# Medical safety huddles to engage frontline physicians in patient safety: calling physicians back to the table

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Accepted 31 August 2023
Published Online First
15 September 2023

Linked

► http://dx.doi.org/10.1136/bmjqs-2022-015725

Check for updates



**To cite:** Pimentel CB, Pimentel MPT, Hartmann CW. *BMJ Qual Saf* 2024;**33**:7–9.

It is broadly recognised that everyone has a role in making healthcare safe,[1] yet hospitals continue to struggle with incorporating frontline physicians in quality improvement and patient safety work.[2] One cornerstone of hospital-based quality improvement and patient safety work is multidisciplinary huddling. Multidisciplinary huddles—brief, focused, stand up meetings involving physicians, nurses, administrators, laboratory workers and other staff—can improve medical care by enabling collaborative and efficient information exchange and fostering a shared view of current clinical conditions.[3] Huddles operationalise healthcare as a cooperative science: all team members work together to deliver more patient-centred, coordinated and effective healthcare,[4] promoting stronger teamwork, communication and situational awareness on the unit floor.[5] This increased communication among members of the team theoretically leads to a better understanding of the daily work of frontline staff, potentially a key to sustaining quality improvement.[6] But huddles' effectiveness may be hampered by pressure from staff time and workload[2] and inadvertent reinforcement of medical hierarchies.[3] In addition, frontline physicians may perceive huddles as having low clinical relevance.[7 8] Given these stumbling blocks, how can huddles be modified to effectively address and escalate frontline physician concerns?

In this issue of *BMJ Quality & Safety*, Rotteau *et al*[8] describe their qualitative study on medical safety huddles implemented at six sites. In contrast with organisation-led, multidisciplinary huddles, these huddles included only physicians. The huddles consisted of (bi) weekly, 15 min 'touch base' meetings aimed at reviewing, anticipating and addressing patient safety issues. Physician leaders guided the huddle conversation using a standardised, three-part script: (1) introduction of the goal to achieve '100% patient and staff safety'; (2) identification of potential safety, quality or service issues occurring in the next week in areas such as staffing coverage, pharmacy, technology, equipment and patient transitions and (3) a review of safety, quality or service issues from the previous week. The six sites already had existing, daily, multidisciplinary huddles, with no or very low physician involvement. Implementation of medical safety huddles, however, led to regular participation of between 30.3% and 88.2% of the frontline physicians within the units. Interviews with 29 physician leaders and participants in huddles across the six sites revealed the following intrinsic motivators as important to facilitating physician participation and engagement: creating a sense of community (relatedness) among physicians, enabling 'safe spaces' for discussions with physician colleagues about professionally relevant safety issues (meaningfulness), providing a sense of progress towards resolving safety issues and creating meaningful ways to have input into one's work environment (autonomy). While not meant to be didactic, these huddles also broadened physicians' understanding of risk factors for poor safety or quality outcomes.

Is there a need for such physician-only huddles? Little research has been done on their potential utility. Huddles are

generally led by unit managers or charge nurses and focus mostly on the nursing and interprofessional teams.[9] In a scoping review of 158 studies of frontline huddles in clinical care, 76% of huddles had physician participation, but only 32% of studies were physician-led, and all but one were multidisciplinary.[9] The study by Rotteau *et al* therefore helps fill a gap, providing us with an in-depth, qualitative analysis of the potential utility of and concerns with physician-only medical safety huddles.

Based on what we know from the literature, medical safety huddles have the potential to engage frontline physicians in improving quality and safety. High-reliability organisations depend on multiple sources of incoming data to continuously monitor for risks to patient safety and opportunities to improve quality.[10] These data include performance on quality measures and compliance audits, internally submitted safety reports, patient experience data and communications—both formal and informal—from managers and frontline staff. Physicians, as a group, are relatively under-represented in submission of safety reports; however, the types of safety events reported by physicians distinctly complement those from non-physician reporters.[11] Physicians routinely deal with emerging risks in patient safety, for example, diagnostic errors, serious illness conversations, coordinating multiple consultants for complex care and human factors in procedural and technical performance. Organisations that fail to adequately engage physicians in gathering safety data will likely have corresponding blind spots in these areas of emerging risk. Medical safety huddles directly engage physicians in conversations about their concerns in patient safety and clinical operations. And although traditional multidisciplinary huddles are designed as safe spaces for raising safety and performance concerns, Rotteau *et al* found that physician-specific huddles enabled discussions of 'safety concerns that were specifically related to physicians' clinical roles, especially when contrasted with '*nursing*' concerns that are typically discussed in the local unit level huddles'.[8] In other words, medical safety huddles create an opportunity for physicians to share role-specific concerns that they would otherwise be hesitant to raise in a broader group.

Medical safety huddles may also be a promising approach to addressing physician burnout. As Routteau *et al* indicate, 'engagement and burnout exist on opposite ends of a spectrum'.[8 12] Burnout among physicians is highly prevalent globally[13] and is associated with a doubling of patient safety incidents.[14] Maslach's Areas of Worklife Model[15] identifies six key areas where job-stressors contribute to burnout: workload, control, reward, community, fairness and values. Medical safety huddles are an opportunity to positively engage physicians in each of these areas. By creating a safe space for physicians to voice and escalate their patient safety and workplace concerns, medical safety huddles can create a sense of community and identify alignment with organisational values. They are, by design, a quick and accessible complement to more intensive educational efforts that focus on integrating physicians-in-training into quality improvement and patient safety programmes (eg, House Staff Quality and Safety Councils,[16] the Pursuing Excellence Initiative Pathway Leaders Patient Safety Collaborative).[17] Patient safety work can be reframed through medical safety huddles as a valuable opportunity for physicians to meaningfully influence how they deliver high-quality, safe care to their patients.

To support high cultural adoption of quality and safety within the health system, it is not enough to gather physicians in the break room and call for a 15 min huddle. The physician-only structure of medical safety huddles is useful for raising issues with patient safety and identifying opportunities to improve physician workflow, workload and perceived lack of control about how work is done. But Rotteau *et al* acknowledge that physician-specific huddles should be integrated into a greater organisational approach to patient safety to keep the huddle discussions relevant and to create pathways for escalation and resolution. Collaboration with other disciplines is inevitably needed to clarify problems or implement changes outside of the physician group. Purposeful integration with the greater organisation—and the resulting opportunities to systematically respond to risk factors for physician burnout—is what can elevate medical safety huddles beyond small groups of physicians coming together in isolation. This integration can be achieved, for example, by a tiered daily huddle system that rapidly identifies and systematically escalates simple to complex safety, quality and operational issues from a broad array of frontline staff to focused groups of senior leaders. Successful models of tiered huddle systems have been designed around location (eg, multidisciplinary groups of staff in a unit huddle together),[18 19] but it may be possible to structure tiers by function or professional role. Alternatively, organisations may choose to recruit specially trained physicians into hospital leadership roles, and then directly incorporate them into huddles across the organisation.[20] In these ways, medical safety huddles can be framed as an approach to convene and integrate physicians into organisational patient safety work, explicitly avoiding the creation of a physician-only 'echo chamber'. As Rotteau *et al* stress, leadership and support from the larger organisation is critical to leveraging the benefits of physician-specific huddles and sustaining physician engagement in quality and safety.

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**Contributors** CBP, MTP and CWH contributed to conceptualisation, drafting and critical revision of the manuscript.

**Funding** CBP and CWH are supported by Career Development Award Number IK2 HX003184 and Research Career Scientist Award Number IK6 HX003398, respectively, from the VA Health Services Research and Development Service.

**Disclaimer** The views expressed are those of the authors and do not necessarily reflect the position or policy of the US Department of Veterans Affairs (VA) or the US Government.

**Competing interests** None declared.

**Patient consent for publication** Not applicable.

**Ethics approval** Not applicable.

**Provenance and peer review** Commissioned; internally peer reviewed

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