Risk Management in Canadian Health Care

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• A VOICE FROM THE FRONTLINES: BULLYING AND MEDICAL ERRORS •

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[*Editor's note*: This is an edited excerpt from Ms. Bartholomew's chapter in William Charney's *Epidemic of Medical Errors and Hospital-Acquired Infections: Systemic and Social Causes* (Florida: Taylor & Francis Group, 2012).]

• In This Issue •

Only six months into my tenure as nurse manager, a sentinel event occurred that directly linked bullying behaviours to medical errors.

On morning rounds, I was informed that a patient had been found with an oxygen saturation of 52 per cent and taken to the ICU. An MRI showed anoxic changes of the brain that were so significant the physician was concerned his patient would not return to baseline. Even on a full re-breather mask, the patient could not converse normally. I took the Patient Controlled Analgesic ("PCA") machine into my office and opened it up to find that the machine had been mistakenly programmed for Morphine instead of Dilaudid—the patient's decreased saturation was a direct result of receiving more than ten times the normal dose of narcotics.

Just then, the door opened and the nurse who was responsible for the patient came into my office. Before bursting into tears, she mumbled something under her breath. After reviewing

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the narcotic administration policy and debriefing her shift, I finally asked, "What did you say when you first came into my office? It sounded like '*I shouldn't have let them get to me*'?" Immediately the young nurse's eyes shot downward to the floor as she told her story …

> *I was about seven or eight minutes late for my shift last night. When I came around the corner of the nurses' station, a group of nurses who had been talking suddenly stopped when they saw me. I don't mean to be paranoid, but the conversation never picked up again. I went into the ladies' room—you can hear from there you know. Ellie said, "She'll never make a good nurse, will she?" Then someone else whose voice I didn't recognize said, "She just doesn't have what it takes. Does she?" I let those words destroy me. This is all my fault.*

No amount of consoling or counselling could remove her pain. Six weeks later she transferred off the unit to the very first position in the hospital. Was this an isolated event or a trend? As a manager, I realized that if I didn't change the conditions under which this event happened, there was a high possibility it could happen again. I understood clearly that my patients would never be safe until the nurses themselves were safe, and that my role as a nurse leader must expand to accept the responsibility for creating and monitoring the atmosphere in which my nurses worked as well as their clinical competence. What were those systemic conditions?

1. Culture of Horizontal Hostility

Horizontal hostility is defined as a consistent pattern of behaviour designed to control, diminish, or devalue a peer (or group) that creates a risk to health or safety (Farrell, 2005). Some specific examples are

Overt: name calling, bickering, fault finding, criticism, intimidation, gossip, shouting, blaming, put-downs, and raised eye brows; and

Covert: unfair assignments, refusing to help and ignoring someone, making faces behind someone's back, refusing to work only with certain people or not working with others, whining, sabotage, exclusion, and fabrication.

The current system is perfectly designed to hide the relationship between bullying and making medical errors because both bullying and horizontal hostility create feelings of shame in all humans, regardless of level of education. Neither physicians nor nurses report them because the common perception is that "there must be something wrong with me." The deep-seated emotion of shame keeps the very behaviours we need to address travelling just under our cultural radar—like an undertow, invisible and strong, taking our profession way off course.

2. Absent and Ineffective Leadership

Despite the data, leadership in health care (from front line to executive level) has failed to create the team environment proven to create a safe environment, and has not heeded the critical call for levelling the power dynamics.

A recent meta-analysis of all articles published on patient safety showed that a patient safety culture possesses seven distinct subcultures. The first one is "leadership." This is where we fail. Leaders do not perceive their own cultural norms because they themselves are a part of that everyday drama. Therefore, they do not dedicate the necessary funds and resources to change the culture, and allow a few disruptive healthcare workers to continue destroying trust. Leaders perceive relationship issues as "soft stuff" and therefore not worthy of budget allocation, so education in this area is slim to none. Ironically, nothing could be further from the truth.

Mistrust Squared: Lack of Transparency

Making harm visible would increase trust, which is the fundamental characteristic of a team. But the damage from medical errors is driven underground in the current culture because of shame and a litigious society. There is a long-standing cultural "meme" saying, "A good nurse/doctor does not make mistakes." Yet our solutions to eliminating errors do not even begin to address these powerful long-standing cultural norms. Both nursing and medical school curriculum has failed to abolish this established myth. For example, I was speaking on creating a "Just Culture" to a group of third-year medical students and asked, "When was the last time you did something wrong?" And a voice from the back of the room called out, "When was the last time I did something right?" We immediately stopped the presentation and discovered that the entire class felt the exact same way. As long as we continue to beat up residents and nurses and deliver their education in silos; as long as nurses and physicians continue to feel ashamed of imperfection and hide their last medical mistake, nothing will change.

Because of a culture of blame and shame, medical errors are underreported and hidden within the system. There is no universal system for re-

porting errors or a way that hospitals are immediately notified of an error to ensure that it does not happen again.

3. Poor Communication Skills and Inability to Confront = Fear-Based Culture

It is also well known that communication is the number one cause of all sentinel events. A recent study of over 4000 healthcare workers revealed that nurses were afraid to speak up because of fear of retaliation, fear of making the situation worse, or fear of isolation from the group (Bartholomew). Health care is a fear-based culture and strong leadership over a long period of time is needed to change a culture. However, due to a focus on financial survival in a time of great change, health care leader's attention is constantly diverted to the bottom line, and the consistency needed to change the current culture has been insidiously sidetracked.

Solution: Systemic Cultural Change

It is well known that **Structure** dictates **Process** that produces **Outcomes** (from Donabedian's seven pillars and eleven buttresses of quality). If we work backwards from the outcomes (medical errors), we can identify the processes (culture of hostility and bullying, maintained by ineffective leadership and poor communication skills) to address the structure that creates medication errors (business hierarchy).

Hostility thrives in a typical hospital hierarchy. It's all about power. How do you prevent medical errors? By disseminating power and forming a team with the core value of safe patient-centric care. Leaders must accept the challenge and personal responsibility for shifting power from a hierarchy to a tribe. What difference does the best surgeon in the world make if post-op you place the patient into a MRSA-infected room? What difference does the best nurse make if she doesn't question a medication order for fear of bothering the physician? All members of the team must know and experience their roles and the value that their specific position brings to the patient.

Health care still functions as a hierarchy with its focus on command and control rather than the relationships between the different parts. This power gradient will always produce oppression, which is the major theory behind horizontal hostility and vertical aggression (Freire). In human groups of unequal power, the dominant group exerts so much pressure downward that the oppressed group cannot direct its power upward—so they unconsciously attach to each other. Nurses are responsible for the outcomes (quality and safety), yet have no access to the resources needed to accomplish that goal (staffing ratios).

Conclusion

Medical errors are severely underreported in a fear-based culture. The problem is further entrenched in the general societal culture where the huge number of harm and deaths due to preventable error never make the evening news. (If it did, we would have more support from the general public and therefore government funding). In the broader societal context, patients continue to place unwarranted and unearned trust in their caregivers and hospitals due to a long-standing belief that when we proclaimed,

"Do No Harm" a century ago, we actually meant it.

How can a system succeed at addressing its inadequacies if it doesn't have a realistic picture or tally of the impact and harm? Or if that harm is so deeply embedded in the culture that it doesn't even register to its own leaders, let alone consumers?

Leaders must understand the culture that they are leading and use this knowledge to frame decision making—especially, budget allotments. The current fear-based culture is characterized by bullying behaviours and self-silencing (Bartholomew). A health care worker must know beyond a doubt that he or she will be respected and appreciated for speaking up and owning patient safety. Only education and leadership can debunk the current myths that keep the information we desperately need to decrease medical errors suppressed in the culture. To reduce medical errors from a social science systems perspective, leaders must focus on language and behaviour, and accept their pivotal role as stewards of a brand new, safe, team-based culture that

- **Chases "Zero,"** *i.e.*, holds the vision that it is possible for there to be NO medical errors if the system is designed to catch them;
- **Holds all staff accountable to the same rules,** maintaining "institutional integrity" that breeds trust; and
- **Creates collegial interactive teams**, **w**here caregivers feel free and safe to ask questions and objectively comment knowing that omnipotence and infallibility are myths.

We will never be able to realistically assess the number of medical errors caused by bullying and hostile behaviours until we create a safe culture. It cannot happen without visionary leaders that poignantly understand that human factors are the trump card in the poker game we play every day with our patients' lives.

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[*Editors' Note*: Kathleen Bartholomew, RN, MN is a sought-after national speaker in the United States of America for the nursing profession. This work was edited and reprinted with permission. The book from which this was excerpted can be purchased from CRC Press <http://www.crcpress.com/search/results.jsf?_kw=epidemic+of+medical+errors&category=+All+Subjects&x=0&y=0>.]

• PHARMACISTS UNSUCCESSFUL IN ENJOINING ZELLERS FROM TRANSFERRING PATIENT RECORDS TO PURCHASER OF PHARMACIES •

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Pharmacists work at retail pharmacies located within Zellers's stores in Ontario (the "Zellers Pharmacies"). This relationship made headlines earlier this year when the pharmacists sought injunctive relief in an attempt to prevent Zellers from transferring patients' pharmacy records to Loblaws and Metro, which had agreed to purchase the Pharmacies. The case of *Brar v. Zellers Inc.*[1] was heard by the Honourable Justice Pattillo on April 27, 2012.

The case turned on the relationship between Zellers and the Pharmacists who operated the Zellers Pharmacies. Their relationship was governed by a licence agreement, which provided that the Pharmacists would pay rent to Zellers and would operate the Zellers Pharmacies from within Zellers stores. Zellers and the Pharmacists acknowledged that all records relating to customers, including names, addresses, contact information, electronic and hard copies of filled and unfilled prescription orders, and other related information (the "Pharmacy Records") belonged to Zellers.

In January 2011, Zellers agreed to sell the leases to a number of its stores to Target, and to close the Zellers Pharmacies. Zellers then notified the operators of the Zellers Pharmacies that the licence agreements would be terminated and arranged to sell the assets relating to the Zellers Pharmacies, including the Pharmacy Records about patients.

The Pharmacists took the position that Zellers's termination of the licence agreements was improper, sued Zellers for damages, and also sought an interim and permanent injunction restraining Zellers from using, selling, or disposing of information pertaining to the Pharmacies or to patients of the Pharmacies.

Zellers, on the other hand, had already notified the Ontario College of Pharmacists (the "College") of the closure of the Zellers Pharmacies and of the fact that the Pharmacy Records were being transferred, in compliance with both the College requirements and applicable privacy legislation.

The Pharmacists argued that the sale of Pharmacy Records caused them to breach their professional obligations as well as those under the *Personal Health Information Protection Act, 2004* [*PHIPA*].[2] In that regard, the Pharmacists contended that they were health information custodians ("HICs") for the purposes of *PHIPA* and could not permit the transfer of the Pharmacy Records without patient consent.

Zellers, however, took the position that it is the person or organization that operates each of the Zellers Pharmacies, and is therefore the HIC in question for purposes of *PHIPA*. As well, HICs are permitted to transfer patient records to a successor custodian (for example, where a pharmacy is sold to another operator), provided they comply with s. 42(2) of *PHIPA*.

Justice Pattillo found that the Pharmacists were required to satisfy the three-part test established in *RJR-MacDonald Inc. v. Canada (Attorney General)*[3] in order to obtain the relief sought, by establishing that

i) there is a serious issue to be tried;

ii) they would suffer irreparable harm if the injunction is not granted; and

iii) the balance of convenience favours granting the injunction.

Justice Pattillo found that Zellers was the HIC in respect of the Pharmacy Records, and that there was no validity to the claims that the Pharmacists own the Pharmacy Records. Justice Pattillo also found that the steps taken by Zellers complied with s. 42(2) of *PHIPA*.

Justice Pattillo dismissed the Pharmacists' motion. While he found that there was a serious issue to be tried, it was limited to whether the Pharmacists' obligations under *PHIPA* override the licence agreements. He did not find any evidence to support the claim that the Pharmacists' businesses, livelihoods, and reputations would all suffer irreparable harm if the injunction was not granted, or that their patients would suffer irreparable harm by breach of their privacy rights. Finally, Pattillo J. found that the balance of convenience strongly favoured not granting the injunction, as Zellers would suffer greater harm if the injunction were granted than the Pharmacists would suffer if the injunction were not granted. Accordingly, the Pharmacists' motion was dismissed.

The most important considerations for the Court in this case appeared to be the fact that the licence agreements anticipated the very situation that developed with the sale of the Pharmacy Records, and that Zellers, as HIC, complied with its obligations under *PHIPA*. Justice Pattillo also noted that the patients' right to access pharmacy services from the pharmacy of their choice was in no way prejudiced by the proposed transfers.

[*Editors' Note*: Lonny J. Rosen, C.S. is a Partner in the Toronto health law firm of Rosen Sunshine LLP. He is an Executive Member and Former Chair of the Canadian Bar Association Health Law Section. This article was originally published as a blog post on <http://www.ngariss.com/blog/2012/05/14/pharmacists-unsuccessful-in-enjoining-zellers-from-transferring-patient-records-to-purchaser-of-pharmacies/> and has been reprinted with permission.]

1 [2012] O.J. No. 2052, 2012 ONSC 2546.
2 S.O. 2004, c. 3, Schedule A.
3 [1994] S.C.J. No. 17 at paras. 48–50.

• *IN MEMORIAM*—ELEANOR A. MORTON •

Mary Jane Dykeman
Dykeman Dewhirst O'Brien LLP

We are deeply saddened to announce the death on October 5, 2012, of our close friend, colleague, and *Risk Management in Canadian Health Care* editorial board member, Eleanor Morton.

Eleanor was on the board from the inception of this newsletter in 1999, and was a leading voice in Canadian health care risk management. She started her career in health records in her native Winnipeg in the late 1960s. She also worked in Australia and Toronto, including almost two decades with the Healthcare Insurance Reciprocal of Canada ("HIROC"). Upon retiring as its Vice-President, Risk Management in March 2011, Eleanor joined the board of the Anne Johnston Health Station, a Toronto community health centre, where she was on the Strategic Planning and Partnership Committee.

At a spring retreat at the Estates of Sunnybrook this past April, we witnessed the quintessential Eleanor—even as her eyesight failed her, she baked a large tray of carrot loaf for staff and the board (citing public sector cutbacks), walked it to the retreat, contributed vigorously to the discussions on quality measures in health care, then departed early with apologies in order to undergo further cancer treatment. She was inspiring, remarkable, loved her family and friends dearly, and working tirelessly to improve the health system. She was also a member of the board of the Institute for Safe Medication Practices, a cause she deeply believed in. She contributed to various advisory committees, including the Canadian Patient Safety Institute and the Ministry of Health and Long-Term Care on medical devices.

She embraced an active lifestyle of cycling, hiking, and travelling. Her illness did not define her; she was certain even while in hospital that she could get a weekend pass to hike in Algonquin Park.

In her final days, she remained dignified and gracious, asking about plans for the Anne Johnston, HIROC, this newsletter, and the sector generally. We talked about the fact that we would write this column and say nice things about her—and as with a visit by 20+ staff HIROC members a day prior, she said this made her feel "important." That's because she was important, personally and professionally. In a recent e-mail exchange with Peter Flattery, CEO of HIROC, he called Eleanor a "mentor"—a sentiment many of us share.

We will miss Eleanor and are grateful to have known her and learned from her.