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How to Save Lives and Influence People

Dr. Peter Pronovost, Medical Director at the Center for Innovation in Quality Patient Care, Professor in the Department of Anaesthesiology/ Critical Care Medicine at Johns Hopkins University's School of Medicine and ICU Management Editorial Board Member explains to Sherry Scharff how one simple strategy has not only saved patients and improved safety in his institution – but made some people rethink the way they do their job.

By first studying the growing catheter-related bloodstream infection rate in Johns Hopkins' hospital over time and implementing a simple strategy- a checklist, Dr. Pronovost has made a drastic impact on the rate of infection, costs and mortality rates. The programme was then implemented in hospitals in the State of Michigan, where it nearly eliminated these infections and saved the state over 200 million dollars (U.S.) a year and countless lives.

Touted as one of TIME Magazine's 100 World's Most Influential People of 2008, Dr. Pronovost is using his influence to benefit critical care patients by striking at the heart of one of its' greatest challenges- standardising quality care around the world.

How Does it Feel to be Named of the World's most Influential People of the Last Year?

To be honest, it's a bit daunting. I find the work I do rewarding as it is-without the accolades. Taking concepts from research and finding ways to apply them to patient care, involves examining sometimes-complex studies and boiling them down into key steps, which can be applied at the bedside is surprisingly simple as an idea. But as a colleague said to me, the reality is that its' simplicity is the genius of it

Why does Something that Seems so Simple have such Drastic Result?

The idea of a checklist is indeed a simple one. But the success of it is not due to noting five simple points on a piece of paper and checking them off as you go. The checklist itself is just a tool. There are really three components key to the success here: In the case of line infections, there are over 80 behaviour-specific actions that are currently listed in the guidelines to lessen the chance of contamination during insertion. First, we chose five, which we agreed were the most important in reducing infections, and having the lowest barrier to use and worded them as behaviours. Then (secondly), we provided a system to measure and provide feedback to the doctors and nurses, which was an important component to keep them invested in the system- seeing the results over time. Finally, we imbedded in the concept of teamwork. Initially the idea of nurses questioning doctors about missing steps in the checklist was not entirely welcomed, as doctors are often concerned with "saving face". Many people say that doctors fear change. I disagree. If you or I won the lottery, our lives would inevitably change. Does this mean we would neglect to cash-in our ticket? Of course not, because people (and doctors alike) don't fear change, they fear perceived loss. And the loss in this case is the loss of power. If a nurse questions them, it is perceived as losing the power or the status in the unit. If we refocus this "loss of power" into advocating for your patient (a goal of both doctor and nurse)-and a team win, this issue of saving face dissipates.

I've Read that the Checklist System has/is Being Implemented in Spain and Elsewhere...

Yes, in fact it is launching in Spain as well as various other countries around the world: Peru, Pakistan, and the UK, as well as in 30 states here in the U.S. It is being organised through state hospital associations in the States and abroad, hospital participation is being initiated through the ministries of health. We will be guiding these projects-the launch, the collection of data, as well as providing materials and technical information. While these projects will be centralised in nature, the participants are empowered to initiate their own strategies in the collection of data, and in the decision-making process as to which components of the system they find efficient in practice. This is just the start of a three-year undertaking.

Are There any Other Problems that You Feel Could be Solved Within the ICU By Employing a Simple Protocol/Checklist System?

There is an infinite list...to highlight a few that we are working on creating checklists for at the moment: End of life/palliative care, MRSA, and ventilator-associated pneumonia. In the interest of improving quality of care, I am always attempting to find the "sweet spot" of what is scientifically sound and practically feasible, a balance between the two. In my background in clinical research I understand that those in the field believe that science is finding new drugs and identifying genes, which can work in early diagnosis and preventive medicine. I think science goes far beyond this idea of simply gene and drug solutions and that there is a science in behaviour-based medicine as well. An article was recently published in JAMA, called "Translating evidence into practice: a model for large-scale knowledge translation". In this article my colleagues and I set out a model for all protocols, with the approach, similar to that of drug trials, being central to success. The phases: (1) Summary of evidence; (2) Piloting and measurement; (3) Making the treatment available to appropriate patients.

What do You See as the Greatest Challenge in Critical Care?

There really is a wealth of information out there, and I know that there are a number of institutions that are doing really good work in particular areas. The challenge is to link these centres, create a pipeline to practice. Often good ideas are lost in translation into practice; to this end, we are actually working creating a software tool, which can pool information and utilise the wisdom of the masses. If I personally focussed on one disease at a time, studied it and the numerous guidelines connected to it- creating checklists for each, it would be incredibly inefficient- surely I would die before completing my tasks! The vision of this software tool, which we are calling the "checklist maker" is that everyone who uses it contributes-ranking the top seven behaviours to eliminate MRSA, for example. By pooling all this data, and giving intensivists and nurses the opportunity to list/rank what they see as priorities we can make knowledge more readily available and certainly more efficient.

Are You Concerned that You will be Forever Known as Dr. Checklist?

Ha ha...no, not really. Improving quality of care and standardising this high level of care is the ultimate goal, and as healthcare professionals we need to learn from situations when things go wrong. If a tool like a checklist is the first step in highlighting our role in the process, then the title is just fine for me.

What do You Think About Critical Care Management?

Leadership is important. There are many practicing doctors, like myself who are trying to implement evidence-based management strategies. That is why there is such a need for tools like this journal, ICU Management -to bridge the gap between management strategies and practice.

Thank You Very Much For Your Time.

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