

Balancing the needs of the individual and the team

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Aims of this presentation

- to raise awareness of the impact of the doctor in difficulty on team effectiveness and functionality
- explore the relationship between individual pathology and team dynamics in creating dysfunctional team work in medicine
- consider how best to intervene in the interests of the individual clinician and the team

Contextual factors

Organisational factors

- Intense and constant scrutiny and regulation
- Relentless pressure to meet targets
- Work redesign – production line approach, dehumanised
- Under-resourced
- “Exploit vocation and take advantage of passion”
- Inconsistent management
- Low tolerance for poor behaviour/bulling & harassment

Professional factors

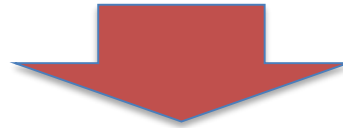
- Rivalry – Reputation – Reward
- Emotional toll of the work itself
- Training and shortages

Interprofessional factors

- New jobs e.g. Consultant Nurse Practitioners (CNS) eroding traditional boundaries
- Team working & respect for multi-professional opinion

Climate of relentless pressure and stress, lack of autonomy, over-work, chronic tiredness and lack of engagement where what was rewarding no longer is

**Traumatised
systems**



Cascade of trauma leaving individuals feeling worn down and worn out with compassion fatigue and fragile resilience

Consequences: a case example

- Professional duty drives work rather than job satisfaction or organisational loyalty
- Feelings of shame, guilt and anxiety about quality of care and impact on patients
- Disempowered individuals who are trained to be powerful and effective
- Lack of control over work or effects of work on home life
- Lack of commitment to broader organisation
- Satisfaction from clinical encounter but being eroded
- Lack of organisational engagement perhaps due to lack of control over work and being bearers of responsibility
- Learned helplessness re ability to effect change or influence local/organisation leadership
- Compassion fatigue and fragile resilience

NEO & HDS psychometric research

- **Bright side traits** – NEO Personality Inventory (Costa & McCrae, 1992)
 - 30 primary personality traits (facets)
 - underlying ‘Big Five’ personality factors
 - Neuroticism
 - Extraversion
 - Openness to Experience
 - Agreeableness
 - Conscientiousness
- **Dark side traits** – Hogan Development Survey (HDS, Hogan & Hogan, 1997)
 - 11 scales measuring behaviour (sub-clinical) under pressure
 - based on DSMiv personality disorders

Derailers: when assets become liabilities

	STRENGTH	Under pressure	DYSFUNCTIONAL BEHAVIOUR
Moving Away	Enthusiastic	→	Volatile
	Shrewd	→	Mistrustful
	Careful	→	Cautious
	Independent	→	Detached
	Focussed	→	Passive-Aggressive
Moving Against	Bold/Confident	→	Arrogant
	Charming	→	Manipulative
	Lively/Vivacious	→	Over-dramatic
	Imaginative	→	Eccentric
Moving Towards	Diligent	→	Perfectionist
	Dutiful	→	Dependent

Source: Hogan and Hogan (1997)

“Derailing doctors” research

Population

- Derailing doctors n = 77 (82% male); mean age = 48.75
- Doctors applying for jobs n = 357

Methodology

- NEO - bright side personality measure
- HDS - dark side personality measure
- Discriminant analysis

Findings

- Controlling for sex & age the greatest discriminators were
 - Neuroticism
 - Extraversion
 - Bold (confident – arrogant)
 - Leisurely (focused – passive aggressive)
 - Excitable (enthusiastic – volatile)

Work in progress ... please do not

quote

NEO findings

- Studies with managers and leaders show success related to:
 - Low Neuroticism
 - High Conscientiousness

Our sample:

- More Neurotic (less resilient)
- Less Extraverted
- Less Agreeable
- Less Open to experience
- Less Conscientious

Work in progress ... please do not quote

HDS findings

- Bold i.e. confident becoming entitled/overconfident/fantasized talent under pressure (i.e. Moving Against i.e. influencing and charming others)
- Leisurely i.e. focused become passive-aggressive/irritated/feeling unappreciated under pressure
- Excitable i.e. enthusiastic becoming volatile/easily disappointed/no direction under pressure

And also more Sceptical, Cautious, Reserved i.e. Moving Away cluster (i.e. detaching and moving away from others)

Work in progress ... please do not quote

Findings suggest

- NEO data - derailing doctors more neurotic i.e. less resilient and more introvert i.e. less extravert - less comfortable in team environments, greater tendency towards introversion potentially more isolated
- HDS data - all 5 *Moving Away* behaviours suggest they do not engage easily when under pressure perhaps not seeking or receiving feedback and support – others move away from them potentially leaving them personally and professionally isolated

Work in progress ... please do not quote

Case study

- High risk surgical specialty
 - Prestigious unit
 - Attractive training placement
 - Strategic pressure for service development
 - Competition for academic positions
 - All but 1 do private practice
 - Work independently of each other
 - “Old-fashioned” approach & communication style
 - No communication between CNSs & surgeons
 - Surgeons united against CNSs
 - Three grievances upheld re bullying & harassment
- Eight surgeons
 - Two professors
 - A academic
 - B innovative
 - capability concerns re two surgeons
 - high cultural mix
 - physical altercation between 2
 - Four Clinical Nurse Specialists (CNS)
 - localised implementation of role
 - narrow interpretation of role
 - no hands-on nursing
 - inflexible approach
 - available by phone/bleep
 - one male CNS works well with surgeons
 - High pressure and stress
 - “We’re all Type A personalities”
 - “Formula 1 fast”
 - Three divorced surgeons, 2 remarried

A spectrum of difficulty in a team

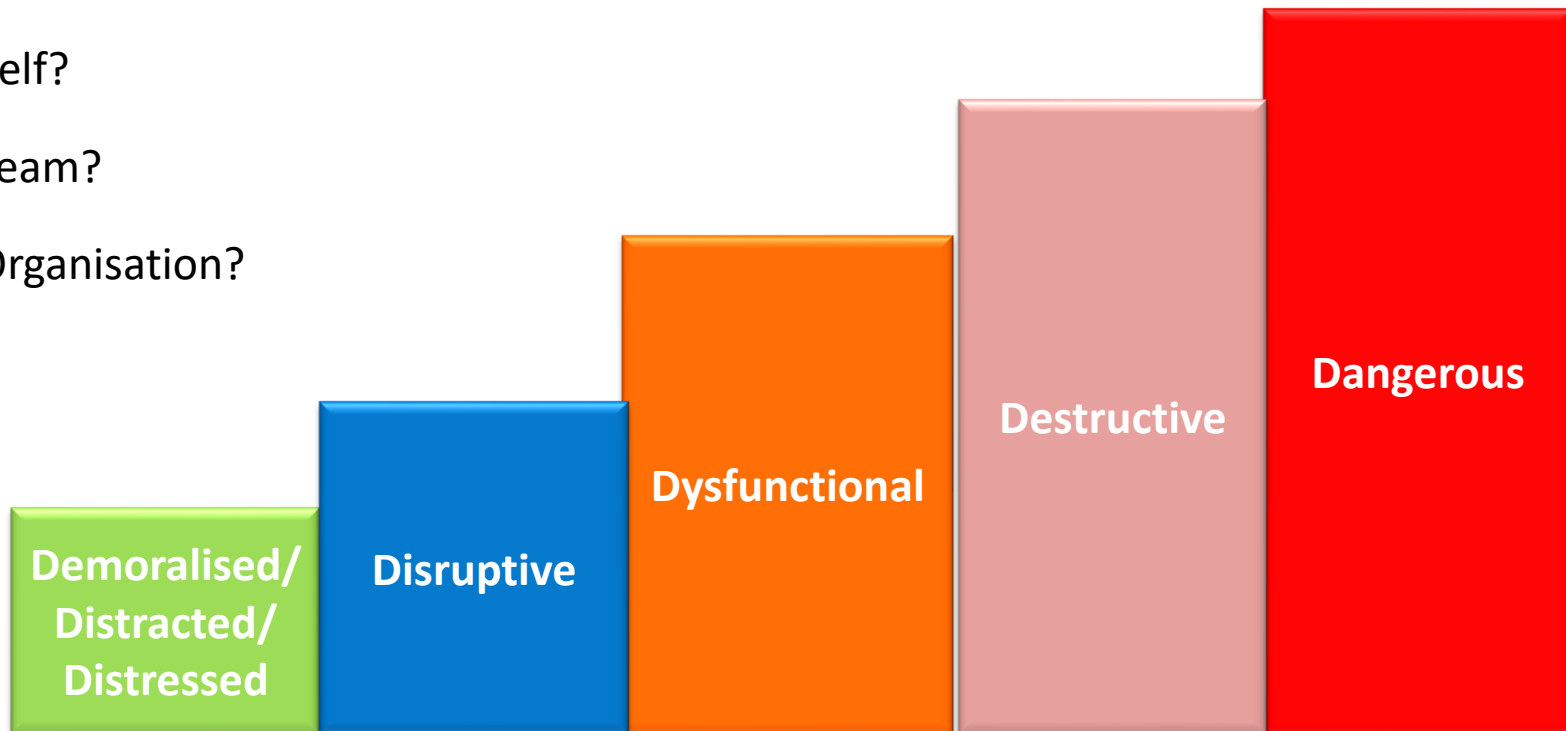
What is the risk to:

Patients?

Self?

Team?

Organisation?



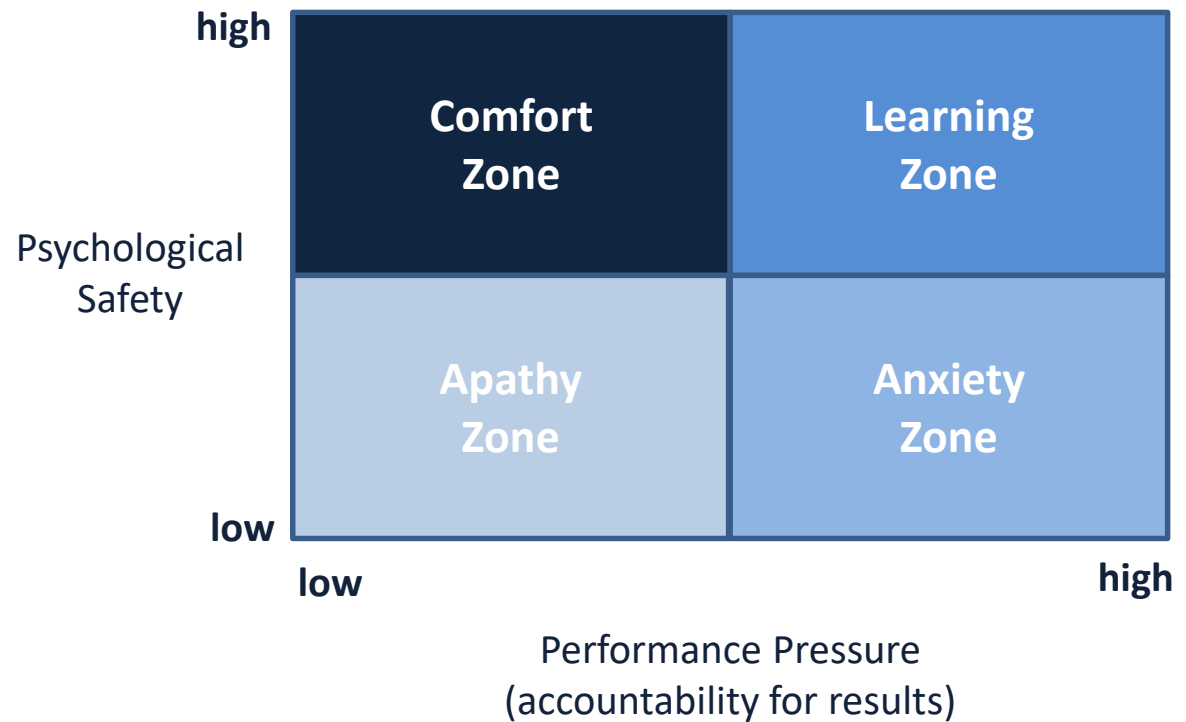
Psychological safety

“Psychological safety is a shared belief that the team is safe for interpersonal risk taking”

(Amy Edmondson)

The competitive imperative of learning

(Edmondson, 2008)



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The shadow side of teams



- Collegial collusion
- Private Practice and Competition
- Informal leadership undermining formal lead
- Legal/union threat/legitimacy paralyzing management action
- Nursing vs Medical rivalry
- Culture of fear
- Sabotage
- Liaisons dangereuses ...

Who is wounded?

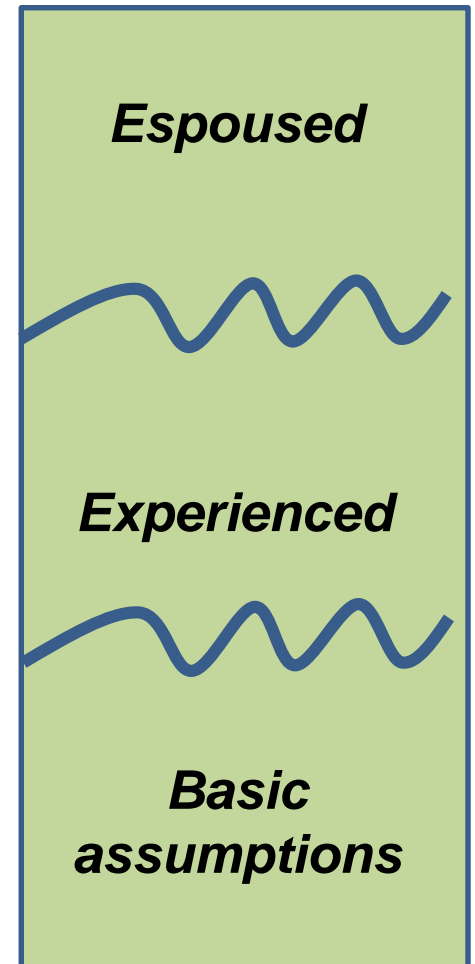


- What is the individual carrying on behalf of the team?
- What is the team carrying on behalf of the wounded healer?
- Is the team “projecting” its difficulties onto one individual perhaps disowning their part in the group problem
- If the focus moves to another person, this might signify something more systemic
- The presenting problem must be tackled at three levels –
 - individual level
 - team level
 - organisational level

Culture

(ref Edgar Schein)

- Culture as espoused or articulated
 - Public statements
 - Core values
 - *We're there as a team for the patients*
- Culture as lived or experienced
 - How individuals actually behave
 - How individuals perceive the culture
 - *We're there to suit ourselves*
- Basic underlying assumptions
 - Invisible, not written down
 - "The way things are done around here"
 - *Surgeons always advantaged*



Team dynamics

Exclusion

- What are the alliances/groups/cabals?
- Who are black sheep? Why?

Conformity – Diversity

- How much challenge and difference is tolerated?

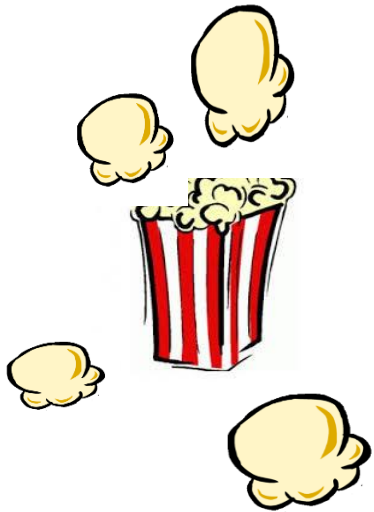
Intimacy – Distance

- Professional and personal boundaries

Competition – Rivalry

- Formal and informal leadership
- Power distribution

Wounded team



- Splitting in team
- Erosion of team identity/trust/cohesion/commitment
- Team can experience being bullied if no action taken
- Resentment about covering for DID; embitterment
- Self-protective behaviour which isolates the index team member
- Lack of confidence in leadership
- Pressure might result in other's showing difficult behaviour
- Relief when the index individual is no longer present
- Anger, concern, guilt, shame, potential further splitting
- Concern about what happens next

Team identity

1. Team identity causes a highly significant increase in team performance
2. Over time the differences in team identity and team performance polarised - teams with strong identities become stronger; those that started weak became weaker
3. At the final measurement, after 6 months, teams with the strongest identities (top 20%) outperformed teams with weak identities (bottom 20%) by 53%.

53% better performance

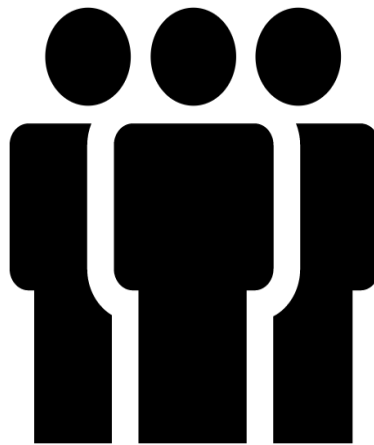
Thomas et al, 2017

For good team work members must

Contribute adequate effort by working towards group goals with intensity and persistence

Perform "emotional labour" by regulating expressions of feelings to facilitate comfortable and positive interpersonal interactions within the group

Perform "contextually" by respecting and adhering to interpersonal and social norms



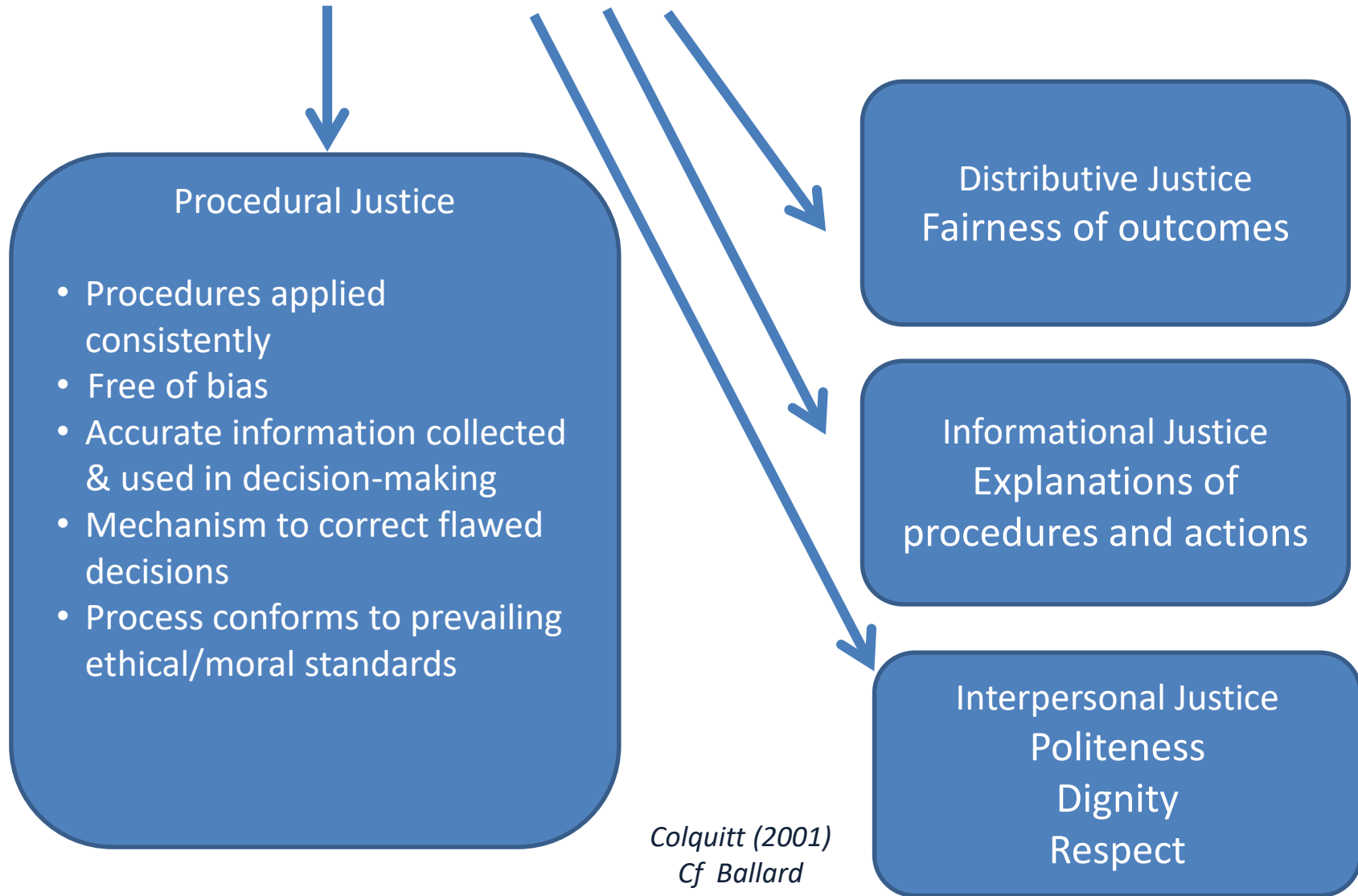
(Felps et al, 2006)

Withholder of effort:
dodges responsibilities ("social loafing") leading to unfairness and inequity

Negative individual:
frequently expresses negative feelings (pessimism, irritation, insecurity, anxiety); blocks progress and upsets others

Interpersonal deviant:
violates norms of behaviour (acts rudely; humiliates, threatens others)

Organisational justice



Compassion fatigue

- Found in professionals engaged in providing care for people who are highly distressed, angry or emotionally demanding
- More common in carers with high levels of emotional empathy
- Associated with symptoms of generalised depression, emotional exhaustion, detachment and lack of enthusiasm for things that were once enjoyed

(ref Tehrani, 2018)

Secondary trauma – compassion fatigue

Re-experience

- Unable to switch off from the work
- Dreams, flashbacks of events
- Over-reactions to work related issues

Arousal

- Unreasonable irritability or anger focused at family, colleagues, situations
- Self-destructive behaviour
- Jumpy, inability to sleep or relax
- Poor concentration leading to increased numbers of accidents or errors

Negative connotations

- Negative self-beliefs
- Lack of interest in things you used to enjoy
- Negative outlook on life leading to unreasonable fears, beliefs and attitudes
- Feelings of isolation from family, friends
- Emotional numbing and difficulty showing sensitivity or positive emotions

Avoidance

- Putting off doing work or dealing with demanding cases
- Not looking too deeply
- Avoiding questions which lead to upsetting responses
- Blocking out or forgetting the most distressing areas

(ref Tehrani, 2018)

Taking timely action

- Take early action
- Think systemically
- Apply equity and fairness
- Carefully managed reintegration
- Provide regular information as and when permitted
- Support for workload
- Recognition of effort
- Opportunity to share events, experience and emotions:
Retreat and Restore

Action

- Individual or Group/Team?
- Work with behaviours and/or emotions?
- Individual support
 - Occupational health
 - Psychological intervention
 - Coaching
 - Performance management
- Team
 - Intra team
 - Inter-team
 - Use organisational values or something more specific?
- Organisation
 - Executive responsibility
 - Job design with sign off at highest level
 - Taking action against a rock star

Retreat and restore

- Private and confidential process is designed for a team affected by a patient/colleague event or experience associated with trauma and stress
- It is not a Schwartz Round, medical debriefing, investigation or enquiry
- A psychologically safe space to share, explore and reflect on the emotional impact
- Reflective, educational and restorative
- No report back or notes taken
- Designed to be self-managed and will not require the use of external facilitators
- Trained internal facilitators (medical consultants) to set up and run the sessions with the help of a toolkit

Thank you for listening

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