Bringing the Cultural Change

Classroom-based CRM Training to Enlighten, Energize & Engage Colleagues

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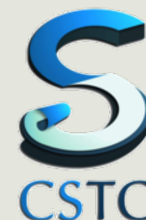

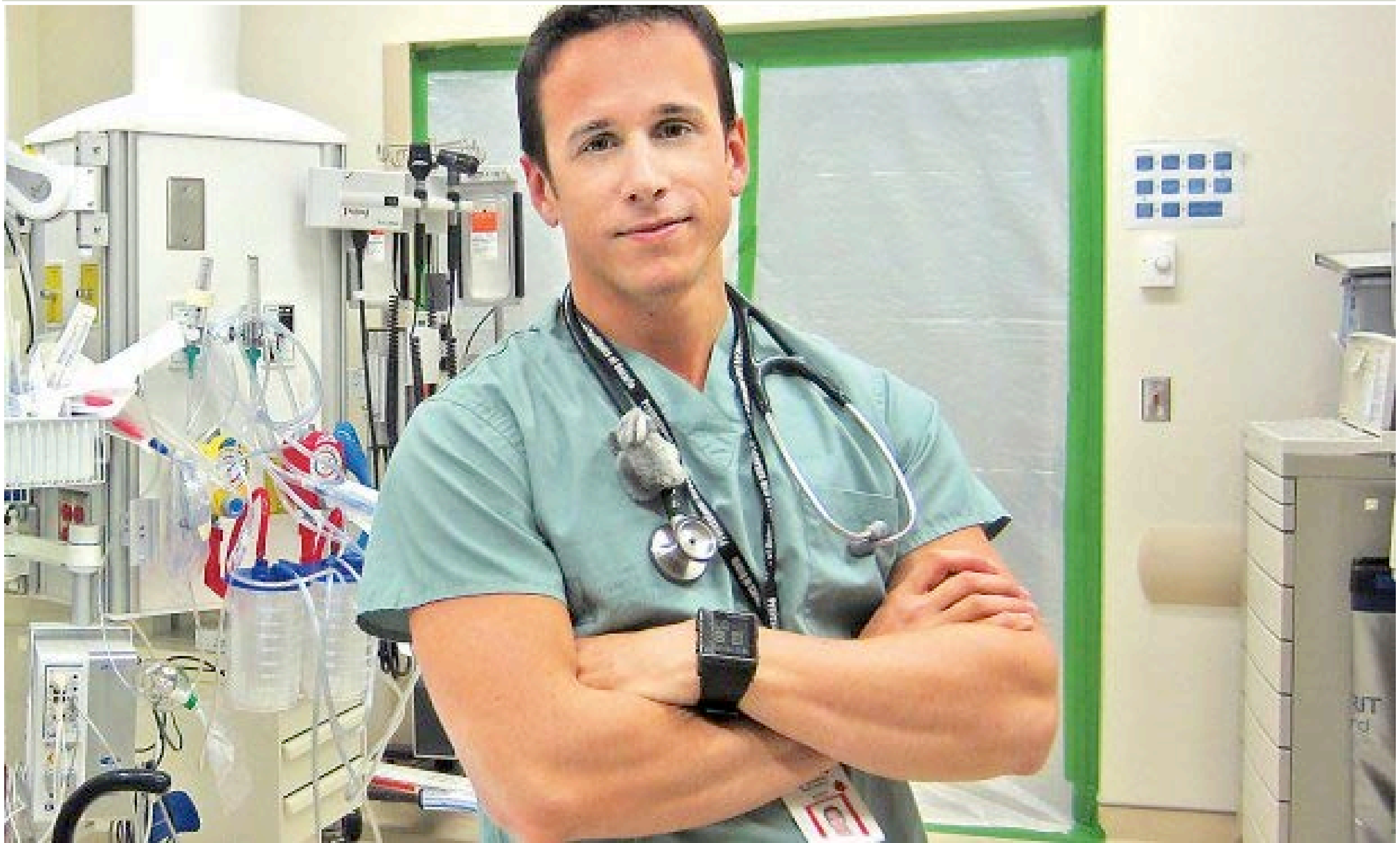

Patients see Doctors as

Smart, Confident, Reliable, Clam, Capable, Scholarly, Rational, Diligent, Respected

Doctors see Themselves as

Lone Agents providing Best Individualized Care

Professionalism of Medicine

- A commitment to
  - highest standards of excellence in the practice of medicine & in the generation / dissemination of knowledge
  - sustain the interests and welfare of patients
  - be responsive to the health needs of society

- Altruism
- Accountability
- Excellence
- Duty
- Honour & integrity
- Respects for others

American Board of Internal Medicine, 2001

Doctors are Almighty

Doctors & Patients all love this image

What's Wrong?

醫院抽痰喉留病人氣管

【專案組記者杜寶琪報道】公立醫院又爆嚴重醫療事故醜聞。一名哮喘病發命危的婦人，在將軍澳醫院接受急救時需用呼吸機救命，但護士調整輸氧導管長度時，將導管內的抽痰喉管一併剪斷，以致一截抽痰膠喉遺留女病人氣管[illegible]氣管內無[illegible]至病人轉往私家醫院[illegible]才[illegible]呼吸道，及時[illegible]醫管局承認護[illegible]在死[illegible]程序而肇事，院方已向病人及家屬道歉。

上月十七日，患有哮喘病的五十一歲女病人突然病發，出現嚴重氣喘及氣胸，由家人送往將軍澳醫院急症室搶救，她心臟一度停頓，情況危急，醫護人員立即為她插入氣管內導管，利用人工呼吸機供氧，婦人經搶救後被送往5C內科病房留醫，但情況仍令其家人擔心。同日下午，家人要求將她轉送到港島一間私家醫院繼續救治。翌日，私[illegible]病人進行[illegible]醫生為該名女[illegible]發現病人氣管內[illegible]並即將其取出，並通知[illegible]醫院。

院方向病人家屬致歉

將軍澳醫院將事故通報醫管局，並就事件展開調查，初步相信是負責調整導管的護士未有完全依足程序，才把該截抽痰喉管留在病人體內。醫管局發言人否認事件涉及人手不足，並稱院方已即時採取措施，及加強對犯錯同事的輔導及培訓，避免發生同類事件，院方亦已向病人及其家人道歉。

The hero who save the day

may not be doing things in the safest way

REFLECTION

The Myth of the Lone Physician: Toward a Collaborative Alternative

George W. Saba, PhD
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Hali Hammer, MD
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ABSTRACT

Cultural values and beliefs about the primary care physician bolster the myth of the lone physician: a competent professional who is esteemed by colleagues and patients for his or her willingness to sacrifice self, accept complete responsibility for care, maintain continuity and accessibility, and assume the role of lone decision maker in clinical care. Yet the reality of current primary care models is often fragmented, impersonal care for patients and isolation and burnout for many primary care physicians. An alternative to the mythological lone physician would require a paradigm shift that places the primary care physician within the context of a highly functioning health care team. This new mythology better fulfills the collaborative, interprofessional, patient-centered needs of new models of care, and might help to ensure that the work of primary care physicians remains compassionate, gratifying, and meaningful.

Ann Fam Med 2012;10:169-173. doi:10.1370/afm.1353.

Human are imperfect

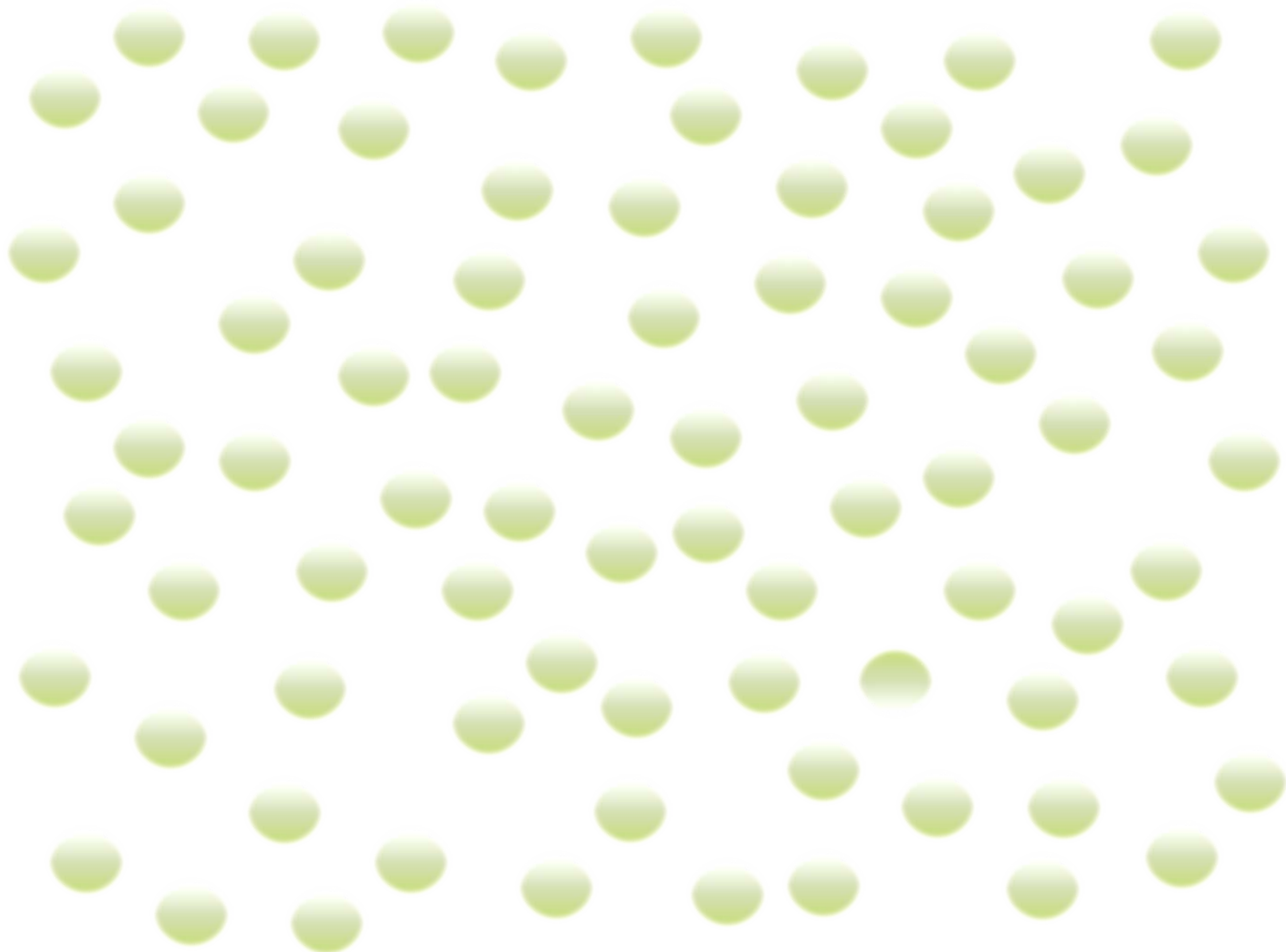
- Limitation in awareness of the surrounding
  - e.g. Inattentional blindness
- Limited ability to made rational decision
  - Cognitive biases

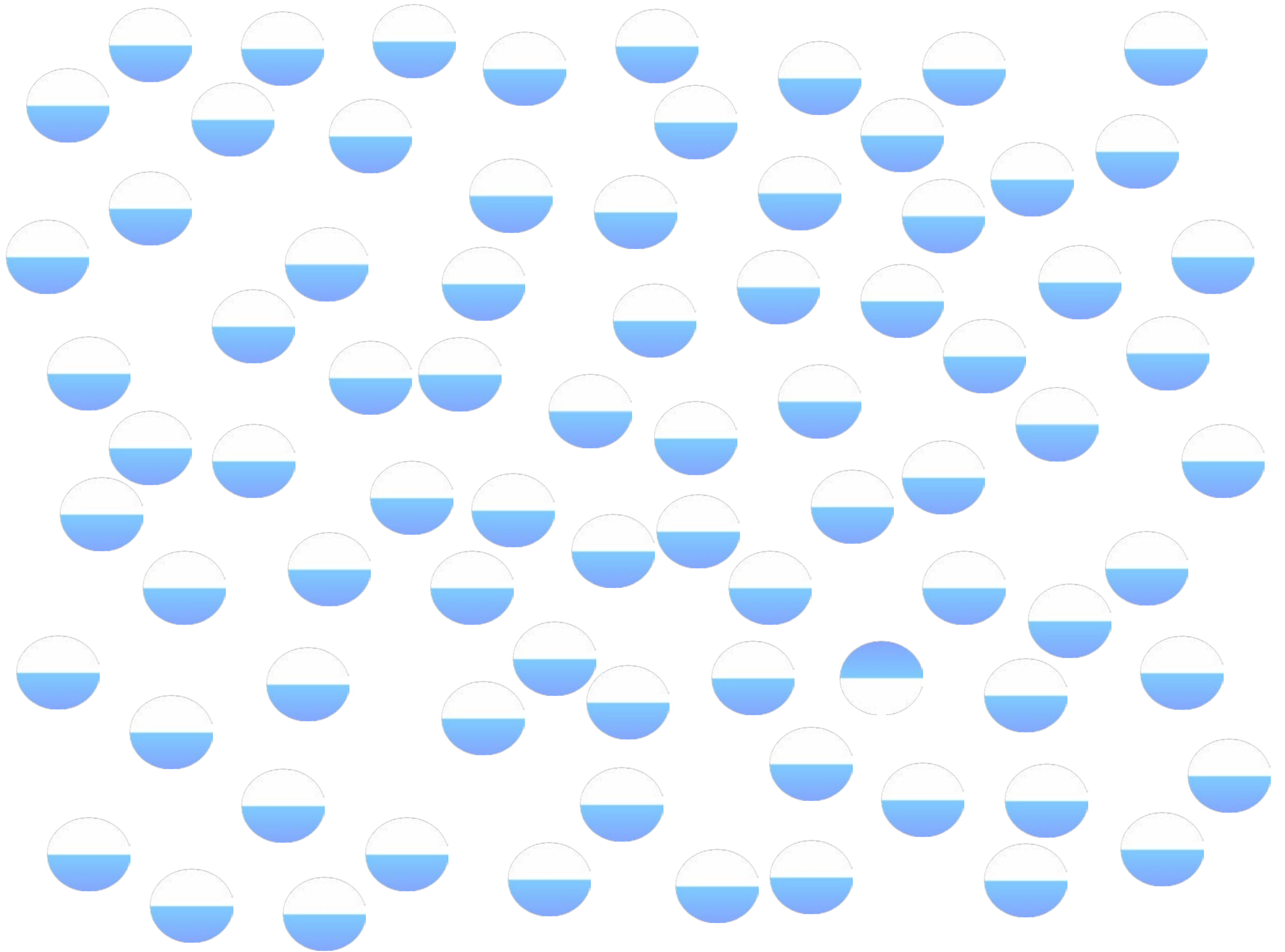
"Succeeds wonderfully . . . readers who heed [these] admonitions may be rewarded with a clearer view of the world" —*Wall Street Journal*

THE INVISIBLE GORILLA

HOW OUR INTUITIONS DECEIVE US

Christopher Chabris and Daniel Simons





The Dark Side of Healthcare Culture

- Disruptive behavior
- Humiliating, demeaning treatment of nurses & juniors
- Passive-aggressive behaviour
- Passive disrespect
- Dismissive treatment of patients
- Systemic disrespect

Perspective: **A Culture of Respect, Part 1: The Nature and Causes of Disrespectful Behavior by Physicians**

Lucian L. Leape, MD, Miles F. Shore, MD, Jules L. Dienstag, MD, Robert J. Mayer, MD, Susan Edgman-Levitan, PA, Gregg S. Meyer, MD, MSc, and Gerald B. Healy, MD

Abstract

A substantial barrier to progress in patient safety is a dysfunctional culture rooted in widespread disrespect. The authors identify a broad range of disrespectful conduct, suggesting six categories for classifying disrespectful behavior in the health care setting: disruptive behavior; humiliating, demeaning treatment of nurses, residents, and students; passive-aggressive behavior; passive disrespect; dismissive treatment of patients; and systemic disrespect.

At one end of the spectrum, a single disruptive physician can poison the atmosphere of an entire unit. More common are everyday humiliations of nurses and physicians in training, as well as passive resistance to collaboration and change. Even more common are lesser degrees of disrespectful conduct toward patients that are taken for granted and not recognized by health workers as disrespectful.

Disrespect is a threat to patient safety because it inhibits collegiality and cooperation essential to teamwork, cuts off communication, undermines morale, and inhibits compliance with and implementation of new practices. Nurses and students are particularly at risk, but disrespectful treatment is also devastating for patients. Disrespect underlies the tensions and dissatisfactions that diminish joy and fulfillment in work for all health care workers and contributes to turnover of highly qualified staff. Disrespectful behavior is rooted, in part, in characteristics of the individual, such as insecurity or aggressiveness, but it is also learned, tolerated, and reinforced in the hierarchical hospital culture. A major contributor to disrespectful behavior is the stressful health care environment, particularly the presence of "production pressure," such as the requirement to see a high volume of patients.

The slow pace of improvement in patient safety has been a source of widespread dissatisfaction for policy makers and the public, but even more to the health professions. Despite extensive efforts by many institutions and individuals, recent studies show little improvement in the rate of preventable patient harm since the Institute of Medicine's (IOM's) "To Err Is Human"[1] sounded the alarm and issued its call for a nationwide safety improvement effort 12 years ago.[1–4]

One explanation for this poor record is that the problem is so large and its causes are so varied. For example, the Centers for Disease Control and Prevention estimates that 5,000 people acquire an infection in our hospitals every day,[5] and the IOM estimates that 1.5 million patients are injured by medication errors every year.[6] Other reasons include our lack of knowledge of how to prevent most complications of treatment, inadequate government investment in patient safety initiatives, and insufficient preventive and remedial measures.[7]

We believe, however, that the fundamental cause of our slow progress is not lack of know-how or resources but a dysfunctional culture that resists change. Central to this culture is a physician ethos that favors individual privilege and autonomy—values that can lead to disrespectful behavior. We propose that disrespectful behavior is the "root cause" of the dysfunctional culture that permeates health care and stymies progress in safety and that it is also a product of that culture.

Disrespectful behavior threatens organizational culture and patient safety in multiple ways. A sense of privilege and status can lead physicians to treat nurses with disrespect, creating a barrier to the open communication and feedback that are essential for safe care. A sense of autonomy can underlie resistance to following safe practices, resulting in patient harm. Absence of respect undermines the teamwork needed to improve practice. Dismissive treatment of patients impairs communication and their engagement as partners in safe care.

In addition to its toxic impact on patient safety, disrespectful behavior affects many other aspects of health care. Quality suffers when caregivers do not work in teams. Disrespect saps meaning and satisfaction from daily work and is one reason nurses experience burnout, resign from hospitals, or leave nursing altogether.[8] Lack of respect poisons the well of collegiality and cooperation, undermines morale, and inhibits transparency and feedback. It is a major barrier to health care organizations becoming collaborative, integrated, supportive centers of patient-centered care.

Students and residents suffer from disrespectful treatment. "Education by humiliation" has long been a tradition in medical education and still persists. Patients suffer when physicians do not listen, show disdain for their questions, or fail to explain alternative approaches and fully involve them in the decision-making process.[9,10] Failure to provide full and honest disclosure when things go wrong

Please see the end of this article for information about the authors.

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Trainee welfare

Bullying of trainee doctors is a patient safety issue

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BACKGROUND

Workplace bullying is a matter for concern to employers because of its impact on staff health, productivity and retention. In the case of doctors in training, it may impact on their learning and their ability to provide safe patient care. Some bullying behaviours may be motivated by a desire to improve performance,[1] but the impact on recipients is likely to have the opposite effect. A trainee who feels humiliated and undermined by a senior colleague will not find it easy to ask

Table 1. Source of perceived bullying

Grade group	Consultants	Other trainees	Nurses	Managers	Patients or relatives	The whole culture at work	Other	Midwives	*N*
Lower	35.2%	16.5%	17.7%	3.6%	2.1%	10.5%	7.7%	6.7%	716
Higher	61.9%	5.9%	6.3%	5.0%	1.0%	11.3%	6.7%	1.9%	1,186
F1	21.4%	29.8%	29.6%	1.6%	1.8%	10.8%	5.0%	0.0%	379
F2	31.3%	22.5%	20.8%	2.0%	1.7%	12.7%	5.9%	3.1%	355
FTSTA	35.1%	19.9%	17.3%	2.2%	0.4%	14.8%	8.5%	1.8%	271
Total	43.8%	15.0%	15.0%	3.6%	1.4%	11.5%	6.8%	3.0%	2,907

Table 2. Reported bullying and other survey items

Item	Group	Weekly or daily	*N* (varies as a result of the N/A options that are excluded from the analysis)
In this post, how often have you felt forced to cope with clinical problems beyond your competence or experience?	Trainees that reported bullying	29%	2,981
	Trainees that did not report bullying	12%	27,740
In this post, how often, if ever, have you been supervised by someone who you feel isn't competent to do so?	Trainees that reported bullying	13%	2,981
	Trainees that did not report bullying	2%	27,740
In this post, how often have you been expected to obtain consent for procedures that you do not carry out yourself?	Trainees that reported bullying	24%	2,650
	Trainees that did not report bullying	14%	23,493
In this post, how often do you work beyond your rostered hours?	Trainees that reported bullying	71%	2,981
	Trainees that did not report bullying	51%	27,740
In this post, how often has your current working pattern left you feeling short of sleep when at work?	Trainees that reported bullying	45%	2,981
	Trainees that did not report bullying	21%	27,740
How often do you consider leaving medicine and pursuing an alternative career?	Trainees that reported bullying	33%	2,972
	Trainees that did not report bullying	16%	27,698

IF YOU
CHANGE
NOTHING,
NOTHING
WILL
CHANGE

©mobijo

Crew Resource Management

in Healthcare

Principles of CRM

- Communication [Believe & attitude]
  - Flattening of hierarchy
  - Assertion
- Teamwork [You are not alone]
  - Leadership / Followership
  - Briefing / Debriefing
- Human Factors [You are not perfect]
  - Situation Awareness
  - Decision Making

CRM in Aviation

- 1st generation (Cockpit Resource Management)
  - Theory + determination of management style
  - Target at believe & attitude
  - Too "psychological"
  - "Altering personality"
- 2nd generation (late1980s)
  - Focus on group dynamics / teamwork
  - Specific strategies
  - "Charm school" for getting along with others

CRM in Aviation

- 3rd generation (early 1990s)
  - Addressing flight deck automation
  - Expanding to flight attendants, dispatchers & maintenance personnel
- 4th generation (mid 1990s)
  - Integration with LOFT (simulation)
  - Specific CRM training for specific procedure
- 5th generation (late 1990s)
  - Emphasis on threat and error management

CRM Training in PYNEH

- May 2009
  - Tasting of Government Flying Services' CRM course

- Sep – Oct 2009
  - Classroom-CRM course from ***Safer Healthcare Inc***
  - Localization of training material – an 8 hour course
  - Train-the-trainer course

Why Classroom Course?

- Can be 'imported'
- Lower cost
  - Instructor
  - Venue
- Widespread training to attain a critical mass
  - Name it to tame it
- Easier scheduling
- Better acceptance

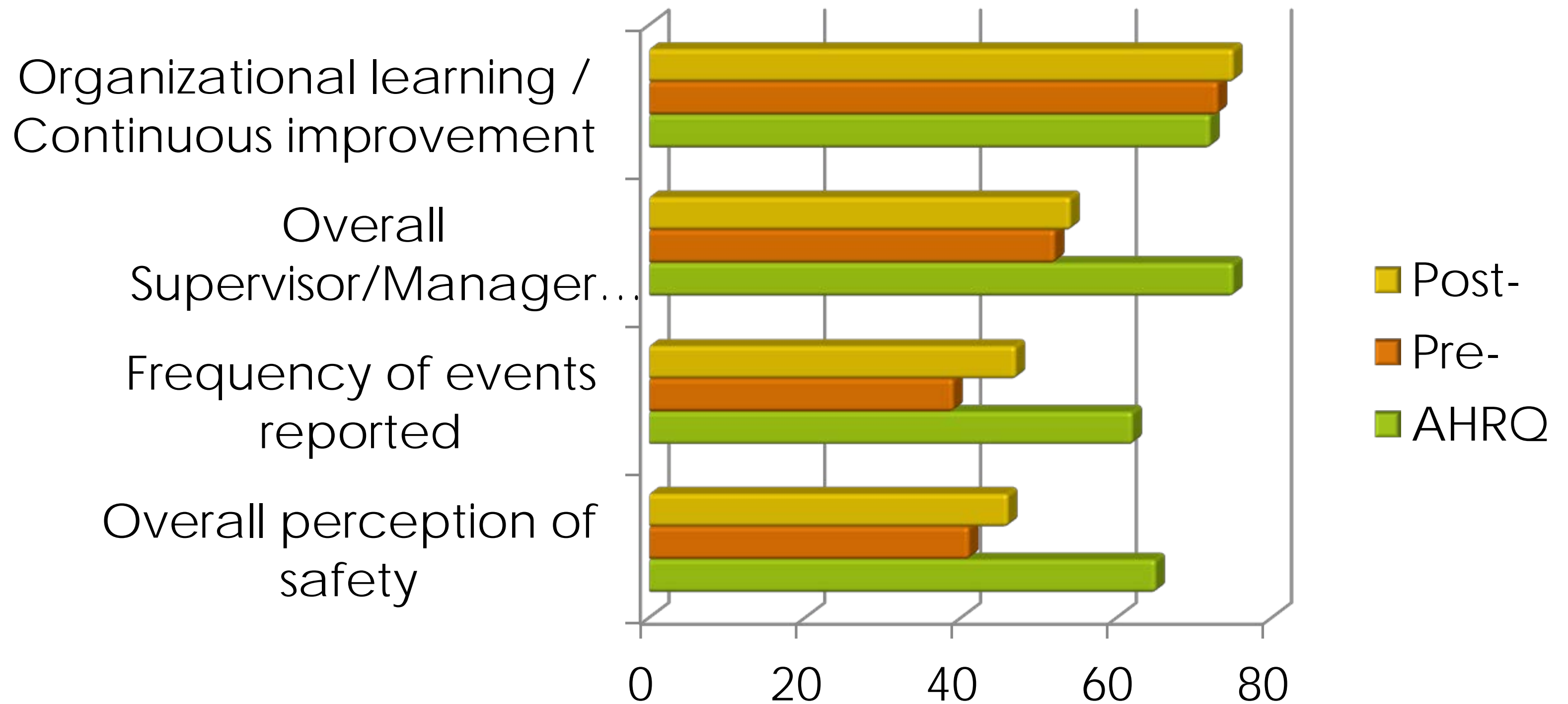
The Programme

- Interactive presentation with video clips
- Educational games
- Role plays
- Group discussion

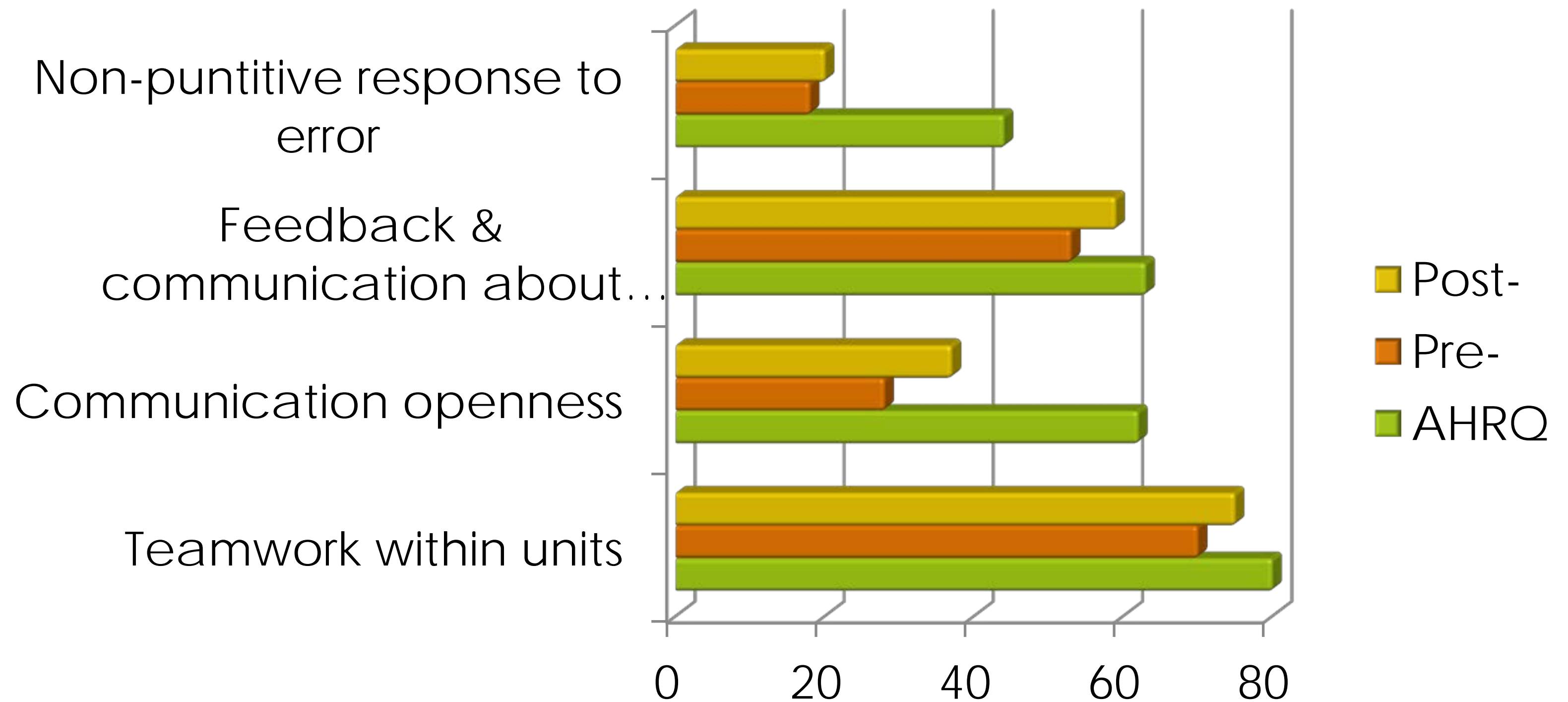
The Participants

	2009/10	2010/11	2011/12	2012/13	2013/14	Total
Doctors	66	266	46	60	53	491
Nurses	165	1029	93	308	280	1875
Allied Heath	12	18	48	11	10	99
Admin	13	1	12	4	1	31
Others	2	2	0	17	7	28
Total	258	1316	199	400	351	2524

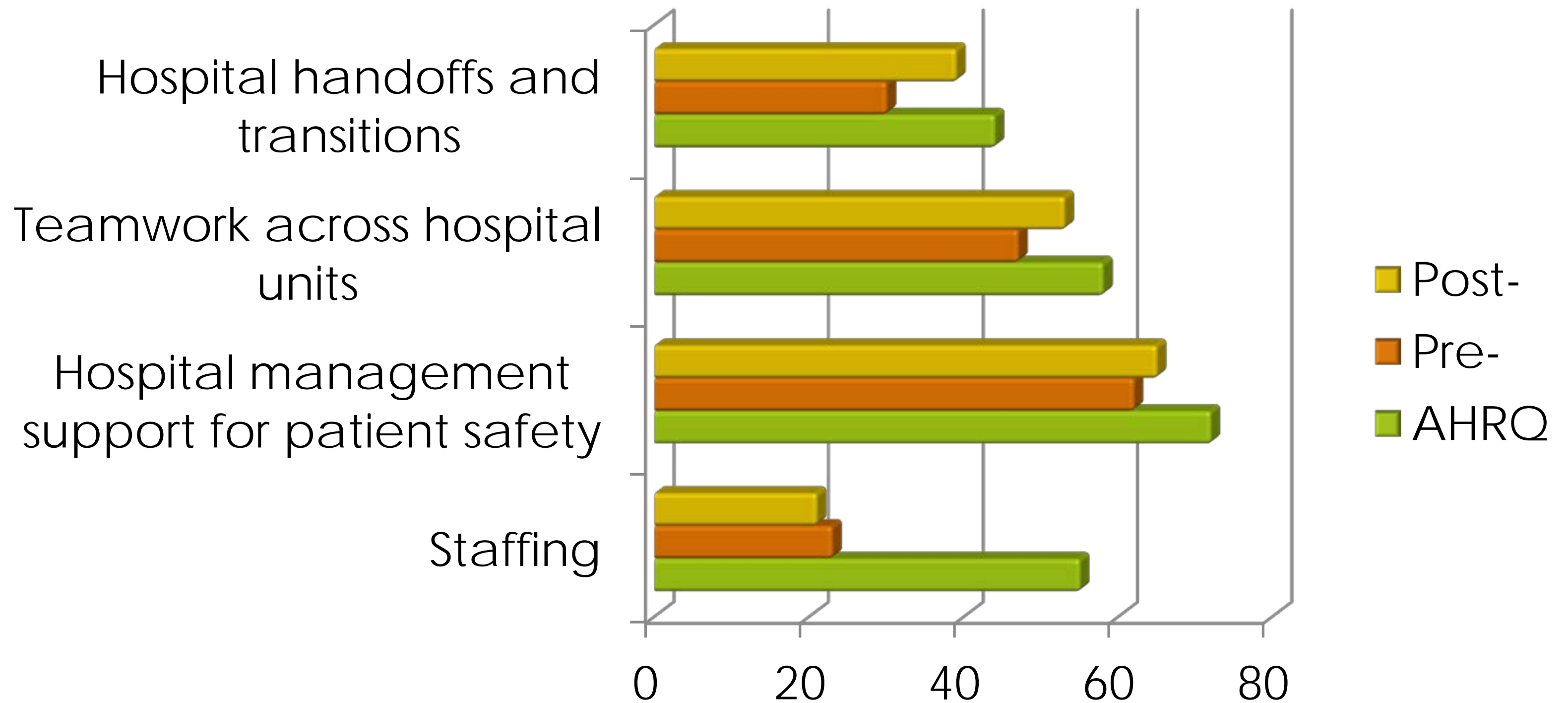
Evaluation



Evaluation



Evaluation



Some Reflections

- Main target is the **silent majority**
  - Experienced & insightful, yet don't choose to speak up

- Most participants grasped CRM principles already, but just cannot 'name' them
  - Standardization of terms
  - Facilitate rather than teach
  - Allow participant to apply the principle in their usual context

Some Reflections

- Avoid saying ‘surgeons are like pilots’
  - Surgeons can be part-time pilot, while NO pilot can be part-time surgeon
    - Culture won’t change overnight

Some Reflections

- Strongest support from Top Management and Department Heads

- CRM is not a
  - Quick fix for patient safety
  - Stand-alone training
  - Method to undermine or control clinical teams

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Harvard Business Review

Cultural Change That Sticks

Start with what's already working
by Jon R. Katzenbach, Ilona Steffen, and Caroline Kronley

With compliments of...
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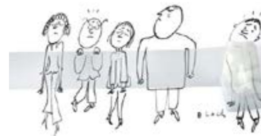

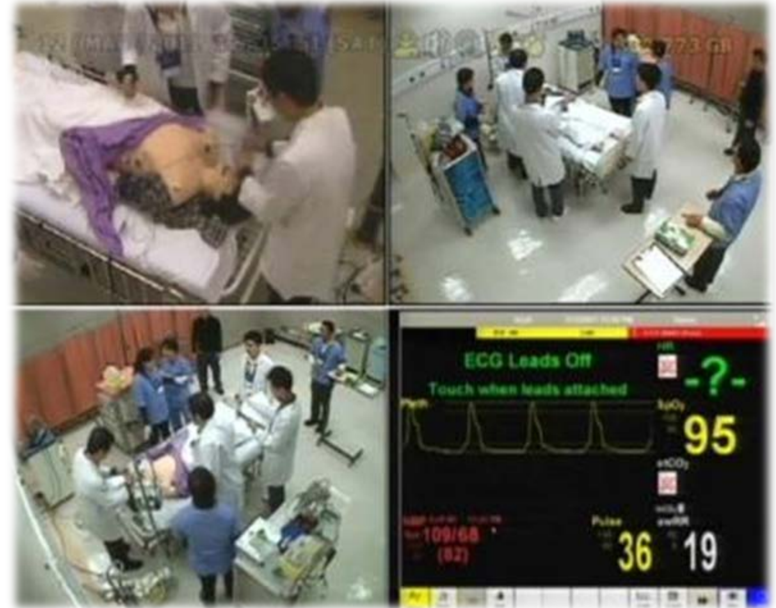

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Thank you