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News Release

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VA's 'Medical Team' Approach Reduces Operating Room Mortality Rates

WASHINGTON – A Department of Veterans Affairs (VA) study published October 20 in the Journal of the American Medical Association concludes that a concept called Medical Team Training (MTT) improves communication, teamwork, and efficiency in VA operating rooms, resulting in significantly lower mortality rates.

“Patients can suffer inadvertent harm at times, despite care from well-trained, experienced, and conscientious health care providers,” noted Dr. Douglas Paull, a VA surgeon and co-director of the Medical Team Training program at VA’s National Center for Patient Safety in Ann Arbor, Mich. “The cause in many such instances is faulty teamwork and communication.

“Fortunately, teamwork and communication skills —often referred to as non-technical skills— can be measured, learned, practiced, and enhanced,” Paull continued. “The MTT Program improves these non-technical skills among providers, delivering on the promise of a safer health care system.”

VA’s nationwide study involved the analysis of more than 100,000 surgical procedures conducted at 108 of its hospitals from 2006 to 2008. MTT had been introduced at 74 of these hospitals. The study found that the decline in the risk-adjusted mortality rate was 50 percent greater in the MTT group than in the non-MTT group.

“MTT is all about communication,” said Dr. Lisa Mazzia, who runs VA’s Medical Team Training Program along with Dr. Douglas Paull. “MTT empowers every member of the surgical team to immediately speak up if they see something that’s not right.”

“When people talk and listen to each other, fewer errors occur in the operating room. That’s the bottom line,” Mazzia added.

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Julia Neily, associate director of VA's National Center for Patient Safety Field Office in Vermont and one of the study's nine authors, said conducting briefings prior to starting surgery, much like pilot and crew work through a pre-flight checklist, proved to be a key component in reducing mortalities because it gave the surgical team "a final chance" to correct potential problems.

Post-operative debriefings also proved valuable, the study found, because they led directly to the prompt resolution of glitches that occurred during surgery. Examples included fixing broken equipment or instruments, ordering extra back-up sets of instruments, and improving collaboration between the Operation Room and the Radiology Department—all of which led directly to less delays while future surgeries were in progress.

Pre-operative briefings and post-operative debriefings are a fundamental component of VA's MTT program, which VA's National Center for Patient Safety began developing in 2003-2004. VA began implementing a nationwide MTT program in 2006.

To find out more about Medical Team Training, contact VA's National Center for Patient Safety at 734-930-5884 or go to www.patientsafety.gov.

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