Circulation

EDITORIAL

Learning From Diversity

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Nallamothu and colleagues[1] take a leap forward in their study, "How Do Resuscitation Teams at Top-Performing Hospitals for In-Hospital Cardiac Arrest Succeed?: A Qualitative Study." The article asks a life-or-death question, applies qualitative methods with sophistication, and cleverly takes advantage of naturally occurring diversity across institutions. In so doing, the authors uncover practical strategies for addressing a pressing clinical problem in affordable ways. At the end of the article, I am left with an inspiring question: What other nuggets of wisdom might we find if we were open to learning from diversity the way Nallamothu and colleagues have done?

The question Nallamothu and colleagues tackle is important. Data from hospitals participating in the Get With The Guidelines–Resuscitation registry indicate a 3-fold difference in risk-standardized survival after in-hospital cardiac arrest,[2] even as average rates improved from 13.7% in 2000 to 22.3% in 2009.[3] Elevating hospitals from median to top performance in risk-standardized survival rates (median, 23.7%; top, 37.5% in the work by Chan et al[4]) across 200 000 in-hospital cardiac arrests could save >25 000 lives per year.

The methods are inventive and applied with rigor. Previous quantitative work[4] had identified 3 important practices among higher-performing hospitals: monitoring for interruptions in chest compressions, frequent review of cardiac arrest cases, and adequate resuscitation training. Nallamothu and colleagues take us a step further with qualitative descriptions of how the top-performing hospitals achieve their success. They used a consistent, conceptually grounded discussion guide that avoided the "leading the witness" problem sometimes found in open-ended interviews. They constructed the codebook inductively and successively over multiple site visits, used a coding team with differing backgrounds, sought to achieve intercoder agreement over time, continued site visits until they reached thematic saturation, and documented how and why they made decisions to provide an audit trail for their work. These are critical to the validity and transferability of conclusions attained with qualitative data, and Nallamothu and colleagues succeeded in their application.

The findings leverage diversity across hospitals to uncover insights that can inform broader policy and practice related to the treatment of in-hospital cardiac arrests. Nallamothu and colleagues identify the importance of having a dedicated or designated resuscitation team. Furthermore, the team members in top-performing hospitals were familiar with each person's skills and deficits, had clearly defined roles, and reported being empowered and backed up to implement their roles. As found in other studies of top-performing institutions,[5–7] leadership and communication were key. Most critical was not perfect communication but rather lead-

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ership and a communication mechanism to address breakdowns and mistakes when they occur. Finally, Nallamothu and colleagues found effective training in top-performing hospitals, which included mock codes in which teams could practice their roles regularly in as close to a real-life situation as possible and debrief the experience in structured ways focused on learning.

Many aspects of this work are inspiring. First, by studying already existing practices with humility and a passion for learning, we can uncover practices that can make our health system safer and save lives yet not cost a huge amount of money. The study reveals yet again ways in which investing in team relationships to ensure that all skills are used to their maximum capacity and the group can learn from its diverse experiences can promote top performance. Certainly, some investments such as backup staff and training regimens are needed, but more centrally, the investments include building strong intragroup and intergroup relationships. Second, the recommendations Nallamothu and colleagues make are in principle achievable by hospitals more broadly, particularly supported by evidence of interventions that can shift organizational culture in ways to improve outcome.[8] This suggests that concerted efforts nationally might in fact result in tens of thousands of lives saved annually. Third, although this could not be measured in this cross-sectional study focused on in-hospital cardiac arrests, the recommendations if implemented more broadly may generate additional benefits to hospitals. Improving norms of working together may generate position byproducts across a host of clinical and management challenges that can slow urgent care, reduce our reliability, and compromise both the working environment for staff and hospital quality of care.

Before moving on to the myriad other clinical studies published this week, we might take a moment to ponder the role of diversity in learning for improvement. In this increasingly divisive and polarizing time, the findings of Nallamothu and colleagues provide an opportunity for researchers, clinicians, and educators to redouble efforts to embrace diversity, to promote the inclusion of all voices, and to create learning—rather than simply performative—spaces in our work settings. This work and others like it renew the call for engaged pluralism, in which our adaptation to increasing diversity is neither to assimilate nor segregate but rather to engage fully, recognizing in others our common goals and seeing others' skills and deficits as part of our own holism.

ARTICLE INFORMATION

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Disclosures

None.

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