A View from the Edge - Creating a Culture of Caring.

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a 6-to-12-month duration of effect, oligonucleotide therapeutics might become competitive not only with biologics, but also with orally administered drugs, an outcome that was unforeseeable only a short while ago. Of course, the future of inclisiran and oligonucleotide therapeutics is completely dependent on the demonstration of their safety.

Conjugated oligonucleotides are chemically defined “large small molecules” that can be synthesized in an advanced oligonucleotide lab within a day. They are assembled from standard building blocks, phosphoramidites, in an automatic fashion using solid-phase chemistry. The cost of oligonucleotides is driven mainly by the cost of its precursors and is expected to be in the low hundreds of dollars per gram on a commercial scale. With a yearly dose of 300 to 500 mg, the manufacturing cost for this class of drugs is on par with that of small-molecule drugs and is probably much lower than that of monoclonal antibodies. Although the manufacturing cost accounts for only a minority of the initial market price of the drug, the relative simplicity of the manufacturing process and the room-temperature stability of the dried oligonucleotides, which can be brought to solution at the point of care, might eventually make this class of therapeutics widely available for a broad population.

Disclosure forms provided by the author are available at NEJM.org.


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A View from the Edge — Creating a Culture of Caring
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In 2008, an occult adenoma in my liver ruptured, and I effectively bled to death in my own hospital. I lost my entire blood volume into my abdomen, triggering what’s known in trauma as the Triad of Death — a kind of suicidal spiral of the blood in which it becomes too acidic and too cold to clot. I would receive more than 26 units of blood products that night — packed red cells, platelets, cryoprecipitate, fresh frozen plasma. I would go into multisystem organ failure, my liver and kidneys would shut down, I would be put on a ventilator, have a stroke and a complete hemodynamic collapse. The baby I was 7 months pregnant with would not survive, but I would — thanks to the incredible skill and grace of the teams of professionals who cared for me.

My recovery involved five major operations including a right hepatectomy. I had to relearn to walk, speak, and do many other things I had taken for granted. But in the process, as a patient, I learned things about us — physicians and other medical professionals — that I might not have wanted to know. I learned that though we do so many difficult, technical things so perfectly right, we fail our patients in many ways.

As a patient, I was privy to failures that I’d been blind to as a clinician. There were disturbing deficits in communication, uncoordinated care, and occasionally an apparently complete absence of empathy. I recognized myself in every failure.

When I overheard a physician describe me as “trying to die on us,” I was horrified. I was not trying to die on anyone. The description angered me. Then I cringed. I had said the same thing, often and thoughtlessly, in my training. “He was trying to die on me.” As critical care fellows, we had all said it. Inherent in that accusation was our common attribution of intention to patients: we sub-consciously constructed a narrative in which the doctor–patient relationship was antagonistic. It was one of many revelatory moments for me.

I heard my colleagues say...
things to me in ways that inflicted more suffering, even when
they believed they were helping.

“We’re going to have to find you a new liver, unless you want to
live here forever.”

“Are you sure your pain is an eight? I just gave you morphine
an hour ago.”

“You should hold the baby,” someone said. “I don’t want to
be graphic, but after a few days in the morgue, their skin starts to

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break down and you won’t be able
to anymore, even if you change
your mind.”

Small things would gut me. Receiving a bill for the attempted
resuscitation of the baby, for exam-
ple. My husband took on the
task of reconciling the bill with
the lack of a baby. The billing de-
partment explained that the bill
was generated when we had failed to enroll her in our insur-
ance plan. No one could explain,
of course, at what exact juncture
we should have called our insur-
ance company, seeing as how
she’d never technically been alive.
It took four phone calls to settle
the charges. A trivial oversight,
by a department ostensibly not
involved in patient care, had the
potential to bring me to my knees.

My experience changed me. It
changed my vision of what I want-
ed our organization to be, to em-
body. I wanted the value of empa-
thetic, coordinated care to spread
through our system. I shared my
story openly. I wanted the system
leaders and every employee to
know that everything matters,
always. Every person, every time.

How do you build and main-
tain a culture of shared purpose
in the infinitely complex arena of
health care? How do you ensure
that you engender in employees a
dedication and commitment to
doing what’s right? Identifying
the gaps between the stated mis-
sion and values of an institution
and its actual delivery of care is
critical. As systems, we have to
recognize and acknowledge our
mistakes, our shortcomings, just
as individual physicians do. We
need to reflect on times when
our care has deviated from what
we intended — when we haven’t
been who we hoped to be. We
have to be transparent and allow
the failure to reshape us, to help
us reset our intention and mold
our future selves.

Bravely, my institution respond-
ed to my experience by radically
revising the way in which we in-
troduce every new employee to our
organizational culture — collo-
quially referred to as “onboard-
ing.” Our institutional leaders had
already launched a “Culture of Caring” curriculum for nursing.
But they understood that to truly
change the culture, all new em-
ployees, including physicians,
needed to internalize our institu-
tion’s values. So they expanded
their efforts, incorporating the
failures and successes of my pa-
tient story to illuminate our
shared purpose and build an en-
gaged culture.

Through the training that was
developed, participants learn to
articulate their purpose as dis-
tinct from their job. Transporters
hear how meaningful it was to
me when one of their own —

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sponding to the unavoidable kind with empathy and by improving our processes and procedures to avoid inflicting the avoidable kind whenever possible.

Our failures are analyzed, and our successes shared. Consider the power of that choice. Early on, all new employees hear about how we recognize and admit to our failures. How we partner to ensure that transparency keeps us from repeating our errors. How we hold each other accountable.

By illuminating our failures, we can begin an authentic conversation about shared purpose, resilience, and building an engaged culture.

We believe that by focusing on our missteps, we can ensure that the path ahead is one of compassionate, coordinated care. When we are ashamed, we can’t tell our stories. They become inaccessible to us. In the wake of painful experience, we all seek meaning. It is the human thing to do, but it is also the job of great organizations. The stories we tell do more than restore our faith in ourselves. They have the power to transform.

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