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CICM WELFARE

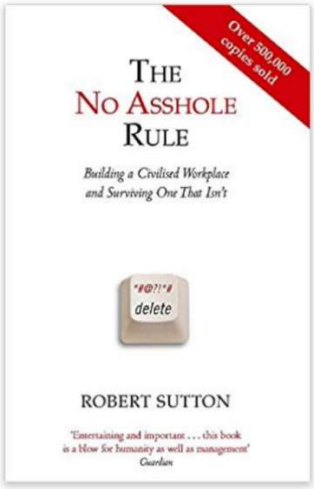
CULTURE AND HEALTH CARE ORGANISTATIONS – SO WHAT IF WE HAVE A PROBLEM?

Over the past 5 years, there has been increasing discussion both in the media and within health care professions about unacceptable behaviour within the healthcare environment [1-6]. As this discussion has progressed, evidence of adverse effects associated with unacceptable behaviour in clinical practice has been emerging. These adverse effects not only impact health professionals, [7-13] but also affect patient care and clinical outcomes [14-19].

A number of Australian and New Zealand specialist colleges and heath care organisations have published statements, action plans and revised guidelines on discrimination, bullying and sexual harassment [20-25], and produced resources to support professionalism and performance [26].

However, it remains clear that there are ongoing problems within health care institutions with unacceptable behaviour, including discrimination, bullying and sexual harassment, as demonstrated by the recent dis-accreditation for training of a number of high-profile intensive care units. It is unlikely that positive change will occur without substantial efforts to overcome the prevailing culturally entrenched behavior patterns [27]. These efforts must acknowledge the wide-spread and insidious nature of the problem (i.e. it is not just certain 'troubled units' or 'troubled individuals' who need to be dealt with) and include systems for non-punitive feedback to individuals about behavioral lapses, and interventions to improve 'psychological safety' and reduce 'systemic disrespect' across organisations.

What is culture, and why does it matter?



Culture can be defined as 'The way we do things around here and why we do them' [27]. A dysfunctional culture with widespread disrespect has been recognised as a major barrier to improving patient safety in health care organisations [28], with the authors describing 6 categories of unacceptable behaviour: disruptive behaviour by individuals; humiliating and demeaning treatment of colleagues including nurses, residents, and students; passive-aggressive behaviour; passive disrespect; dismissive treatment of patients; and systemic disrespect. It is important to note that while the first 5 categories consider disrespect by individuals and groups, the last 'systemic disrespect' category captures disrespect from the organisation or system towards the individuals who work or receive care within it.

In his book 'The No Asshole Rule' (© 2007, Business Plus, New York) Professor of Management Science at Stanford University Bob Sutton describes the costs for individuals and organisation of unacceptable behaviour perpetrated on others by individuals. He notes that unacceptable behaviour is common, with surveys suggesting that it persistently affects up to half of people surveyed in general employment but around 90% of nurses. He points out that although

unacceptable behaviour has a profound negative effect on the individuals who experience the behaviour, it also adversely affects those who witness it. This leads to reductions in individual performance and productivity, and increased staff turnover, with resulting costs to organisations both functionally and financially.

In health care settings, there is evidence that exposure to rudeness impairs diagnostic and procedural performance in clinicians. In a study of 24 neonatal intensive care teams, randomised exposure to rudeness resulted in impaired diagnostic and procedural performance [17]. Another study, of 76 anaesthesia trainees randomly exposed to incivility in 67 simulated crisis encounters [15], assessed a range of technical and non-technical performance domains with raters blinded to intervention. The residents who were exposed to incivility scored lower on every performance metric, with 64% achieving an overall 'pass' grade in the incivility group, versus 91% in the control group. Interestingly, self-reported performance was similar between groups, suggesting a relative lack of awareness of impaired performance under these circumstances.

Unacceptable behaviour in clinicians also has been shown to adversely affect patient outcomes. For example, a study of 13 653 patients who had surgery performed by 202 surgeons showed that patients of surgeons with more unsolicited complaints about unacceptable behaviour from their co-workers had higher rates of both general and surgical complications [18], with adjusted complication rates 12 - 14% higher for patients whose surgeons had behaviour reports compared with patients whose surgeons had no reports. In another study looking at unsolicited patient complaints, patients of surgeons with more reports of unacceptable behaviour also have more complications, with an adjusted rate of complications 14% higher for surgeons in the highest quartile of complaints, compared with the lowest quartile [19].

Learning to see

Before we can address unacceptable behaviour in our organisations, we need to be able to recognise it in ourselves and others, acknowledge it, and acknowledge its adverse effects. However, at present, unacceptable behaviour is so enculturated in health care organisations that 'learning to see' may be difficult. For example, Dr Adrian Anthony, the inaugural chair of the Royal Australasian College of Surgeons Operating with Respect Education Committee, has said:

"If you had asked me before the Expert Advisory Group report came out, I would have said I had never seen or experienced bullying in Surgery….

Then I read the report, and realised that I had seen it every day, but failed to recognise it because it was a normal part of the way we did things……"

Common, enculturated misconceptions about disrespectful behaviour in health care can be seen in our approaches to teaching and learning and building resilience, where, despite beliefs to the contrary, exposure to unacceptable behaviour has been shown to degrade the learning experience [29, 30] and erode resilience, contributing to burnout [9].

What can we do about it?

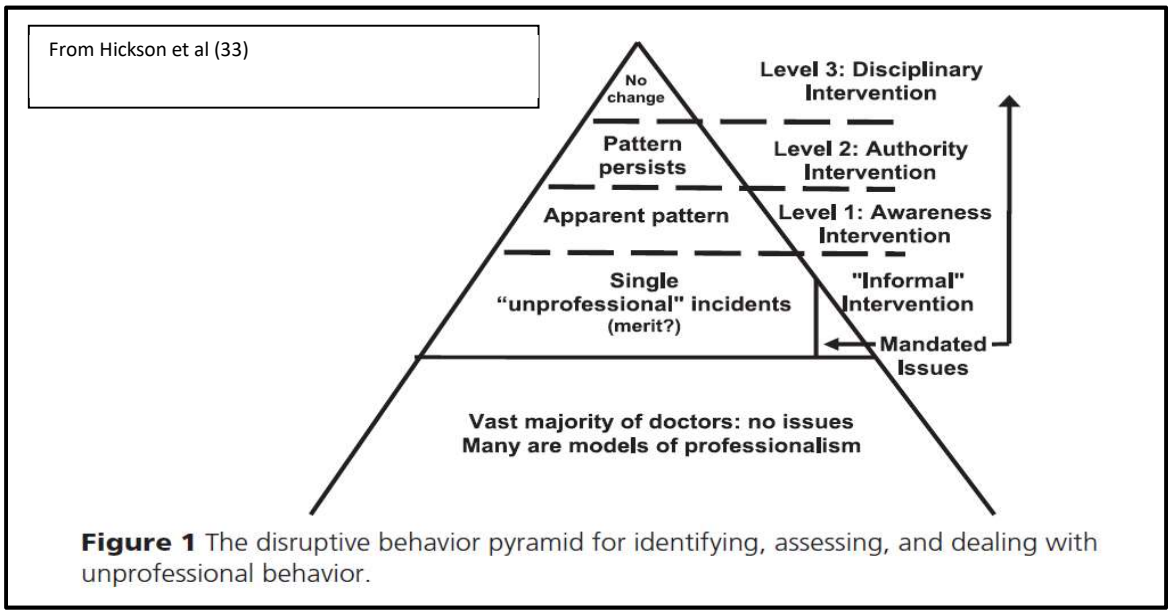


Figure 1 The disruptive behavior pyramid for identifying, assessing, and dealing with unprofessional behavior.

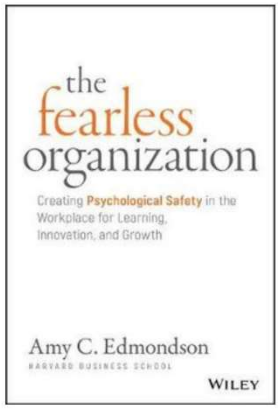
Vanderbilt University School of Medicine (VUSM) has been collecting data and researching interventions to reduce unacceptable behaviour and improve patient safety for almost 30 years. Over that time, they have implemented a number of systems to monitor and address unacceptable clinician behaviour, collecting both unsolicited patient reports, and more recently co-worker reports [31, 32]. They aim to communicate 100% of reports of unacceptable behaviour back to the clinician concerned. Early work investigated the relationship between patient complaints and litigation – unsurprisingly, physicians with more complaints are at higher risk of litigation [33]. Subsequently, they have developed a model for addressing disrespectful behaviour which has four graduated interventions: informal conversations for single incidents; nonpunitive "awareness" interventions when there is a repeated pattern of behaviour; development of action plans if the unacceptable behaviour persists; and a disciplinary process which includes medical and mental health assessments if there is persistent unacceptable behaviour despite an action plan [31, 32]. Skills for informal interventions with colleagues are taught as a routine part of the VUSM curriculum.

Their published data varies from cohort to cohort, and on whether patient reports, co-worker reports or both are considered, but demonstrate that the vast majority of physicians (in the order of 85%) never get a complaint. Around 12% of physicians have an occasional report, and 3% receive multiple reports [34]. Of the clinicians who receive an intervention, 60% will not have another report, up to 20% may leave the organisation, and a small percentage never improve [32, 34].

RACS
LET'S OPERATE WITH RESPECT

The Royal Australasian College of Surgeons "Operating with Respect" eLearning module, face to face workshop, and RACS Speak Up app have been developed using the Vanderbilt concept that low-level interventions are effective in the majority of cases. The resources aim to raise awareness and help clinicians to develop skills in providing informal, peer to peer feedback about behaviour.

Amy Edmondson is the Novartis Professor of Leadership and Management at the Harvard Business School and has spent over 30 years researching psychological safety in organisations. Her new book, “the fearless organization” (© 2018, John Wiley & Sons, Hoboken New Jersey) summarises her work demonstrating that psychologically safe organisations perform better. Keys to psychological safety include: reframing failure, so that it is safe to acknowledge it, with an emphasis on uncertainty and interdependence; and reframing the role of the ‘boss’ as one who sets direction and invites input, with humility and by asking good questions, supported by structures and processes; and responding positively, by expressing appreciation, destigmatising failure and also sanctioning clear violations (which is what the Vanderbilt framework aims to do).



Supporting the importance of psychological safety, a recent study of 137 English National Health Service (NHS) hospital systems for the period 2012–2014 [35], investigated the relationship between mortality rates and levels of openness among staff. Adjusted for hospital operating capacity, a one-point increase in the standardized openness score was associated with a 6.48 percent reduction in hospital mortality rates, suggesting that the ability to speak up freely about things that may negatively affect a patient, and the ability to question those in authority, has important patient safety implications.

Conclusions

There is evidence that enculturated unacceptable behaviour in healthcare results in reduced individual and team cognitive and procedural performance, situation awareness, communication of potential safety issues, teaching and learning effectiveness, and individual and organisational resilience, with increases in adverse surgical outcomes, patient complaints, litigation and risk of clinician burn-out. This not a problem isolated to ‘troubled units’ or ‘troubled individuals’, nor is it a problem entirely due to systemic disrespect of individuals within organisations.

We must address this issue urgently, to stop harming each other and our patients.

So, my challenge to each one of us is:

When will we:

- ‘learn to see’ unacceptable behaviour and actively call it out in ourselves and others
- give others permission to provide feedback about our behaviour
- start managing ourselves to reduce behavioural ‘slips’
- work actively with our health care organisations, to reduce systemic disrespect, improve psychological safety, and systematically manage a graded response to repeated episodes of unacceptable behaviour.

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