

VitalSmarts™ White Paper

Intensive Care for Health Care

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Moving Away From Agonizing Fear and Silence— Stepping Up to Crucial Conversations

Imagine the following scenario: A nurse in a neonatal ICU mixes up the timing of an endocrine stimulant test. The infant isn't harmed, but everyone is concerned. The nurse gets yelled at, disciplined, or even fired. The following week another nurse in that unit fudges her numbers to cover up the same error. Though the error may go unnoticed, the potential risk to the patient has just increased because the nurse felt that the issue was not safe to discuss.

Many hospital employees work in agonizing silence and fear—they see serious problems, but are afraid to speak up because of the culture they've been presented with. Hospitals are full of well-intentioned, big-hearted people who get caught up in complex systems that drive them to abusive, sloppy, wrongheaded, even dangerous, acts. Luckily, hospitals have so many layers of protection between any single act and actual harm to a patient that relatively few bad outcomes occur—but those that do can be devastating.

Because the patient is rarely harmed, most errors and inappropriate actions go unanalyzed. Studies show that fewer than 5 percent of known hospital errors are even reported, much less resolved.

Let's go back to our opening scenario. Imagine that when the nurse's mistake is discovered, the team discusses their concerns openly. As they discuss the mistake they realize that part of the problem is that each endocrinologist uses a unique testing protocol. The team gets together with an endocrinologist and neonatologist and they develop standards for the most common protocols. The open discussion has made it much less likely that the error will occur again, and it has helped to foster a culture where problems can be safely brought up and solved before tragedy strikes.

Disturbing Statistics

VitalSmarts has completed an initial survey of ninety-four health care employees together with a series of twenty focus groups, twenty individual interviews, and sixteen hours of observations at five hospitals, and can report the following preliminary findings about the culture surrounding the all-too-critical issue of communication:

- More than 40 percent of a sample of ninety-one nurses have held in a concern about a physician for three months or longer—letting it fester and build, rather than confronting it.
- More than 40 percent of these same nurses describe their concern as serious enough that they would take special precautions if a family member were admitted to the unit involved.
- More than 50 percent of these nurses have held in a concern about another nurse on their team for three months or longer—again letting it fester and build.
- Nearly 70 percent of these nurses describe the problem as serious enough that they are considering leaving their job over it.

Simply put, there are some very crucial conversations that are not being held well, or not being held at all, within many health care organizations. These numbers are disturbing in light of the fact that these are the very establishments in whose hands we place our lives and the lives of our loved ones.

What happens to good people along the road to delivering world-class and humane health services? How do so many get sidetracked into horrific working conditions, preventable errors, and unhealthy relationships? That's what we at VitalSmarts wanted to know. To discover the underlying cause behind all this turmoil, we entered a variety of health care systems and conducted dozens of focus-group discussion and one-on-one interviews. We also watched people at work—for hundreds of hours. And sure enough, we learned that people were hard working, dedicated, and well trained. No surprise there. But the circumstances, the systems, and the human dynamics tended to push people away from healthy collaboration and trust and toward something far less helpful. The culture itself fights against the kind of collaboration and respect required to deliver good health care.

Here are the three chief culprits.

- The Trust Dynamic
- Social Retaliation
- The Culture of Individual Heroics

This paper will describe these three factors, give examples of the challenges they create within a hospital, and identify the kinds of one-on-one discussions (crucial conversations) that must succeed if these dynamics are to turn positive.

The Trust Dynamic

This first dynamic is one that can easily draw good people into bad cycles of behavior. It begins with a reasonable question about trust, but often ends in resentment, accusations, and abuse. We'll take a tour through this cycle to see how it operates, and then explore how to turn it from negative to positive.

When physicians walk into a unit they look around for familiar faces. If they don't seem someone they know, they begin to wonder who they can trust. It turns out that just wearing a nurse's uniform isn't enough to earn that trust. The physicians we interviewed said they first thing they did was assess the staff's capability. Below are some of the conditions under which they ask themselves "Can I trust them to do what's required?"

- The physician doesn't have patients in the unit very often, so hasn't had an opportunity to get to know the nurses.
- The unit is large, so there are many nurses the physician hasn't worked with before.
- The unit has had a lot of turnover, so many of the nurses are new.
- The nurses rotate across shifts, so the physician hasn't gotten to know many of them.
- The nurses seem young or inexperienced.
- The patient is especially ill and requires a special level of care.
- The physician provides care that is especially advanced relative to what the nurses ordinarily provide.

When these factors come into play it's only reasonable for a physician to think twice about how much trust to place in the nursing staff. If the physician isn't sure about the staff, he or she can't pretend to trust them, because the stakes for the patient are too high.

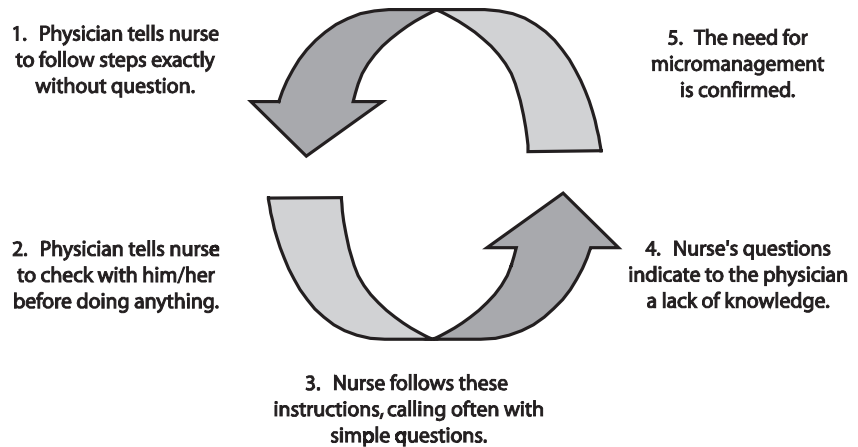
Micromanagement

If the physician decides that the nurse is missing basic skills, has a poor work ethic, or isn't interested, then he or she begins to micromanage the situation. The physician gives very exact instructions, demands that these instructions be followed to the letter, and orders that all changes be approved in advance. This micromanagement is very one-way, with little chance for the nurse to have input.

Micromanagement is sometimes appropriate. For instance, nurses who work with patients undergoing bone marrow transplants often praise the physicians who understand their need for detailed guidance. However, micromanagement is in the eye of the beholder. Nurses who believe the physician has accurately understood their knowledge, skill, and motivation feel supported. Nurses who believe the physician has underestimated them feel devalued, disrespected, or wronged.

Unfortunately, nurses often feel underestimated by physicians. The physician's use of micromanagement then begins a negative cycle that can lead to abusive and intimidating behavior.

Micromanagement Cycle

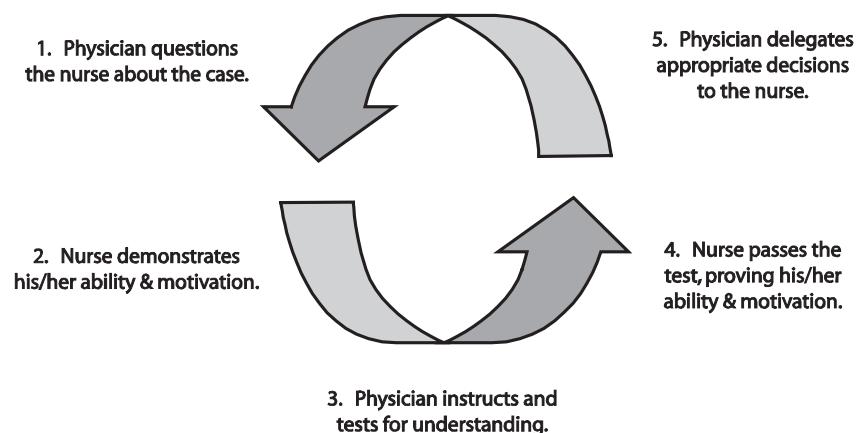


At the end of the day, the nurse believes the physician is a jerk and the physician believes the nurse is an idiot.

Teaching Cycle

A more positive cycle begins when the focus is teaching, testing, and coaching.

If the physician's initial assessment is that the nurse is able and interested in learning, then he or she may invest a bit of time in teaching and coaching. Investing in a teaching moment begins a positive cycle that can build understanding and trust.



At the end of the day, the nurse and the physician respect and support each other.

Moving from Micromanagement to Teaching

Micromanagement is overused by physicians and by nursing managers in many hospitals and within many units. Once the cycle begins it often spirals into ill will, intimidation, and abuse. The remedy is to find ways for people to recognize when they are in the cycle, step out of it, and hold the conversations that will ensure the appropriate level of management and instruction. These crucial conversations include:

1. Telling a physician that you're more skilled or more motivated than he or she realizes
2. Talking to a physician about gaining more autonomy when it is appropriate
3. Asking a physician to give you more guidance when you need it
4. Asking a physician to explain or coach you through an issue—when the time is right

This cycle of micromanagement, intimidation, and abuse is driven by an inaccurate (or at least controversial) assessment of a nurse's ability and motivation. If physicians and nurses can learn to talk about this assessment and discuss any disagreements they have about it, they can turn the cycle from negative to positive.

Social Retaliation

Successful health care is a team sport. Patient safety and well-being require the coordinated actions of a cohesive team of diverse professionals. No one person knows enough or has enough time and energy to provide adequate care. Unfortunately, many teams within hospital units splinter into factions and cliques that argue over petty issues and play out forms of aggression that sound more typical of a junior high school than a hospital.

This kind of frustration is rampant within hospitals. In interviews, people complain about a team member not sitting with them at lunch, a team member criticizing another's clothing, a team member spreading rumors about them, etc.

At first these complaints sounded trivial, but people were serious. They cried as they described how their teammates made them feel, and many gave examples of skilled team members who had quit their jobs over these kinds of slights. In VitalSmarts' preliminary survey, the most common complaint was, "A team member who talks behind people's backs, gives people the cold shoulder, or is mean to other team members." Nearly 70 percent of these same nurses indicated that this problem was serious enough that they were considering leaving their jobs over it.

What is it about a hospital that elevates social retaliation and backbiting to such a level? A major factor is the work environment itself. Hospitals require a greater level of social interaction than almost any other workplace. Nurses and other staff members are together continuously, discussing treatments, sharing information, and making requests of one another. In addition, most staff members work twelve-hour shifts and share emotionally intense experiences. It is only natural that the unit becomes a social place as well as a workplace. Social exchanges are real and important within hospital teams.

At the same time hospital teams include a brutally rigid hierarchy that puts RNs, LPNs, Scrub Techs, Nursing Assistants, Unit Secretaries and others into a clear ranking. For the most part this ranking reflects differences in education, authority, and pay. However, it is often reinforced by differences in sex, race, age, country of origin, and class. In addition, the hierarchy's whole purpose is to drive differences in tasks, and these tasks range in prestige from emptying bedpans to saving lives.

This hierarchy also has a huge impact on the social network within most units. It is difficult for team members to act as social equals when they are so unequal within the pay and skill scheme. As a result, friendships and other social relationships are often strained or artificial. Teammates often worry that requests they make when they are performing their jobs will be interpreted as inappropriate social requests or favors. For example, a nurse might ask a tech to empty a bedpan or clean a room. This is a very legitimate request for a nurse to make of a tech. But it's not a legitimate request to make of a friend.

This blending of favors, requests, orders, and demands creates a minefield within many units and the explosions take the form of social retaliation. Friendship and accountability must be reconciled in order for teams to be effective. Team members need to be able to hold each other accountable without the fear of social retaliation.

Moving from Backbiting Cliques to Team Accountability

Most of these team issues can only be solved by the team members themselves. They can't be solved by a team's manager. Imagine a manager trying to tell an employee that he or she needs to sit with the others at lunch or stop giving another employee "the eye." Social retaliation is fairly impossible to document and is often seen as outside of a manager's range of authority. Yet social retaliation has a huge impact on how team members perform their jobs and hold each other accountable.

In order to deal with this important factor, team members need to be able to hold the following crucial conversations with each other:

1. Holding a teammate accountable (without worrying about whether he or she will treat you differently as a result).
2. Making requests of teammates (without worrying about whether they will treat you differently as a result).
3. Confronting a teammate who is gossiping, spreading rumors, or talking behind someone's back.
4. Confronting a teammate who is using the "silent treatment" or giving someone the "cold shoulder."

Team members need to be able to hold each other accountable regardless of their position on the team to avoid the kinds of behaviors that can be so destructive within a health care team.

The Culture of Individual Heroics

Mistrust and retaliation both thrive in a culture of individual heroics. The health care industry values autonomy of action and individual accountability. When lives are at stake, people aren't willing to turn over anything to anyone who they think may put the patient at risk. This saddles individuals (usually physicians) with wildly unrealistic expectations. It demands that they act as heroes or reveal themselves as villains.

Here's how this works. When physicians graduate from medical school they might as well be given capes, like superheroes—but capes with targets on them. Society, including its legal and insurance structures, treats physicians as if they were all-knowing, all-powerful, and all-to-blame. Many physicians worry every day whether an innocent slip or mistake will knock them off their perch of success, sending them into a downward spiral of malpractice, fraud, and bankruptcy.

In reality, health care has become too complex for any one individual to be endowed with so much credit and so much blame. And yet physicians do hold a unique position. Their training is extensive and exceptional. It is not uncommon for them to be the only people in a room full of professionals who truly understand the disease, the set of options, or the course of treatment. In these cases they really are on their own. Other times they are the only people who can judge whether a treatment has been successful. Again, they are on their own.

But they can't be everywhere all the time. So physicians have to find ways to extend their reach. They have to find ways to bring benefits and provide better care to more patients. Extending their reach means involving more people, more technology, and better organization. They can't treat their patients and then stay with them around the clock until they're fully recovered. They need to be able to rely on nurses and other staff members, but the culture of individual heroics makes that difficult.

Doctors may want to delegate to others on the staff, but who will the lawyers go after if a nurse makes a mistake? The law views the physician as the Lone Ranger, and to quote a physician from one of our interviews, "Everybody knows that you don't sue Tonto!" Society holds doctors accountable for many outcomes that are well beyond their control.

This culture creates a number of challenges:

Cut-off from data. Physicians may be more talented, or believe they are more talented, than the people around them. They aren't just the Lone Ranger. They're the Lone Ranger with a dozen or so years of schooling. After years of being the most educated person in the room, they may stop listening to the people around them. However, the people around them often have additional information. For example, a nurse may have observed a patient all day long and as a result knows many things the physician can't know—regardless of the doctor's talent.

Unwilling to make improvements. Physicians may believe they are so much more talented than the people around them that they can't allow others to constrain their

decision making in any way. They and they alone have to decide what to do and then do it. The risk is that the physician will resist evidence-based improvements because they call for standardization and control. The physician may feel that these changes will cut him or her off from options that allow for idiosyncratic, in-the-moment choices that save lives.

Isolationist attitude. Physicians may come to see themselves as the patient's only advocate, and adopt a "me against the world" attitude. They may think they need to protect the patient from an incompetent staff and uncaring administration. In truth, the physician may be the patient's strongest advocate and certainly the advocate with the greatest legal liability, but viewing the hospital staff and administration as villains will undercut the physician's ability to collaborate and help the patient or improve the hospital.

Excessive self-sacrifice. Physicians and others may buy into a culture of self-sacrifice in which individuals are supposed to work themselves beyond exhaustion instead of building in reasonable handoffs among team members. While it is true that handoffs can be dangerous, especially in the middle of a surgery, the culture of heroics takes this reality and pushes it to a dangerous, sleep-deprived extreme.

Unrealistic expectations. Heroes are not allowed to make mistakes. Mistakes are taken as signs of personal and professional failure that deserve punishment. While accountability is important, it is also important to analyze mistakes to look for root causes. Too often in health care the person who makes the mistake is punished, but the conditions that made it possible for the person to make the mistake are never fully understood. When this happens, nurses and doctors spend all of their time dealing with emergencies instead of preventing them.

Cover up. Because mistakes are punished, people become reluctant to admit them. Talking about medical errors may become taboo, making it almost impossible to identify the root causes of the errors.

Simplistic dichotomy. People are seen as heroes or villains instead of as ordinary people with a range of talents. Since villains are seen as unworthy and beyond redemption, there is no incentive to invest in them. Heroes, of course don't need to improve. Since people won't be changing, the way to improve a team is to search out the weakest links and fire them instead of investing in training and development.

Moving to a Culture that Values Teams

Hospitals need to help physicians extend their reach so that they can serve more patients more successfully. Central to this effort will be moving to a culture that values teams and organizational systems as well as individuals. People need to be able to admit that they are not superhuman heroes—that they have to sleep and eat, that they aren't all-knowing, and that they sometimes make mistakes. They have to feel safe that if they admit they aren't heroes they won't be cast out as villains. When things go wrong, health care professionals also have to be able to take their focus off the last person to touch the patient (often the

doctor) and to examine the organizational forces that drove the person to take whatever action he or she took.

Below is a list of crucial conversations that must be mastered as a hospital moves to a more well-rounded culture. Are people comfortable and capable of holding the following high-stakes discussions?

1. Questioning an action or decision that you don't understand or that you disagree with.
2. Discussing a mistake or near-mistake you've made without worrying that you'll be punished.
3. Discussing mistakes you've seen others make without putting yourself or the other person into jeopardy.
4. Challenging practices and actions you disagree with.
5. Asking questions, getting information, or seeking coaching when you need to.
6. Admitting when you're not at your best, and questioning others when they are not at their best.
7. Working with others to create standards or protocols that everyone will follow.
8. Challenging those who violate standards or protocols.
9. Working together to analyze errors and near errors and in developing practices to prevent recurrences.

It is difficult or even impossible to have these crucial conversations in a hospital or unit that still lives in the culture of heroics. These questions would be seen as inappropriate or threatening, or as admissions of incompetence, and would be worthy of punishment. As a hospital moves to a culture of safety—where people use errors as opportunities to improve the system—these questions become an accepted and unremarkable part of the work environment.

Summary

VitalSmarts has identified three dynamics that underlie many of the problems hospital employees cite in interviews, focus groups, and surveys. The Trust Dynamic shows how well-intentioned people can get trapped within a cycle that leads to disrespect and abuse. The positive teaching cycle shows how many avoid this trap—and points the way toward eliminating much of the abuse.

The Social Retaliation Dynamic is an area that has been largely ignored and where dramatic improvements can be made. Showing team members how to resolve these nagging bouts of social retaliation will improve team performance and accountability in critical ways.

Both of these dynamics flourish within a Culture of Heroics that puts too much responsibility on individuals and too little emphasis on improving teams and organizations. Mistakes are seen as individual failures, and are either covered up or punished. Individuals see few reasons to work as a team because successes and failures are attributed to the individual, not the team. Equally dangerous is that since individuals carry the burden of responsibility, casual analyses typically examine individuals rather than systems.

Changing these dynamics will not be easy because each is complex and the result of several underlying forces. However, it is clear that these dynamics can be tracked by measuring the success of a relatively few crucial conversations. Hospitals that make these conversations possible, successful, and eventually easy, will be a long way along the path to safe and effective health care.