of the examples he provides is of a nurse in San Diego, Georgia Sandler, who wanted to educate African American women about their diabetes and breast cancer risk. She started in a logical place: churches. She thought the church was the perfect place to gather a group of women together. The problem is that the few—very few—women who stayed after the weekly service already were interested in the topic of health prevention and knew a lot about both diabetes and breast cancer. She realized that the setting was wrong. People were tired and hungry after the church service and not interested in staying for yet another "sermon." By changing the teaching setting to beauty salons and enlisting hair stylists as her "health educators," Sandler created a tipping point that resulted in a highly successful grassroots health promotion movement.

Examples in nursing of tipping points are many: the Magnet hospital movement, nurse practitioners, and our own critical care specialty, to name a few. All of them could easily have failed instead of taking root as they have to become important components in our healthcare system. All 3 required "salesmen" and "connectors," the terms Gladwell[2] uses to describe people who are experts in the topic and who have, because of their personal charisma, a vast network of friends and colleagues whom they can enlist to support the change. For a movement to take root and real change to occur, one or more champions who are respected and genuinely liked by their peers are needed.

Change also requires that early adapters of change exert peer pressure and see certain situations in a new

context, not in stereotypes. This last point may be the greatest challenge of all in creating healthy work environments in the ICU, since we all have been educated in our single disciplines, each with its own unique traditions and metrics that stretch back centuries. Professional stereotypes are a strong part of our hospital tradition and may, in the end, present the biggest hurdle to change in the hospital.

A New Model of Care

We need a new model of care. We need to break away from what we've been taught and what we've learned to accept as the norm. In this issue, that new model is eloquently presented in a lead article written by Drs Kathleen McCauley and Richard Irwin, past presidents of the American Association of Critical-Care Nurses (AACN) and the American College of Chest Physicians, respectively.[3] These 2 organizations have long worked toward defining and supporting a new model of ICU care—one in which the patient is firmly at the center, families are partners, and interdisciplinary collaboration and communication is the norm rather than the exception. If implemented, the strategies they recommend will lead to healthy work environments in the ICU.

Many Voices in the Chorus

Many US hospitals have made a commitment to transforming their environments and have implemented strategies suggested both in the AACN standards for establishing and sustaining healthy work environments[4] and by McCauley and Irwin[3] in their article. For example, the Blue Ridge Group studies and reports on issues germane to the academic health center. The group recently published a report on medical training[5] that echoes the recommendations of AACN for creating healthy work environments. According to the report, medical students must learn a "culture of quality." The group defines such a culture as one that recognizes "the unique contribution of each discipline and the importance of support personnel in continuously improving the patient experience and clinical outcomes ... recognizing the most important team person at any given moment in a high performance high risk organization is the person with the most valuable information."[5(p17)]

If medical and nursing students are going to learn to be effective members of interdisciplinary teams, they must learn to recognize the unique contribution of each discipline, knowing when to lead and when to follow. If they are going to be effective communicators, they must be educated to communicate clearly and appropriately in their early education and must see such communication modeled in clinical rotations. All members of the team must commit to following evidence-based practice whenever possible; that is, whenever appropriate data or guidelines are available.

We believe that these recommendations require a seismic shift in the way health professionals are educated. We can no longer afford to educate members of each discipline in their own silo and simply hope that they will learn the principles of teamwork on the job. Students must learn together and apply guidelines together, using specific case scenarios. When one considers the average medical, pharmacy, or nursing curriculum, the challenge becomes clear.[6]

An Invitation

Something stood out in dramatic relief for both of us as we reviewed reports and articles prior to writing this editorial. Discussions about how best to change the work environment are taking place in the silos of our disciplines. Hospital administrators have met with each other, academic physicians have met with each other, and, yes, nurses have met with each other to discuss how best to develop an interdisciplinary team and a healthy work environment. Each group has tried to be inclusive of the other disciplines, with the American Hospital Association Commission and the Institute of Medicine being the most successful at achieving broad representation in their working groups. AACN and the American College of Chest Physicians work well together and communicate easily with one another. Nevertheless, we all struggle to be inclusive in our association work and in our recommendations about how best to change the work environment that we create in the hospitals in which we work.

We know that many wonderful examples of interdisciplinary education and practice exist across the nation; we hope that readers who know about one or more of them will share the information by writing to us. Letters to the Editors remain an important way to communicate successful change strategies. We also know that some of you have hired airline pilots for team training, have redesigned clinical committees, have developed interdisciplinary education curricula, and have established other changes in your units that have moved you toward healthier work environments. Please share these experiences with other readers. We need our own tipping point.

The statements and opinions contained in this editorial are solely those of the Editors.

REFERENCES

1. American Hospital Association Commission on Workforce for Hospitals and Health Systems. *In Our Hands: How Hospitals Leaders Can Build a Thriving Workforce.* Chicago, Ill; April 2002:20.

2. Gladwell M. *The Tipping Point: How Little Things Can Make a Big Difference.* New York, NY: Little, Brown and Company; 2000.
3. McCauley K, Irwin RS. Changing the work environment in intensive care units to achieve patient-focused care: the time has come. *Am J Crit Care.* 2006;15:541-548.
4. American Association of Critical-Care Nurses. AACN standards for establishing and sustaining health work environments: a journey to excellence. *Am J Crit Care.* 2005;14:187-197.
5. The Blue Ridge Academic Health Group. *Report 9: Getting the Physician Right: Exceptional Health Professionalism for a New Era.* Atlanta, Ga: Emory University Woodruff Health Sciences Center; 2005.
6. Institute of Medicine. *Health Professions Education: A Bridge to Quality.* Washington, DC: National Academy Press; 2003.