Faculty of Medical Leadership and Management

Annual Conference October 2012

Disruption and Distress in Teams

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Shuttle Columbia Crew
In Remembrance
Feb 1, 2003


MN
Minneapolis
DEVELOPING
NORTHWEST AIRLINES FLIGHT
OVERSHOT RUNWAY BY 150 MILES

Themes

- Early warning signs: recognising and acting on them
- Causes and contributory factors
- The impact of personality and behaviour
- Roles and responsibilities of medical leaders
- Practical steps for addressing team dysfunction

Which specialty is most vulnerable?

Emergency Medicine

Cardiology

Cardiac surgery

Colorectal surgery

Fetal medicine

Gastroenterology

General practice

Histopathology

Neurology

Neonatal medicine

Obstetrics and Gynaecology

Oncology

Ophthalmology

Orthopaedic surgery

Paediatrics

Psychiatry

Pathology

Palliative Medicine

Radiology

Renal medicine

Respiratory medicine

Urology

The context for team dysfunction

- Bullying
- Target-driven priorities
- Disengagement from management
- Low staff morale
- Isolation
- Lack of candour
- Acceptance of poor behaviours
- Reliance on external assessments
- Denial

(*from the Francis Inquiry into Mid Staffordshire,2009)*

Disruptive behaviour

"A physician [doctor] with disruptive behaviour is one who cannot or will not function well with others to the extent that his or her behaviour, by words or actions, interferes or has the potential to interfere with quality healthcare delivery."

The College of Physicians and Surgeons of Ontario, Canada

Distress

- Loss of power, status and autonomy
- Pressure to “compromise” standards of care
- Feeling let down by the Trust/the NHS
- Becoming “employees”
- Losing close colleagues
- Newly appointed consultants not coping
- Learned helplessness and anger
- Feeling unable to confront co-workers/seniors

Typical behavioural "derailers"

Moving away

- **Volatility:** Mood swings are hard to predict
- **Habitual distrust:** Combative and mistrustful of authority
- **Excessive caution:** Conservative ;worry about making mistakes
- **Aloofness:** Dislike working in teams and can be withdrawn
- **Passive resistance:** Stick rigidly to their own agenda

Moving against

- **Arrogance:** They're right and everybody is wrong
- **Manipulation:** Use their charm; can be reckless and impulsive
- **Melodrama:** Want to be the centre of attention
- **Eccentricity:** Think it's fun to be different just for the sake of it

Moving towards

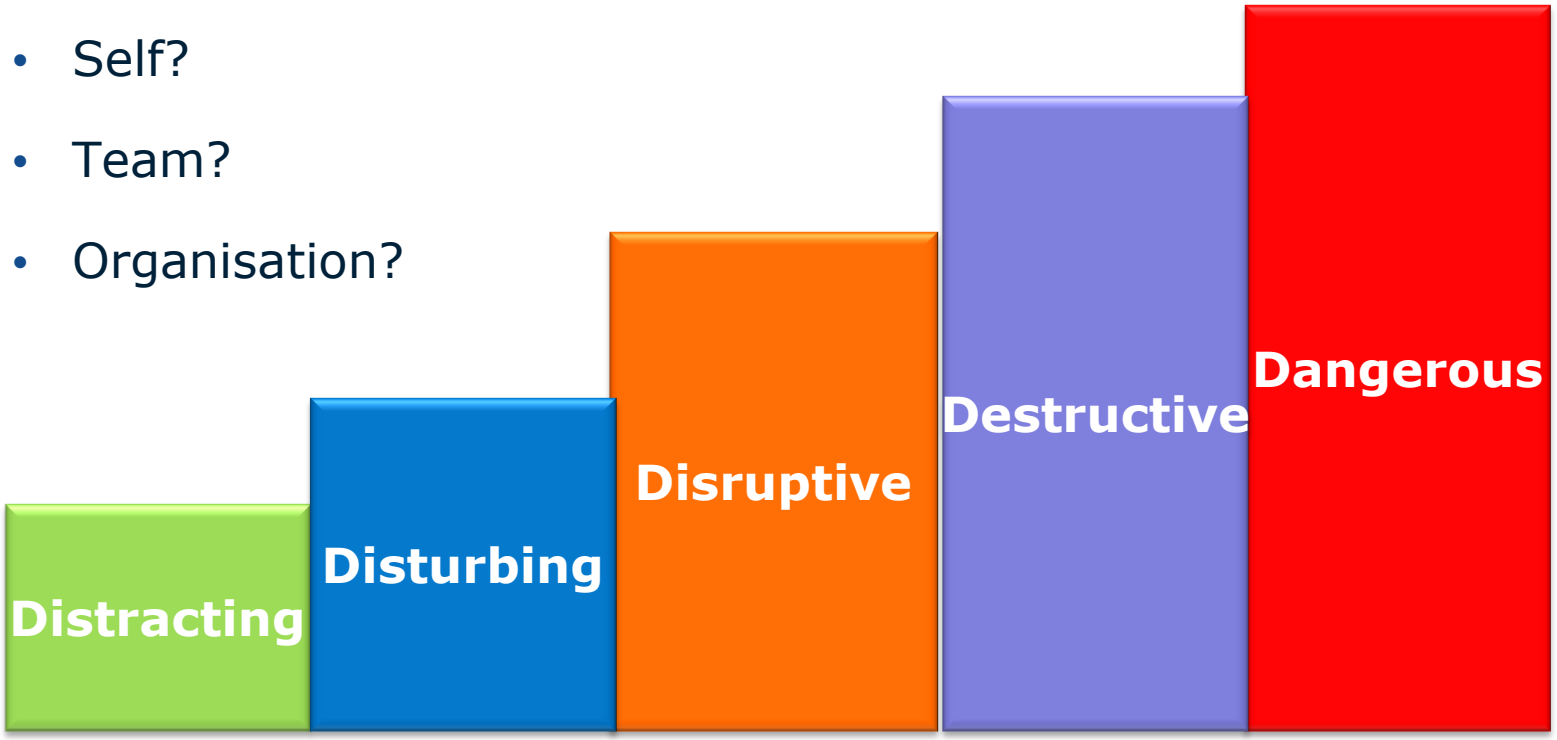
- **Perfectionism:** Obsess about detail and won't delegate
- **Eagerness to please:** Can't make independent decisions

Adapted from Hogan and Hogan, 2001

How difficult is difficult?

What is the risk to:

- Patients?
- Self?
- Team?
- Organisation?



Disruptive behaviour – impact on staff

Individual

- Frustration 95%
- Stress 95%
- Lost ability to concentrate 85%

Team communication

- Levels of communication reduced 95%
- Team collaboration impaired 92%
- Information transfer compromised 89%

Rosenstein A, O'Daniel M. Managing disruptive physician behavior: Impact on staff relationships and patient care. Neurology 2008;70;1564-1570; see also

Flin, R Rudeness at work. BMJ, 2010;340:c2480

Causes of disruption

- Dysfunctional personalities
- Absence of boundaries
- Relationships gone bad
- Over-ambitious new consultants
- Poorly managed mergers
- Poor leadership

Early warning signs of lapses

- **Clinical impact**: poor patient handover; refusal to cover
- **Stress**: sickness, absence & excuse making higher than usual
- **Team Behaviour**: staff playing one clinician; off against another; ingroup-outgroup; poor quality meetings
- **Avoidance**: no communication, missing/late for meetings; failure to reach agreement; blaming others – failure to take individual responsibility
- **Undermining**: public contradiction/criticism of professional opinion, ideas, leadership
- **Sabotaging**: absence from crucial meetings; passive aggressive
- **"Grievance and grudge"**

The shadow side

- Work load inequities
- Private practice
- Camps, cliques and factions
- Collegial collusion
- Culture of fear
- Liaisons dangereuses

The 7 "undiscussables"

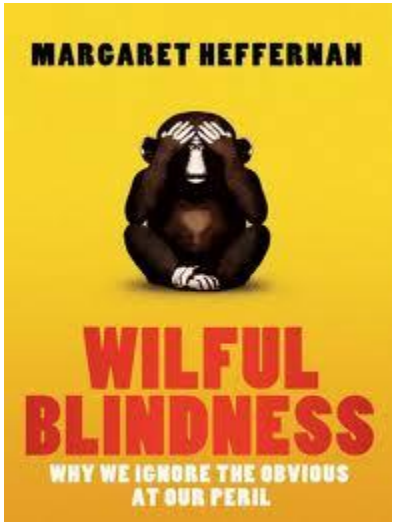
1. Broken rules
2. Mistakes
3. Lack of support
4. Incompetence
5. Poor teamwork
6. Disrespect
7. Micromanagement

"Silence Kills" (Maxfield et al, 2010)


insert knife
here
here
here
here
here
here
here

Why don't these issues get tackled earlier?

- Fear of confrontation, retaliation, repercussions
- Denial
- Lack of ability
- Lack of "evidence"
- Don't believe it will do any good
- "Not my job"
- Helplessness
- Easier to turn a blind eye



Discussing the undiscussables.

Health caregivers who are able to speak up and resolve undiscussables:-

- Report better patient outcomes,
- Are more satisfied with their workplace,
- Exhibit more discretionary effort
- Are more committed to staying in their unit and their hospital.

The anatomy of team dysfunction

When things go wrong in a team…

- Lack of clarity or mutual understanding of roles
- Lack of structure in the team or team task
- No clear shared vision and explicit goals
- Inadequate resources
- Poor organisational climate
- Perceived inequalities
- Poor leadership

Adapted from West and Markiewicz, 2006.

Who is the troublemaker?

- Projection
- Disowning
- Systemic

The Five Dysfunctions of a Team

(Lencioni, 1995)

Status and Ego

Low standards

Ambiguity

Artificial harmony

Invulnerability

Overcoming the Dysfunctions

(Lencioni, 1995)

Reward contribution to team goals

Regular reviews; team rewards

Create clear and common priorities

Confront & persist with difficult issues

Admit weaknesses; seek help

Managing the problems

An holistic approach

..which requires

strong LEADERSHIP!!

at every level….

Some "golden questions"....

1. How would the team behave differently if you:

- **Removed** one or more members out of the team -where would the attention or blame next become focussed?
- **Moved** one or more members into different roles?
- **Changed** the leadership: how would the team respond?
- **Introduced** someone new into the team what would happen to them?
- **Reconfigured** the team

2. What are the payoffs for the team "behaving badly"

3. How are others colluding to perpetuate this?

4. How does power work in this team?

Case study: the issues

Poor consultant engagement in leadership of the department and new ways of working

- History of antagonism towards management
  - 1 consultant working to rule: questions about his commitment
  - 1 on maternity leave
  - Poor quality middle grade support
  - Clinical Director believed to have "favourites" – so 2 camps exist
  - Flood of IR1 forms submitted by nursing staff
  - High turnover of managers

Questions

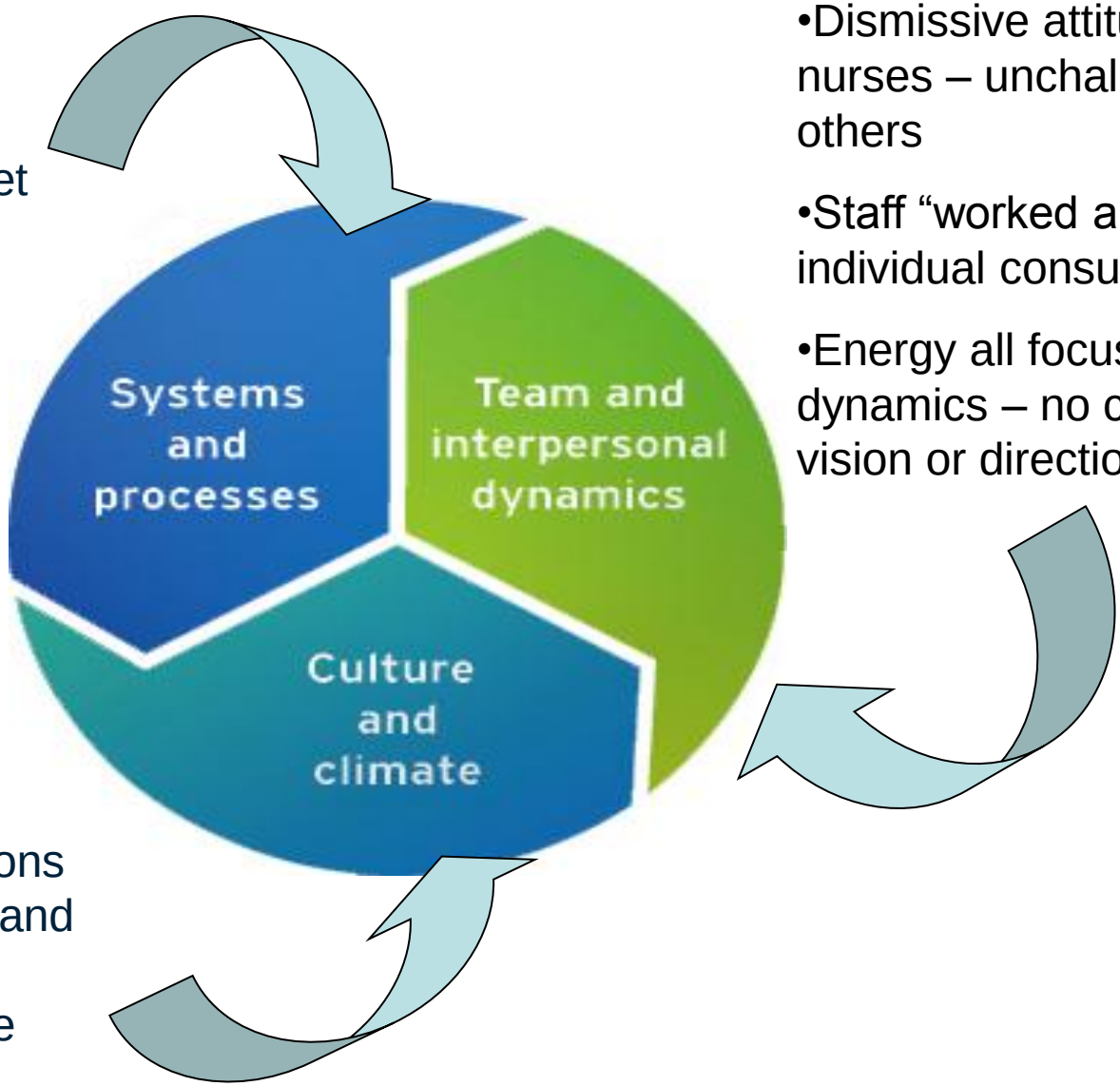
1. Where is the problem situated?

2. What are the risks and to whom?

3. What approach(es) would you consider?

Case study: findings

•No mechanism to get concerns heard
•No performance management
•Meetings poorly run – decisions revisited or sabotaged



•Dismissive attitude to nurses – unchallenged by others

•Staff "worked around" individual consultants

•Energy all focussed on dynamics – no common vision or direction

•No appreciation or recognition from senior management
•Transactional interactions
•Ideas rejected out of hand
•Department isolated
•Critical leadership style

Case study: Recommendations

- Appoint "champions" to raise department profile
- More visible support for the CD from senior management
- Strengthened performance management
- Appoint substantive Matron to engage nursing staff
- Clinical Director "summit" meeting with the CEO and MD to clarify mutual expectations
- Programme of visits by CEO and MD to be visible sponsors of change
- Change management workshops
- Managing shadowing programme to increase insight into roles and pressures

Rebuilding a troubled team

Critical factors for moving forward

- Revisit the PURPOSE, GOALS and VALUES of the team
- Build understanding of individual differences
- Establish team "rules" of behaviour in the workplace
- Commit to decisions as a team – and stick to them!
- Hold everyone accountable for behaviour as well as results
- Stay focussed on what matters: patient safety at all times!!

“Team” rules

Extract from a code of behaviour for a clinical team

We will give time to all our colleagues to express their view without interruption

We will not publicly criticise a colleague

We will not engage in malicious gossip

We will agree to engage in constructive discussion about past issues

We will commit to decisions made by the whole team

We will not start side conversations in meetings

We will approach a colleague directly if we have a concern

What kind of intervention?

External vs Internal Intervention

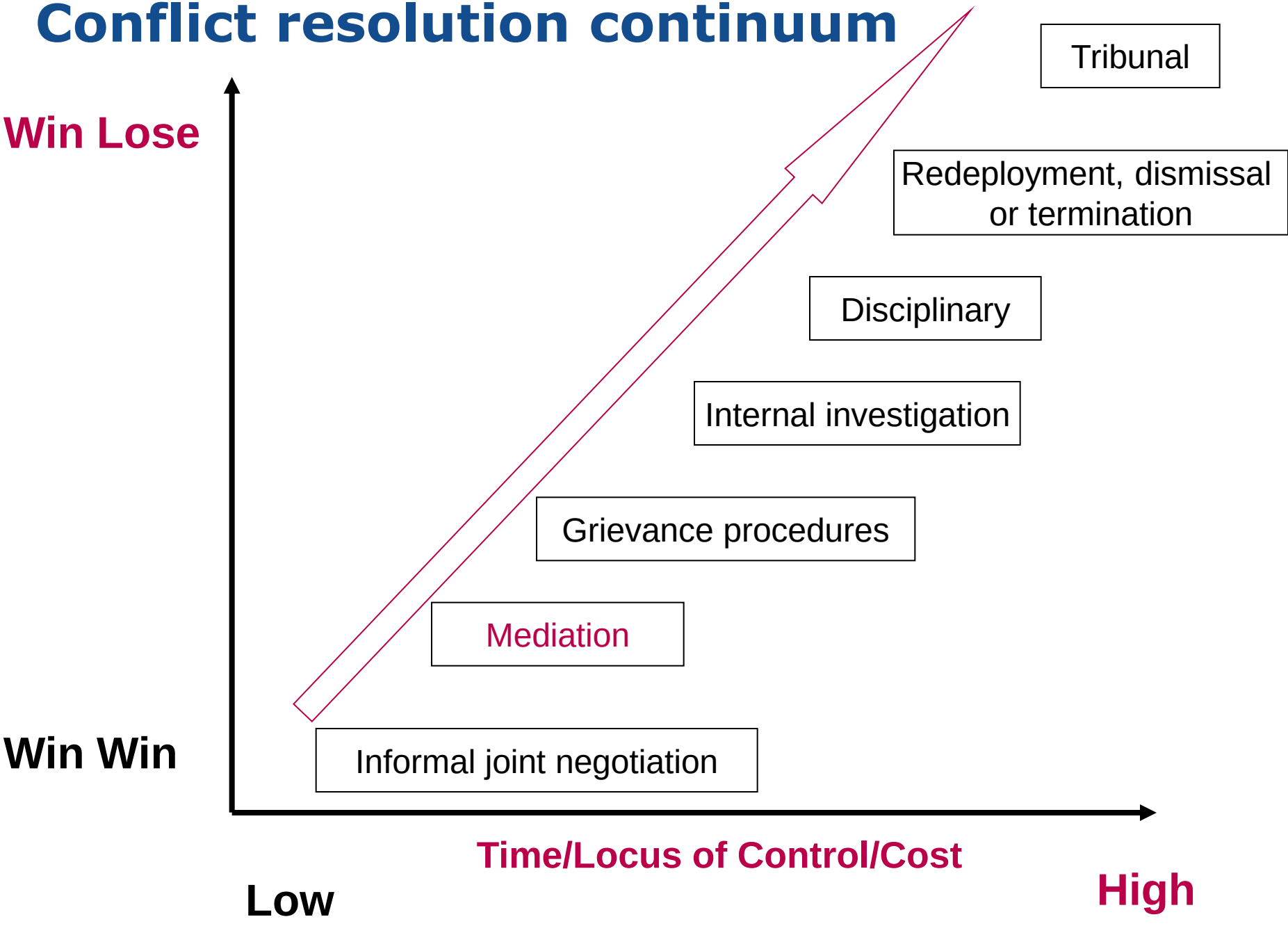
Internal

- What has been tried already?
- Do you have internal expertise? How is it viewed?
- How much goodwill is left?

External

- Raises the stakes; signals intent
- Brings experience of other doctors
- Legitimacy
- Objectivity

Conflict resolution continuum



Mediation: preconditions for success

- Willingness to resolve
- No disparity in status
- No outstanding grievances

Messages for leaders and managers

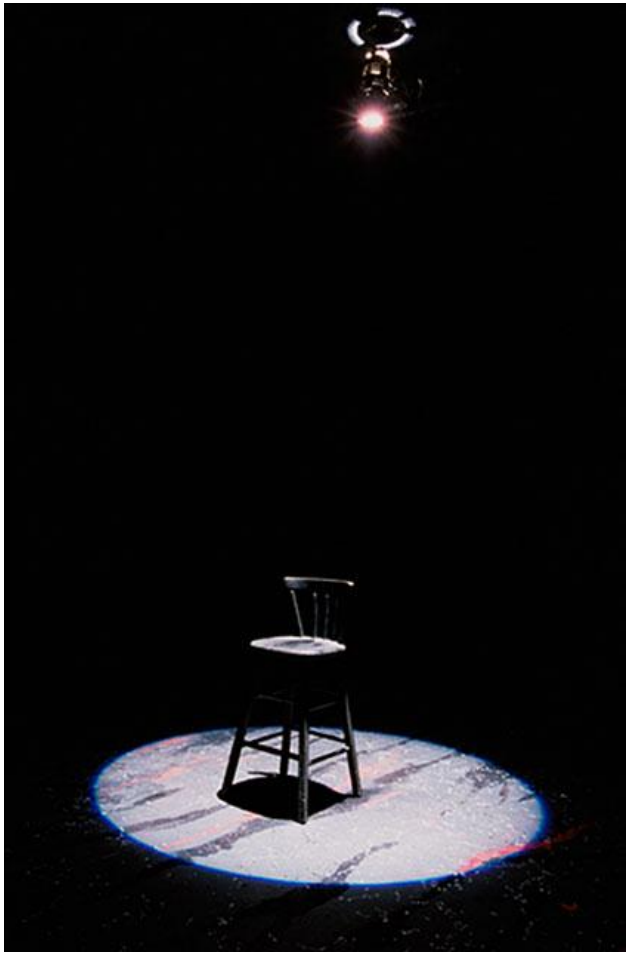
Pitfalls

- Burying bad news
- Misplaced duty of care
- Collusion - silence kills
- A scattergun approach
- Team masking individual dysfunction
- Mediation without the right pre-conditions
- No follow up
- No sanctions for lapses
- No accountability

Essentials for leaders and managers

- Sustained visible “sponsorship” from senior people!
- Timely and proportionate action
- Explicit behavioural expectations and outcomes
- Clear roles and boundaries
- Clarity about what is and is not negotiable
- Sanctions and the willingness to apply them if all other attempts fail

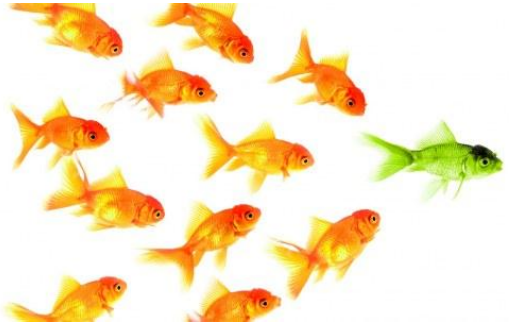
.. and be prepared to put the spotlight on yourselves as leaders and managers!....



Prevention

- Robust selection
- Realistic expectations of new consultants
- Mentoring (new consultants and new leaders)
- Buddying e.g. manager/clinician
- Culture of feedback and accountability
- Competent HR advice (and willingness to use it!)
- Timely and proportionate response to early signs
- Reflexivity
- Team skills training

- **STRONG LEADERSHIP!!**



Thank you for attending….

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