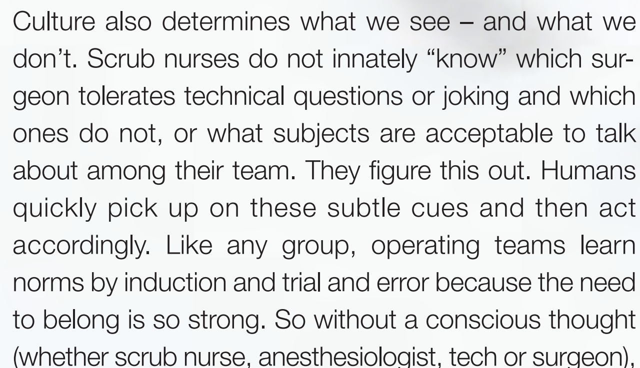
Breaking Free From Our Cultural Chains

By Kathleen Bartholomew, RN, RC, MN

Human beings rarely, if ever, succeed at accurately perceiving their own culture.

So deeply entrenched is culture that no one talks about it: the unspoken rules and behaviors (called norms) are never written down, and yet everyone knows them. We learn these norms the hard way through the process of assimilation into a culture. For example, when Shelli was a new scrub nurse with only six months' experience, she failed to anticipate that the surgeon would need a particular scalpel. Immediately, her experienced preceptor deftly handed the correct blade to the impatient surgeon with a glare in Shelli's direction. At that moment, Shelli learned that if she was not on top of the surgeon's needs, she would end up feeling embarrassed and looking incompetent. Shelli did not find this information in her orientation manual.



Culture also determines what we see – and what we don't. Scrub nurses do not innately "know" which surgeon tolerates technical questions or joking and which ones do not, or what subjects are acceptable to talk about among their team. They figure this out. Humans quickly pick up on these subtle cues and then act accordingly. Like any group, operating teams learn norms by induction and trial and error because the need to belong is so strong. So without a conscious thought (whether scrub nurse, anesthesiologist, tech or surgeon),

we mimic the behaviors of those around us in order to be accepted. After a while, no one even notices the subtle, unspoken rules. And why would they? Everyone exhibits the same behaviors. The norms are now downloaded into our subconscious mind.

Culture even determines our perception of the scrub nurses' work – much of which goes unnoticed. In a review of 13 papers looking at scrub nurse skills, there were no behaviors that could be classified as leadership or decision-making.[1] The vast amount of problem-solving, anticipation and critical decision-making that scrub nurses demonstrate constantly during surgery is invisible.

In addition to operating room norms, each subgroup has its own specific norms as well. For example, residents learn quickly that asking questions is a sign of vulnerability and weakness; and to protect each other no matter what.[2] Scrub nurses learn to assess situations without interrupting, and they read surgeons' demeanor to sense the appropriate time to ask a question. This is known as "prudent silence."[3] Some group norms have to do with errors, i.e., "Don't ever speak about a sentinel event outside these walls." And for those who break these unspoken rules, there are serious repercussions – the worst of which is being ostracized from the group. There is nothing more painful for any human being, no matter the role or education level.

Group Think

When individuals merge and form a group there are always things they can do, things they must do and things they can never do. For example, healthcare workers do not typically share their feelings in high-tech, high-pressure environments because feelings are perceived by the general culture to be "soft stuff." Ironically, this belief couldn't be further from the truth. Feelings not only matter, but are conveyed unconsciously, because 93 percent of all communication is non-verbal. If you think someone doesn't like you, they probably don't. In a study of collaboration among residents, nurses and physicians, the single most important factor in producing positive collaborative outcomes turned out to be affect. Our bodies consistently express what we feel.[4]

Another overarching cultural imperative holds that in a dangerous environment, the group must stay together in order to stay safe. In one case, a surgeon accidentally began incising the wrong breast for a mastectomy procedure. The incision was only an inch long when the circulator screamed and the physician stopped, acknowledged the mistake, and sewed up the cut. After the operation, the surgeon called his team together in the room and said: "I need to know that you are with me on this one. There is absolutely nothing to be gained by telling this patient what happened. I'm asking for your support to tell her that the incision on her left breast was exploratory."

This misuse of power tells us more about the culture this physician is 'leading' than any statistic ever could; and his use of coercion raises the impetus to be safe to a higher status than even ethics.

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It could be the difference between life and death.

Wrong site surgery has recently moved into the number one position as the most frequently reported hospital error.[1] This is despite a conscientious effort to eliminate this problem before it occurs. What is needed is another layer of safety...something that will improve our chances of correcting the mistake before it happens.

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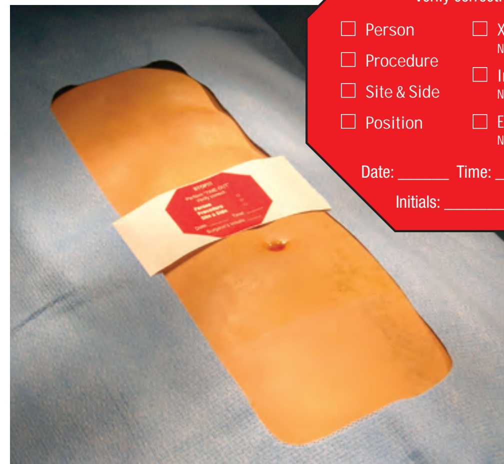

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In the operating room, each player has a specific role: surgeon, scrub nurse, circulator, perfusion specialist, etc. Each role also comes with a set of expectations for behavior. On top of this, every operating room has its own unique culture. For example, scrub nurses in the United Kingdom perceived their main responsibility was to not upset the surgeon and to keep the surgeon happy.[1]

Ignorance Squared

Educators often state that the worst knowledge deficit is when "You don't know what you don't know." So if we are so deeply entrenched that we can't perceive our own culture, then how do we rationally and logically assess whether our operating room is, for example, a just culture or a blame culture? A collegial interactive team or just a group of people working in the same place at the same time? We learn about the culture by listening to their stories.

The Play of "Human Error"

The drama in our worlds will tell us more about our culture than anything else because it is riddled with feelings: anger, shame, embarrassment, hurt and grief. These are powerful emotions felt at one time or another by every member of the team simply because we are human beings working in a complex, high-stress environment with the same people every day. When humans work that closely and frequently, their relationships become the dominant value. Dana Jack calls this "self silencing."[5] Healthcare workers silence themselves because they value the relationship with their coworkers more than anything (even the patient) and fear reprisal. On a very primal level we are keenly aware that our survival depends on the group's survival. A deeply worrisome example of this comes from a new study where 80 percent of nurses demonstrated knowledge of best practice for oxytocin administration during delivery, yet only 22.5 percent would actually implement the appropriate clinical action if the physician asked them to increase the dose.[6] There is nothing stronger than culture – not even education. Not upsetting the physician even trumps best practice.

Groups quickly learn not to speak up about certain issues. One OR team feared they would be diminished in the eyes of their peers when a sentinel event was made public, missing entirely the opportunity to use their experience for teaching, improving the system and building a healthy culture around mistakes. Unknowingly, our well-intentioned but predictable responses perpetuate the predominant culture. Humans under stress will consistently default to previously learned behaviors and responses.

The Behaviors We Can Expect

- **Human error** - inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake. CONSOLE
- **At-risk behavior** – behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified. COACH
- **Reckless behavior** - behavioral choice to consciously disregard a substantial and unjustifiable risk. PUNISH

Standing up to the predominant culture is a monumental task. This quest is better undertaken as a team because of the critical amount of support that is needed in any organization to produce adaptive change. For example, at Cincinnati Children's Hospital, every employee computer when turned on displays an icon labeled "Patient Safety Tracker" in the upper right hand corner stating how long it has been since harm has come to a child in their care. If an event occurs, you can then click on another box for details of the event, which are general knowledge. The result: no one loses focus. This admirable demonstration of transparency takes phenomenal leadership and support from the bedside to the boardroom.

In the healthcare culture, however, transparency and open dialogue are the exception rather than the rule. Instead of these healthy behaviors, several other survival behaviors have been observed. Sometimes leaders inadvertently

> *"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes."*
>
> – Dr. Lucian Leape

divert their group's attention away from the real issue because it is too volatile, painful, or simply, unpredictable. In this way, the group is once again united – although dysfunctionally. In one emergency room, for example, staff were furious with the ICU and would complain incessantly about how poorly they were treated by this department. As Dr. Phil would say, "What's this doing for you?" In this case, as in many others, having a common enemy united the group. Another behavior that fuels an unhealthy culture occurs when groups or individuals are at odds with each other. They never sit down at the same table face-to-face. If they did, then the rumors and gossip might end the saga that sustains them. The sad reality is that well-intentioned people are unaware of the strong emotional maneuvers designed at a very primal level to simply keep the group safe.

Emotions and the Blame Culture

Emotional drama is more prevalent in a blame culture than a just culture because the ethos of a just culture re-focuses on the event as an opportunity to learn and share. When an event is submerged, defensive emotions will emerge larger than life every time. Another indication of a blame culture is secrecy. Members of the team being kept in the dark about a serious incident is another indication of a blame culture.

In a healthy safety culture every surgeon, tech, scrub and circulator would know about an error or near-miss as soon as possible in order to produce a heightened sense of awareness and to decrease the chances of the same error occurring again. Clearly, these events are complicated, and it often takes time to gather information. But information is shared as it is gathered with the whole team. Unbelievable as it seems, this is just not happening at most healthcare facilities, and our well-respected leaders fail to see their own behavior. For example, one day a surgeon shared the details of a disturbing sentinel event that happened to him just a few days earlier. Yet his colleague sat next to him oblivious and uninterested in his dilemma because, after all, it didn't happen to him – even though they worked in the same OR!

The Second Victim

In every sentinel event, there is more than one victim. The first is the patient – harm or vulnerability to harm is tangible, perceived and acknowledged. The victim's emotional state is tended to very carefully. We invest a great deal of time and emotional energy in understanding the impact of the error on the individual and their family. Forms are filled out documenting the error and we work diligently through root cause analysis to change our system and processes so that the

> *What we know changes what we see.*
> *What we see changes what we know."*
>
> – Piaget

event never has the opportunity to occur again. But there are other victims as well whose pain is not so visible.

In the healthcare culture, we seldom speak about the second victim – the scrub, tech or surgeon who assumes whether rightly or not, that they could have anticipated or prevented the event; who beat themselves up and privately grieve their role in the play of "Human Error." The impact of mistakes on clinicians is devastating. Any healthcare worker will confirm the difficult process of forgiving themselves – especially if the event results in harm or death. Unfortunately, the current system frequently does not provide the consolation and solace they so desperately need.

Blame vs. Just Culture

There is a movement in the healthcare industry to shift from a blame culture toward a just culture. This call to action is being heralded by concerned patient safety advocates. A blame culture is characterized by secrecy, overt or covert punishment for mistakes, ostracism and strong emotional responses such as blaming and shaming. Individuals are often targeted (named) and the focus is "who did what?" rather than on system issues. This is "the way we've always done it." A just culture is characterized by open dialogue surrounding errors, inclusion of all involved, a clear understanding of whether the error was human error, at-risk or reckless behavior and appropriate management response[7] as well as a focus on processes, learning and sharing.

Research shows that the hospital culture in and of itself is a good indicator of whether a just or blame culture prevails. Some hospitals have a command and control-based philosophy, whereas others are engaged in a commitment-driven philosophy. A consistent pattern emerged from the research: a blame culture is more likely to occur in hierarchical organizations, and a just culture is more likely to occur in institutions that actively engage employees in the decision-making process.[8] In other words, the greater the number of hoops you have to jump through to get what you need to do your job, the greater the hierarchy and the greater the tendency toward a blame culture. Successful patient safety programs are not top-down driven initiatives. They are a core value.

Conclusion

In 1999 Dr. Lucian Leape, a professor at the Harvard School of Public Health, briefed a congressional sub-committee on the state of human error management in health care. Sadly, the statistics from a decade ago have not changed. An estimated one million people are injured by treatment errors at hospitals every year, resulting in an estimated 120,000 deaths. But because of the punitive healthcare culture, Leape revealed that only two to three percent of major errors are actually reported through incident reporting systems, mostly because "workers often report only what they cannot conceal."[9] Research specific to the operating room found that OR/PACU staff reported more frequent witnessing of unsafe patient care.[10] Our stories tell us that in the healthcare culture we value the safety of our group more than the patient, ethics or even best practice. How can this change?

A culture does not change overnight. Nor will any culture sharply change direction as a group. Imagine an army of 12

million healthcare workers marching shoulder-to-shoulder in one direction. It's dangerous for a single individual to fall out of step. If we could only visualize the thousands of wounded and deceased in one place, then the entire army would immediately about-face. But we can't. And we don't.

People die and are harmed from healthcare-related errors one-by-one; and they will only be saved one-by one as each individual's awareness rises above the group, and we consciously and courageously decide to break the cultural chains that bind us to our old familiar ways.

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About the author

Kathleen Bartholomew, RN, RC, MN, has been a national speaker for the nursing profession for the past seven years. Her background in sociology laid the foundation for correctly identifying the norms particular to health care – specifically physician and nurse relationships. For her master's thesis, she authored Speak Your Truth: Proven Stategies for Effective Nurse-Physician Communication, which is the only book to date that addresses physician-nurse communication. She also wrote Stressed Out About Communication, a book designed for new nurses. Save 20 percent by using source code MB84712A at www.HCMarketplace.com or call customer service at (800) 650-6787. To increase performance with High Reliability Organization methods, Kathleen has now partnered with ConvergentHRS.

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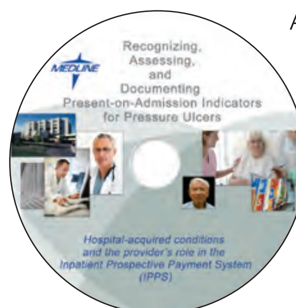

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