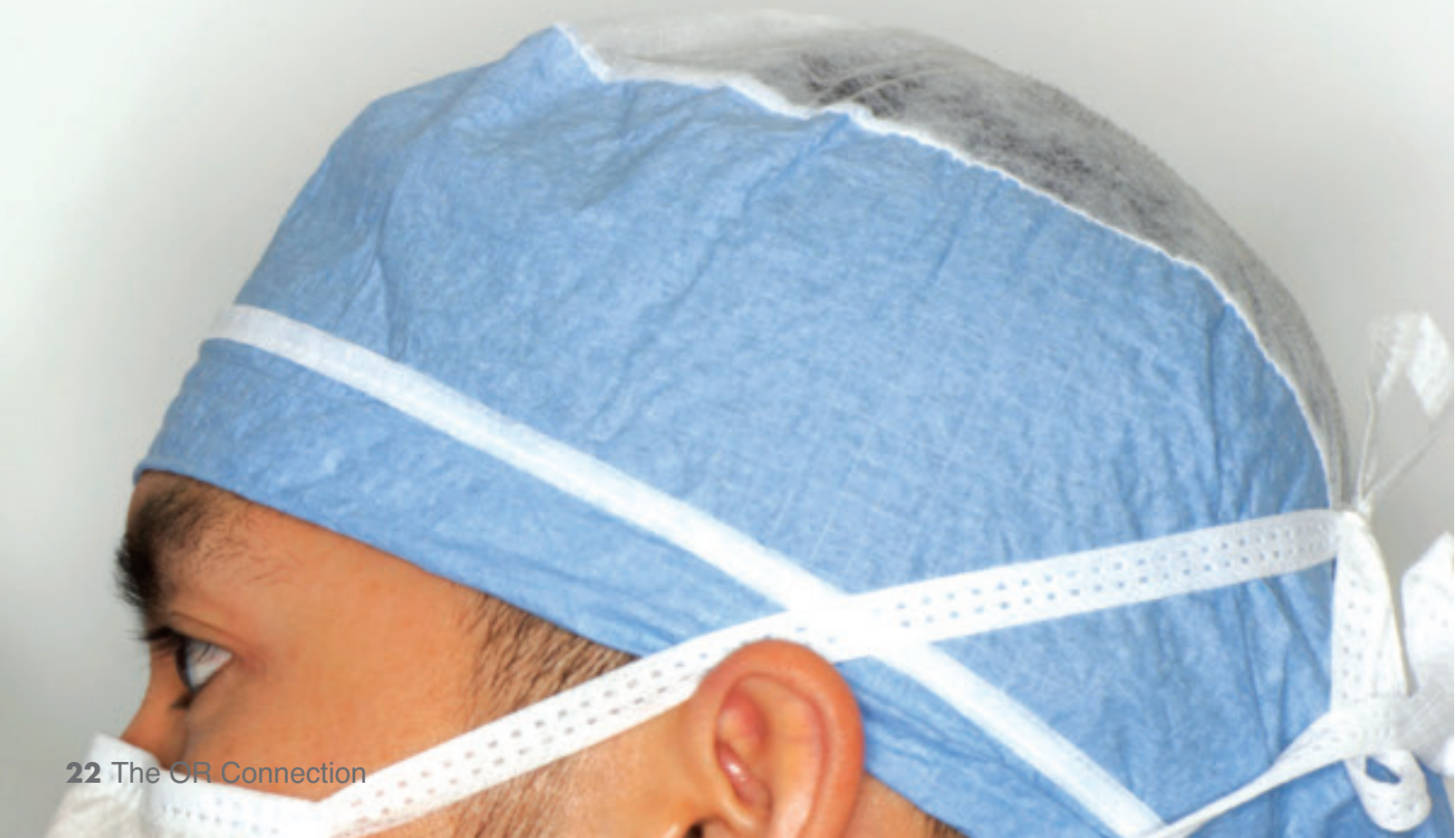
THE SILENT TREATMENT



by Kathleen Bartholomew, RN, RC, MN
and John J. Nance, JD

Recently, a highly accomplished orthopedic surgeon was scheduled to work on three consecutive cases with his OR team. The operating rooms were state of the art within the medical center's newly constructed orthopedic hospital, which had not yet celebrated its first birthday. A system of time outs including use of the World Health Organization (WHO) surgical checklist had been in place at the medical center for almost three years now, with multiple checklists for patient identification, pre-op procedures and instrumentation.

The surgeon was scrubbing in for his second case when the charge nurse approached him from behind and quietly said, "Doctor, I have something to tell you. The instruments that you used for the first case were not sterilized." With the second patient already under anesthesia, there was no time for the surgeon to discuss the small bombshell that had just been lobbed in his direction, but his thoughts couldn't let it go: "Where's the checklist for when things go wrong?" he thought sarcastically to himself, having seen system error after system error despite the apparent adaptation of techniques used by high reliability organizations. Sharply, he gave an order for Gentamycin for his first patient and turned his attention, as best he could, to his next case. He dreaded the moment when he would have to tell his patient – a man who trusted him implicitly for a second knee replacement. But things just got worse.

His second case was a lawyer who had a long history of surgeries due to rheumatoid arthritis. The physician had literally spent hours selecting the best implants for this complicated revision, talking to vendors at great length to ensure the compatibility of the various systems and carefully relaying his recommendations to the patient, who was extremely involved after five surgeries.

Three powerful forces impede communication in health care: time pressures, knowledge and culture.

"Socket," he said at the appropriate moment with hand extended, eyes still fixated on the open wound.

"Socket," he said again, irritated after nothing had landed in his hand.

From his peripheral vision he picked up on commotion. He turned and looked up at the circulating nurse who quietly said, "It's not here doctor." Fully focused on getting the piece he needed STAT, the surgeon immediately got on the phone to the vendor, trying to negotiate the use of another implant despite his careful planning.

"She's under a spinal … it will be wearing off. I can't wait that long – why isn't it here?" he said loudly over the phone. Finally, after half an hour, the vendor arrived with the implant. Both relieved and frustrated, the surgeon closed and turned to his third case, which was uneventful – and painfully, as silent as the second case. In fact, despite the two major mistakes of the day, not a single person in the operating room had mentioned either event.

"The saddest thing was that no one said a word," the surgeon said soberly. "I work with these people all the time and you think someone could have at least said, 'I'm sorry that happened,' or something like that. But instead, there was nothing but this awkward silence. More than anything, I'm still bothered by the silence."

As well he should have been.

As noted communication expert Susan Scott says, "The conversation isn't about the relationship. It is the relationship."[1] This orthopedic surgeon is an outstanding physician, known and respected for his skill and compassion – the only surgeon who would actually drive to a patient's house. Yet, he could not communicate his disappointment to his team – and his team refused to reach out to him; or vocalize any concerted team effort to make sure these errors would never happen again. Despite the very best of intentions and the adoption of standardized checklists and procedures, this team has a long way to go. The level of trust and feelings of personal safety in the group simply aren't high enough for anyone to risk being vulnerable and actually address a painful truth – that as a team they had systemically screwed up.

Worse, violating every premise of regarding mistakes as important messages from the underlying system, they were willing to squander and discard the obvious opportunity to improve their own techniques, not to mention the opportunity to share what had happened (and how to fix it) with other surgical teams. Patient safety can only be enhanced when bad experiences are shared, probed, understood, and procedures changed. In fact, collegial interactive teams – groups of professionals dedicated to a common goal and willing to care about each other and trust each other enough to honestly report and evaluate any failure – never hesitate to put a failure on the table for discussion. And never – never – does an effective collegial team care so little for their own that they permit silence to shroud the human pathways of interaction between them.[2]

Three powerful forces impede communication in health care: time pressures, knowledge and culture. Understanding their impact is the first step to creating collegial and effective teams in which relationships go deeper than the mask of composure. Honest and meaningful relationships can only happen if we are free to speak our truth at all times.

Culture – the undertow of health care

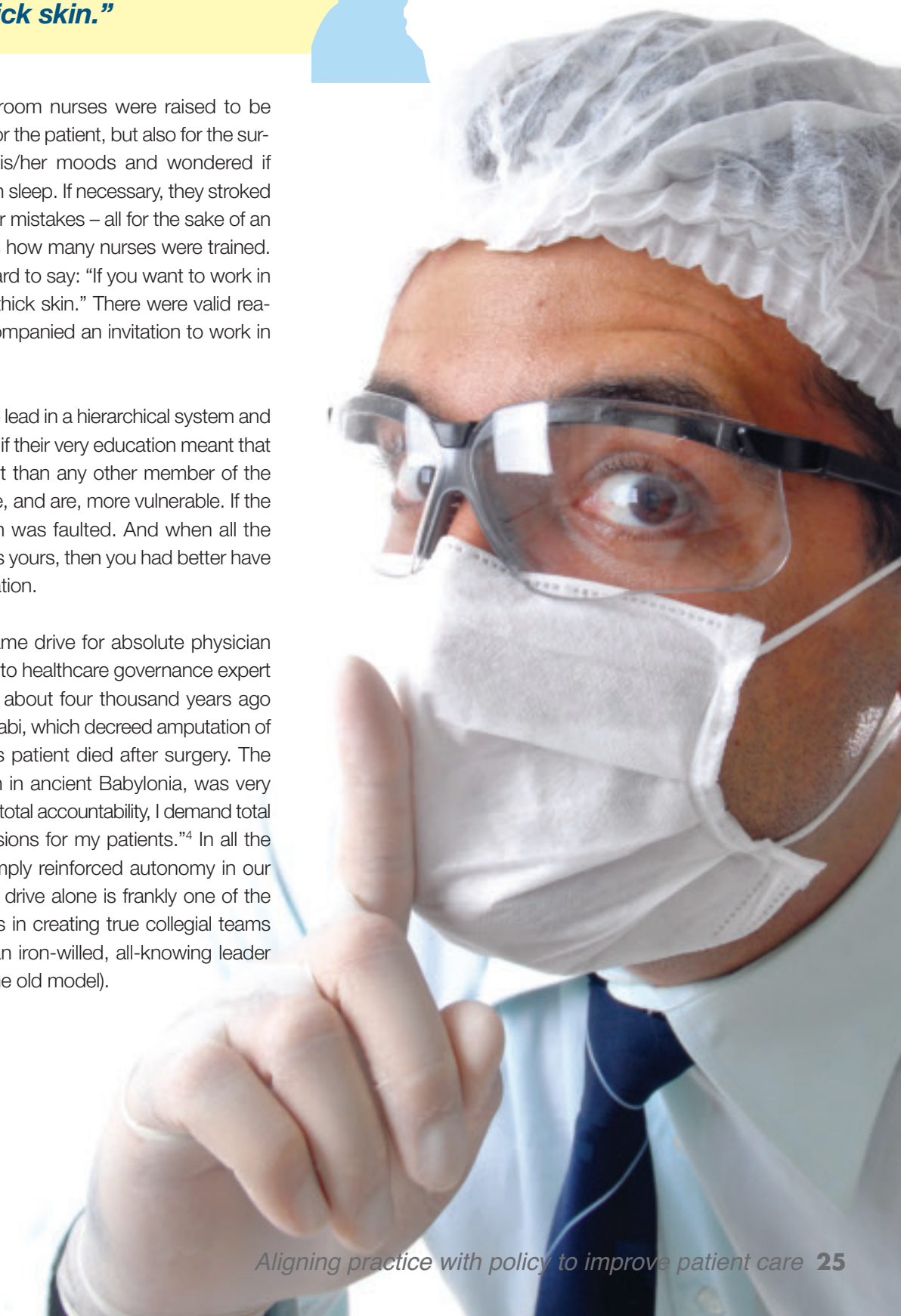
There is no force more powerful in an organization than culture. As all business experts counsel: "Culture kills the best of strategies." In fact, the phrase and the concept of "This is the way we've always done it!" is the mindless battle cry of culture-resisting change. Culture is never written down or spoken – but known by everyone.

Instructors were often heard to say, "If you want to work in the OR, you better have thick skin."

For decades, operating room nurses were raised to be humble; to care not only for the patient, but also for the surgeon. They monitored his/her moods and wondered if he/she had gotten enough sleep. If necessary, they stroked egos or took the blame for mistakes – all for the sake of an uneventful surgery. This is how many nurses were trained. Instructors were often heard to say: "If you want to work in the OR, you better have thick skin." There were valid reasons why a warning accompanied an invitation to work in the OR.

Physicians were trained to lead in a hierarchical system and taught to act and think as if their very education meant that they were more important than any other member of the team.[3] Certainly they were, and are, more vulnerable. If the patient died, the surgeon was faulted. And when all the responsibility and liability is yours, then you had better have total control over the situation.

In essence, this is the same drive for absolute physician autonomy that according to healthcare governance expert Jaime Orlikoff, originated about four thousand years ago with the Code of Hammurabi, which decreed amputation of a physician's fingers if his patient died after surgery. The physician response, even in ancient Babylonia, was very understandable: "If I have total accountability, I demand total autonomy in making decisions for my patients."[4] In all the millennia since, we've simply reinforced autonomy in our medical culture. And that drive alone is frankly one of the principal stumbling blocks in creating true collegial teams in the OR – rather than an iron-willed, all-knowing leader and obedient followers (the old model).



Today, the massive profession-wide push for major improvements in patient safety includes considerable pressure on doctors to step away from the old model and shoulder the responsibility of being an effective leader in building meaningful, collegial relationships. But even the best leaders can't lead if the members of the would-be team refuse to shoulder their reciprocal responsibilities to be receptive and communicative and trusting. That's what happened to the unhappy orthopod left wondering why he got the silent treatment. Whatever culpability he, as the surgeon, might have had for not breaking the silence, his "team" also has a vital role. The responsibility for a true team is a shared responsibility.

Start the conversation. What is the current culture of your OR? Can you speak up at any time to ask a question or stop the line? The culture of the operating room in the previous case was to 'lay low when things go wrong.' No member of the team ever acknowledged this, or said these words out loud. As a team, they learned over the years to hibernate until the 'storm' passed. But until someone steps forth and starts acting differently, nothing will change. Only the courage to act differently over a long period of time, even without the support of the group, can move cultural inertia. If you can do this, you are a true leader – regardless of your position.

What is the single most important thing you can do to impact culture on an individual level? Speak your truth. But how?

Knowledge is power

Communication classes are noticeably absent from both medical and nursing school curricula. Yet the number one cause of adverse outcomes in a study of 2,400 sentinel events by The Joint Commission was communication errors.

Communication omissions happen frequently. The operating room coordinator didn't know the bowel resection was going to be lappy because "nobody told him." The tech didn't know that the surgeon switched systems for his lumbar fusions because "nobody told her." Likewise, the orthopedic surgeon didn't know that his team cared, and that they were just as upset as he was about the events of the day, because nobody said anything. In the Silence Kills study,[5] fewer than 10 percent of physicians, registered nurses and clinical staff could directly confront their colleagues about their concerns. Why aren't people talking?

A recent study of over 2,500 hospital nurses gives us some answers.[6] Nurses were asked to identify a conversation that they needed to have in order to create a healthy work environment.

When asked why they had avoided the crucial conversation, they responded:

- Fear of retribution
- Fear of retaliation (unfair assignment or schedule, refusing to help, refusing a vacation)
- Fear of being isolated or excluded from the group
- Fear of being gossiped or talked about
- Fear of being wrong
- No time
- Fear of upsetting the status quo; rocking the boat
- Why bother? Nothing will change; it's no use

The primary denominator here is fear. As long as we live in fear, nothing will change. Healthcare workers share a passive-aggressive style of communication. They say why they are upset – to everyone in the department except the person they are angry with. In addition, the most common

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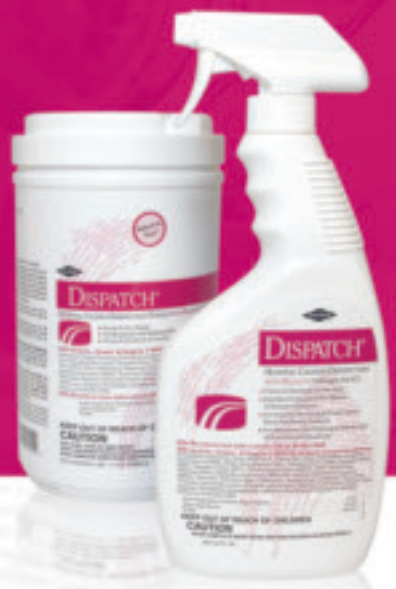

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way nurses deal with confrontation is avoidance. Nothing is worth upsetting the relationship. Noting this, it is imperative that leaders teach assertive communication and confrontation skills in the workplace.

One very simple model is called the D-E-S-C Communication Model. It provides a great framework for organizing your thoughts and feelings.[7]

D - Describe the behavior
E - Explain the effect of the behavior
S - State the desired outcome
C - Say what happens if the behavior continues

For example, the physician could have approached the team this way after the surgeries:

DESCRIBE - I want to talk to all of you about the silence in the operating room today. No one said a word all day.

EXPLAIN - The silence is what upset me the most. Having to explain the unsterile instruments to my patient was extremely upsetting; as was not having the right implant. But the silence made me feel like I was alone, or surrounded by strangers.

STATE - When something happens that is not normal (unanticipated event or error), I would appreciate your support or acknowledgement of what happened. I want to create an atmosphere where every member feels supported, and today, I certainly did not.

CONSEQUENCE - If we continue to ignore issues as a team, then we are not a team.

Time is money AND…

For every good idea to improve patient safety and clinical quality there is a voice reminding us that time is money. Money governs healthcare in America. No surgeon, OR scheduler, or CEO can refuse to be concerned about how efficiently an OR can be used. Pressures have become so intrusive on the surgical team that beepers and Blackberries now provide a constant opportunity for interruption and distraction that few patients on the table would appreciate if awake. While only preliminary data is emerging to validate what we already intuitively know, the fact is, the higher the pressure on time, and the higher the level of distraction in an OR, the less concentration on the procedure. To the extent that a surgical team is constantly disrupted by mid-procedure personnel substitutions, thoughtless intrusions, and

highly distracting communications, patient safety is compromised. Time pressures drive distractions that fragment and fracture teamwork and the ability of a surgical team to stay focused and supportive of each other.

How does the leader of a would-be collegial interactive team respond to such pressures? By taking the time to discuss issues outside the OR, tracking outcomes and reviewing all outliers. A team cannot coordinate their actions or responses if they don't make the time to come together before the fact and at least go over the basics of what they're about to do; as well as openly discuss unintended outcomes.[2]

Example: During a bariatric surgery the surgeon asked the anesthesiologist, "Is the stomach clear?" and the anesthesiologist answered "Yes." And so the surgeon stapled the stomach – to the tube. For when the surgeon asked if the stomach was clear, the anesthesiologist thought he meant 'clear of fluids' - and not the tube they had inserted for decompression. After the event, the checklist was revised to include teaching and now reads: "Before stapling, I will specifically ask, 'Is the stomach clear of the tube' because before I staple, I need the tube to be pulled. Respond 'clear' when the tube is pulled."

SCOAP (Surgical Care and Outcomes Assessment Program) is the future of surgical quality improvement. It is a physician-led voluntary collaborative creating an aviation-like surveillance and response system for surgical quality. SCOAP's goal is to improve quality by reducing variation in process of care and outcomes at more than 40 hospitals in the state of Washington. SCOAP is an engaged community of clinicians working to build a safer, higher quality, and more cost-effective surgical healthcare system. http://www.scoap.org/index.html.

Find your voice

In the opening case scenario, every team member failed to communicate. The truth is that neither checklists, nor procedures, or process improvement will work in the absence of meaningful, collegial relationships in which every member of the team feels comfortable communicating what they see, feel and know at all times. Silent cultures never change. Find the courage. Find your voice.

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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. *Stressed Out About Communication* is 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.

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