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Clinical sensemaking: a systematic approach to reduce the impact of normalised deviance in the medical profession

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The burning platform and the rapidly shifting framework

Patient safety and patient-centred care are emerging as key drivers in healthcare reform. Things have changed but often as a byproduct of financial reform. Belatedly, safety and quality benchmarks are being integrated into all healthcare organizations' strategic goals. There is more focus on patient-centred care, but these are early days. Patients still experience needless harm and often struggle to have their voices heard, processes are not as efficient as they could be and costs continue to rise at alarming rates while quality issues remain.

Major changes are needed in the delivery model. Given the pressures on healthcare, the systems that will thrive will focus on quality of care (including cost efficiency), through innovative healthcare delivery that results from the alignment of incentives with payers, patients and other participants in the healthcare equation. Effectively engaging clinical staff and particularly physicians is critical to this change in the design and delivery of effective healthcare systems.

The findings of the Francis[1] report into the failings of care at Mid Staffordshire, the New South Wales Special Commission into Acute Care Services in NSW Public Hospitals (Garling Inquiry),[2] and the cover up by the Clinical Quality Commission (CQC) of the University Hospitals of Morecambe Bay NHS Trust failings,[3] echo loudly the findings of the Bristol and Queensland inquiries, respectively.[4,5] These inquiries found that during the periods under investigation, many staff, patients and managers had raised concerns about the standard of care provided to patients. The tragedy was that they were ignored and the concerns were covered up. The senior UK regulator, CQC, has come under fire in recent years for failing to protect patients and prevent a series of scandals, as it relied on systems which essentially let hospitals vouch for their own patient safety. Senior managers seemed more concerned about protecting their reputation than about the lives of patients in the systems under their oversight.[6] One of the most shocking things about the scandal concerning Morecambe Bay and CQC's role in regulating that trust is that it was allowed to happen after the devastating events at Stafford. Finally and perhaps of most concern, these public reports found a widespread culture of denial, a lack of attentiveness to patient concerns and normalised deviance.

System flaws set up good people to fail. People often find ways of getting around processes which seem to be unnecessary or which impede the workflow. This is known as normalisation of deviance. This accumulated and excepted acceptance of cutting corners or making work-arounds over time poses a great danger to healthcare. Similar findings have been described in other investigations into major episodes of clinical failure[5,6] suggesting that health systems are failing to heed the lessons of history.

It is widely understood today that the first step towards improving the safety and quality of care is addressing the perceptions – the varying mental models held by care providers and state agencies, about care delivery.[7] There has been an important re-conceptualisation of clinical risk through emphasising how upstream 'latent factors' enable, condition or exacerbate the potential for 'active errors' and patient harm. Understanding the characteristics of a safe, resilient and high-performing system requires research to optimise the relationship between people, tasks and dynamic environments.[8] The socio-technical approach suggests that adverse incidents can be examined from both an organisational perspective that incorporates the concept of latent conditions and the cascading nature of human error commencing with management decisions and actions

(and equally inactions). There are consequences for inaction in complex health delivery systems where inaction can lead to patient harm. Organisational resilience is found in the responsiveness of care delivery teams to an emerging hazard. Some teams are more resilient – able to recover from errors reliably without leading to patient harm, while others do not learn and repeat the same errors.[9]

Ineffective engagement and inauthentic partnering with clinicians remains some of the biggest obstacles globally in addressing the growing implementation gap in providing cost-effective, and quality care. Physician discontentment, cynicism and growing numbers of burnt-out clinicians all point to a serious trust gap.[10] Several studies have identified the need to 'engage physicians' as the biggest challenge in healthcare reform, for example, in the efforts to mobilise key stakeholders to support hospital-based efforts to improve care transitions and reduce avoidable rehospitalisations.[11] Physician involvement is key to their leading, facilitation and participation in accelerating the adoption of new care models, in large part because new care models require doctors to significantly change their behaviour.

Innovation in patient care is best designed in concert with those on the front lines of healthcare delivery – patients and clinicians – and incorporating relevant knowledge from other scientific disciplines such as operations research, organisational behaviour, industrial engineering and human factors psychology.[12] In order to best engage with medical staff, the focus of improvement efforts should be on bringing even more scientific discipline and measurement to the design of healthcare delivery. Developing innovative care models that lower the complexity and cost of delivering healthcare, while simultaneously improving clinical outcomes and the patient experience is needed. The goal is to provide cost-effective, safe, patient-centred care, to address the central issue of improving the net value of benefits obtained from healthcare.[13] Active regulation has an important role to play as a 'backstop' against failure, but it is only actions on the ward and board that will deliver compassionate care for patients.

From finding causes to sensemaking

Improving care requires those who manage care to have an ability to make sense of that care.[14] Despite the growing interest in producing and publishing more quality indicators, the context of everyday clinical experience is not captured well by evidence-based statistical measures. There is, therefore, an urgent need to build a ground up capacity of clinicians to make sense of the complexity in care.[15] A recent analysis of 100 root cause analyses (RCA) suggest that the next stages in patient safety efforts should involve practical experimentation with meaningful tools and methods at the local level.[16] It is timely to assess the quality of information made available through clinical governance compliance efforts, its interpretation and real value to safety improvement. Clinical experience is more dynamic than the simple cause and effect sequences created in RCA flow charts and data registries.

The challenge for hospital executives and policymakers around the world is that there is no readily available process for controlling future events or predicting how clinicians might respond to uncertain situations. Knowing the clinical workplace, attending to what clinicians value and hold dear to their hearts and making sense of what needs to be done are the key to the successful engagement of clinicians and thus to meaningful and sustained patient safety improvement.[17]

The role of managers and normalised deviance

The Mid Staffordshire inquiry and the Morecambe Bay investigation point to an evolving culture of normalised deviance, cynicism and the need for standards for how to rekindle professionalism in a demoralised workforce in the NHS.[18] By deviance, we mean organisational behaviours which deviate from normative standards or professional expectations (for example, low handwashing compliance before patient contact, minimal consultant oversight of hospital care on weekends, suppressing information about poor care, etc.). Once a professional group normalises a deviant organisational practice, it is no longer viewed as an aberrant act that elicits an exceptional response; instead, it becomes a routine activity that is commonly anticipated and frequently used. A permissive ethical climate, an emphasis on financial goals at all costs and an opportunity to act amorally or immorally, all can contribute to managerial and clinician decisions to initiate deviance.[18]

Institutionalised deviance typically continues until actively stopped from inside or outside the organisation. Normative standards of behaviour arise from within organisations, becoming embedded within organisational culture and norms. They are not simply imposed by more powerful organisations such as the state or professional colleges. Managers and clinicians themselves are thus participants in the construction of the commonly accepted standards of behaviour and realities under which they operate. A process of social learning and observation moves

an organisational practice from an innovation that requires active efforts of sensemaking to a routine behaviour that operates as a habitual response to common organisational problems (i.e. the successful uptake of routine handwashing by medical staff). If organisational and professional leaders and regulators do not meaningfully respond to organisational deviance, then organisational members are likely to conclude that there are few regulatory consequences or normative improprieties in violating accepted standards of behaviour. Shining a bright light on these practices by skilled practitioners and regulators, with forced transparency, public reporting of data and community oversight can greatly diminish these behaviours.[19] The new vision and leadership at the CQC are promise that these imperatives will be heeded.

Healthcare services are currently too fragmented for effective application of the patient-centred model of quality improvement. Effective improvement of care requires meaningful efforts to address the trust gap with clinicians.[10] At the most basic, this will involve a re-conceptualisation of the patient from the passive object of medical intervention to an active 'consumer' or 'user' of health services who co-produces and 'owns' their own health. Reframing patient care is needed from one that is task oriented at the level of the practitioner, to a systems-based, microsystems-based, patient-centred model that looks to the actual relationships within the socio-technical microsystems in which care is actually delivered.[20] This must also include a commitment to full disclosure when things go awry, setting up peer support programmes for clinicians who have harmed patients and long-term support for patients, families and providers involved in adverse care.[21] Recent evidence confirms that open disclosure programs based around peer support guided by senior clinicians who mentor and support clinicians before and during an adverse event leads to better patient, provider and organisations, outcomes.[22]

Strategies to be implemented by management

Don Berwick's report about how to move the NHS to become the safest healthcare system in the world speaks to the need for a unified will, investment and psychological safety. But above all, it will require a learning culture firmly rooted in continual improvement.[23] Real change is not a stable activity directed from above, but an emergent feature of effective local healthcare systems. Within organisations, the active engagement of clinicians is a management task. To truly engage the medical profession, health managers and leaders will need to explore and understand the delivery of care below the surface. Rules, standards, regulations and enforcement have a place in the pursuit of quality, but they pale in potential compared to the power of pervasive and constant learning.[22] A specific strategy is thus needed for HOW we can learn more about WHAT sense local clinicians make of current challenges in healthcare and WHY local viewpoints on care delivery make the most sense.

This will mean that quality and safety initiatives will need to be agile enough to embrace continuing local adaptation at the coalface of care. The key strategies are not the usual suspects. We are moving from a decade of highly structured top down programs to local ownership. Engagement of clinicians will be a byproduct of sensemaking by clinicians and strategies to promote this must:[15] (1) mobilise clinicians to 'move and experiment' with their own systems; (2) provide permission, space and time for clinicians to find purpose and set their own direction in partnership with their patients and consumers; (3) direct attention to 'what is happening' at the service delivery level; and (4) 'facilitate respectful interaction' between clinicians and managers.

The leadership task for all in healthcare is to effectively engage with and understand the care delivery process as the core business of healthcare. In doing so, all participants (including patients and carers) can collaborate in ensuring that local ownership of the care process leads to improvement, maximising safety and value and minimising the dangers inherent in normalised deviance.

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