Chesley B. “Sully” Sullenberger: Making Safety a Core Business Function

Captain Chesley B. “Sully” Sullenberger III became a source of inspiration and hope for millions after his successful emergency water landing of a disabled airliner in the Hudson River on Jan. 15, 2009, dubbed the “Miracle on the Hudson.” After listening to the cockpit recording from that day, one aviation specialist said of Sullenberger, “That guy has been training for this all his life,” remarking on the calm and decisiveness with which Sullenberger handled the emergency.

In many ways, the aviation specialist was right. What most people don’t know is that Sullenberger has been dedicated to the pursuit of safety for his entire adult life, starting in the U.S. Air Force, where he served as a fighter pilot and attained the rank of captain, and later through service to the Air Line Pilots Association as well as major airlines, where he has taught courses in safety to hundreds of crew members.

Sullenberger, who delivered the keynote address at ANI: The HFMA National Institute in 2012, is an international lecturer and keynote speaker on the importance of aviation and patient safety, crisis management, and lifelong preparation. He serves on the editorial board of the Journal of Patient Safety and is a member of the Greenlight Group, a team of experts supporting a number of global healthcare research and development initiatives.

hfm spoke with Sullenberger about the business case for patient safety.

Q. When an airplane crashes, hundreds of people are affected, and it makes national news. When a medical error occurs, it usually affects one person at a time. How can we create a sense of urgency around healthcare safety?

A. We need data, but we also need effective and very personal storytelling. Tell the story of a patient who had an entirely preventable healthcare accident at your institution and demonstrate how it can happen again, and that it’s happening all the time, right under our noses. Transparency in health systems is critical.

When executive teams look at their own data compared with the data of market leaders, they are often shocked. Even many hospitals in the bottom tier have no idea that they are performing below average. We need transparency for everyone. Everyone who works in an organization should know what that organization’s safety numbers are, including the infection rates and other important metrics.

We know that there are an estimated 200,000 preventable medical deaths in this country every year. That is the equivalent of 20 airplanes crashing a week with no survivors—almost three per day. If that happened in aviation, there would be a nationwide ground stop. Airlines would park their fleets. Airports would close. There would be congressional hearings. There
would be a presidential commission. The National Transportation Safety Board (NTSB) would investigate and find root causes. No one would fly until we had solved the problems. But in health care, mistakes affect just one person at a time. Mistakes are buried. Failures are buried.

What we have right now, quite frankly, in health care are islands—visible islands of excellence in a sea of invisible failures, with risk lurking just below the waterline. We need to widen those islands of excellence. We need to connect these islands with more dry land. We need to address these areas of risk. That is going to require transparency, it’s going to require data, it’s going to require personal storytelling, and it’s going to require effective use of health IT.

Q. Tell us how aviation safety has changed in recent years and how those learnings apply to health care.

A. For more than a century, aviation has learned costly lessons that were paid for in lives—lessons that we now offer up to medicine for the taking. The more I engage with the healthcare industry, the more similarities I see to aviation. That shouldn’t be surprising, because what we’re ultimately talking about is improving human performance in complicated systems that involve inherent risk.

In the late 1990s, a government/industry partnership called the Commercial Aviation Safety Team (CAST) was created to develop methods for fully understanding the chain of events leading to accidents and other incidents and to identify and implement high-level interventions to proactively reduce air travel fatality rates. CAST embodies a systemic approach to risk. In the 10 years after CAST was implemented in 1998, the fatality rate for commercial air travel in the United States was reduced by 83 percent.

Taking a systemic approach to risk means understanding that bad outcomes are almost never the result of a single fault, failure, or error, but instead are the end result of a causal chain of events. It also means realizing that we can no longer define safety solely as the absence of accidents and incidents. We must go beyond that to look proactively at risks and mitigate them before they can lead to an accident. That has made a huge difference in aviation safety in the past 10 years.

We are beginning to use the safety management system (SMS) concept in aviation. SMS makes safety a core business function—at least as important as financial considerations—and holds management at every level responsible for safety. That makes safety a transparent part of everyday business. Of course, this approach requires great leadership. It requires a culture change. And it requires that decision makers, who are often far removed from the implications of their choices, come to realize that administrative and budget decisions are also safety decisions.

Decision makers are often financial experts, but not subject-matter experts; they need to develop an understanding of the science of safety. The leaders, the board members, and the C-suite hold the keys to change. They are the ones who have to lead change. As James Oberstar put it when he was chairman of the House of Representatives Transportation and Infrastructure Committee, “Safety begins in the boardroom.”
Q. Do you see synergies between the trend toward value-based care and improved safety?

A. Yes. One of the reasons that many still think of safety as a cost, not a value, is that we aren’t doing a good job of accounting for the invisible—but-very-real cost of not having good quality—the cost of not having good safety. When the accounting improves and we see the numbers, when there is better transparency, then it’s much easier to give the green light to safety initiatives. As we move away from a pay-for-procedure to a pay-for-outcome system, organizations that can change and can make quality and safety improvements will be the ones that survive. Those that can’t or won’t improve quality and safety as payments are reduced will suffer financially because they won’t be paid when patients are harmed.

Q. You have advocated for the development of a national medical safety board, analogous to the National Transportation Safety Board. What are the advantages of that approach?

A. As we saw recently with the Asiana 214 investigation, we are so fortunate to have an agency like the NTSB to investigate transportation accidents in a systemic way.a You have probably seen in the news coverage how wide the focus of the NTSB investigation ultimately will be. They are going to take a very broad, systemic approach to identify the probable cause and all the contributing factors and, most important, to make recommendations to prevent a recurrence. The NTSB routinely issues public end-of-investigation reports that have a standard format and a presentation methodology that could be of great benefit to American health care.

Pilots from my generation can quote you chapter and verse on the specifics of all the important accidents that occurred in the past 50 years. For example, when we’re taxiing out for takeoff, we make sure to pick the appropriate point of the taxi that’s distraction-free to begin doing the before-takeoff checklist. We remind ourselves not to be like Northwest Flight 255 in Detroit back in the 1980s; we want to avoid distractions and make sure all the proper steps are completed without interruption.b So we sensitize ourselves to findings about the causes of accidents and we remember them. That’s the best way to honor the people who have lost their lives in that accident and others.

I think there is a place in medicine for a formal process that studies errors systemically, finds the root causes of errors, makes recommendations for fixing them, and disseminates those recommendations so they become universally used best practices. Health care would transition from a culture of blame, where aviation was 40 or 50 years ago, to a just culture in which accountability is fairly balanced with learning, and continuous learning and continuous quality improvement are integral.

Q. How does the aviation industry treat the cost of safety? Is it built into other costs?

A. In aviation, we are transitioning to making safety a core business function. Safety should be part and parcel of everything we do. Of course, that means we need people in the C-suite and at other levels of management who are trained in the science of safety. Every decision that is made, whether it’s administrative, budgetary, or otherwise, should take safety implications into account because there is such an important business case for doing so.
Q. What can healthcare finance leaders do to improve safety?

A. Healthcare finance leaders can understand the science of safety and give the green light to safety initiatives that have been proven to work. They can make sure these safety initiatives are sustained. And they can encourage a culture where everyone on the team cares about safety, not just people who have certain job descriptions.

Speaking to the last point, I am reminded of an experience I had on a flight into Minneapolis a number of years ago on a cold winter day. We were scheduled to depart Minneapolis less than an hour after we landed. As the passengers were deplaning, an airline worker who was loading bags outside on the tarmac came up to the cockpit, all bundled up in his winter gear. Addressing me, he said, “Captain, I see what might be oil dripping from beneath the cowling of the right engine.” I thanked him for his report and told him that I would have the first officer look at it when he did his preflight inspection and see that it was taken care of. So the worker went back out and finished loading bags. My first officer then verified that engine oil was dripping from beneath the cowling of the right engine. We immediately contacted our airline’s maintenance people. Long story short, when they came and fixed it, the mechanic found out that oil was dripping because they had added too much oil at the previous airport.

Here is the critical part of the story, as it relates to teambuilding and leadership in aviation: You need to create a shared sense of responsibility and enlarge the team to include everyone who touches the airplane. I wanted to close the loop and inform this baggage handler of what we had found. We know that to keep people motivated and to reinforce that sense of being part of a team, we have to give people occasional feedback. They need little successes along the way to know that what they did contributed to the goals and the success of the organization. Rather than summoning this baggage handler up to the cockpit, I put on my overcoat, went outside, and searched him out. I think it may have impressed him that I made the effort to do that. I told him what we had found. Then I thanked him again for what he had done, for bringing to our attention an issue that might have resulted in an engine malfunctioning during the flight or needing to land somewhere short of our destination. Then I went one more step and encouraged him to do it again on another flight for another captain, if the situation ever presented itself.

You see, what he had done was nowhere in his job description. His job description was handling the bags. But because he had gone beyond the narrow confines of his job description and done something that he knew was important, I wanted to encourage him to do it again. That is just one example from one flight on one day in this robust, resilient safety system we have in aviation. And those are the kinds of teams we need to develop in healthcare.

Q. What is your takeaway message for healthcare finance leaders?

A. As healthcare finance leaders, you should demand true risk management. That means demanding the business case for investments in safety. Teach your teams how to communicate safety investments in validated financial terms. Run scenarios that address the safety impact of budget cuts. Take the long view and realize that some short-term cost savings initiatives will have long-term negative implications for quality and safety, and that will
be more costly in the long run. Safety is about much more than preventing medical errors. It’s about managing risk.

There are those who say that the human body is much more complicated than our airplanes. There are those who counsel patience and say that these patient safety issues are complicated and they simply take time to fix. But I take a different approach.

I wish we were less patient. Every day, when each of us goes to work, through our attitudes and behaviors, we are choosing individually and collectively how many lives are going to be lost every year in this country. And the harm is so great, the numbers are so huge, that I don’t think we should wait 20 more years until there are 4 million more preventable medical deaths. I disagree with those who say these deaths are the unavoidable consequence of providing care. We should change the way we do business now. It’s not going to be easy, but it is possible.

footnotes
b. Northwest Airlines Flight 255 crashed after take-off on Aug. 16, 1987, at Detroit Metropolitan Wayne County Airport, killing 154 people. The National Transportation Safety Board determined that the probable cause of the accident was the flight crew’s failure to use the taxi checklist to ensure the flaps and slats were extended for takeoff.
c. A cowlings is the removable cover of an aircraft engine.

About Captain Sullenberger

Captain Chesley B. “Sully” Sullenberger was propelled into the spotlight after safely guiding a US Airways jetliner to an emergency landing on the icy Hudson River in January 2009. Named one of the world’s 100 most influential people that year by TIME magazine, Captain Sully is a 40-year accomplished pilot, instructor, and aviation safety expert who has logged more than 20,000 flight hours. Sully also founded Safety Reliability Methods, a consulting company dedicated to management, safety, and performance, serves as aviation and safety expert for CBS, and is a contributor to CBS News.

In collaboration with DuPont Sustainable Solutions, Sully developed and was featured in an award-winning video training program, Miracle on the Hudson: Prepare for Safety, which helps employees increase their commitment to safety and transform their organizations’ safety culture. Sully is also the author of two books, including Highest Duty: My Search for What Really Matters, and Making a Difference: Stories of Vision and Courage from America’s Leaders.

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