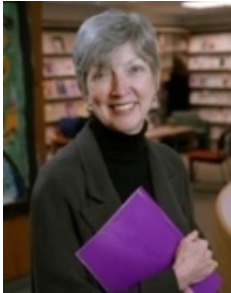


Narcissism and Performance Variations: Applications to the Normalization of Deviance

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Performance Variation and “The Normalization of Deviance”



- Diane Vaughan. “The Dark Side of Organizations: Mistake, Misconduct and Disaster.” Annual Review of Sociology, 1999;25:271-305.
- “Organizational Rituals of risk and Error,” in Organizational Encounters with Risk (2004) by Bridget Hunter and Michael Power, eds.

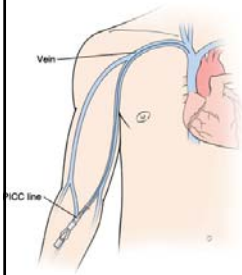
Familiar Deviations

Not washing or sanitizing hands sufficiently, not gowning up or skipping some other infection control measures, not changing gloves or instruments when appropriate, failing to check armbands, not performing safety checks, using abbreviations, not getting required consents or approvals before acting, violating policies on storing or dispensing medications.

One of my favorites

“When I was a medical student, I was observing what turned into a difficult surgery when, about an hour into it, the surgeon inadvertently touched the tip of the instrument he was using to his plastic face mask. Everyone in the OR just froze for a few seconds and stared at him. Without asking for or being offered a sterile replacement, he just continued operating. About five minutes later, he did it again! And still nobody did anything. I was really puzzled, but what do I know? So when the operation was over, I asked one of the nurses. “Oh, no big deal,” she said. “We’ll just load the patient up with antibiotics, and he’ll be OK.” And as far as I know, he recovered just fine.”

Preventing line infections



- Wash hands with soap
- Clean patient’s skin with chlorhexidine
- Put sterile drapes over the entire patient
- Wear a sterile mask, hat, gown, and gloves
- Put a sterile dressing over the catheter site once the line is in
- One study: Physicians skipped at least 1 of these steps in more than 33% of patients

Compliance Problems at the Veterans’ Administration Medical Centers

- “Investigators with the inspector general’s office at the VA testified Tuesday (June 16, 2009) that fewer than half of the VA facilities using endoscopes had posted proper cleaning guidelines for the equipment as well as documents showing that the staff is trained in such procedures.” (USA Today, June 17, 2009 4A)

Ouch.....



"In Miami, a tube that was supposed to be cleaned after each colonoscopy was instead cleaned at the **end of each day**, affecting patients between May 2004 and March 2009."

The Ventilator Disaster



Anesthesia Monitoring Shortcuts Are Common!

- One study found that about 17% of anesthesiologists remove blood pressure and/or ECG cables before the patient's emergence from anesthesia and tracheal extubation;
- Another study of academic anesthesiology departments found that 16 percent use only a pulse oximeter to monitor safety when performing peripheral nerve blocks (rather than the standard ASA-recommended monitoring)
 - Richard Prielipp et al., "The Normalization of Deviance," Anesthesia & Analgesia, May 2010.

“Resident Pathogens”

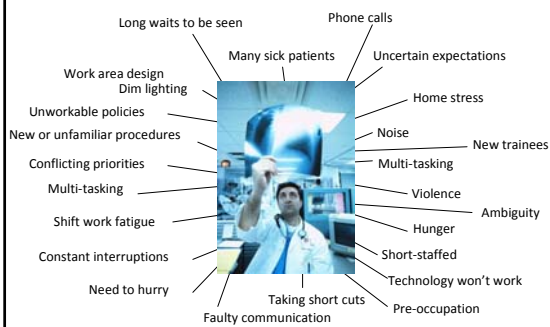


- “In the past, reliability analyses and accident investigations have focused primarily upon active operator errors...(but) rather than being the main instigators of an accident, operators tend to be the inheritors of **system defects** ...Their part is usually that of adding the final garnish to a lethal brew whose ingredients have already been long in the cooking.” *Human Error*, 173.

Error-prone organizations....

[E]ven when recognized, problems are worked around; people improvise to “get the job done,” even when indicators suggest something amiss. They fail to contain problems or improve processes, leaving factors that confounded one person’s work to confound again. (Spear SJ, Schmidhofer, M. Ambiguity and workarounds as contributors to medical error. *Annals of Internal Medicine*, 2005;142:627-630.)

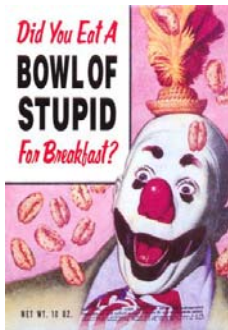
Not Deviations But Resident Pathogens Nevertheless



Why does the “normalization of deviance” or “routine nonconformity” occur?

Answer: Lots of stuff...

THE RULES AND SAFETY STANDARDS ARE STUPID!!!



- The rules are
 - STUPID
 - CUMBERSON
 - NONSENSICAL
 - COUNTERINTUITIVE
 - INEFFICIENT
 - IMPOSSIBLE
 - CREATED BY IDIOTS (i.e., supervisors and administrators)

Knowledge Issues Bearing on Noncompliance

Ignorance Map



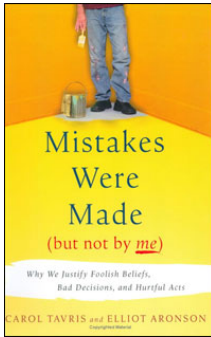
- Various disciplines might understand or interpret the standards or rules differently
- Workers don't know the standard or policy exists or understand its significance;
- Workers might even **distrust** standards that are new to them.

Judgment calls



- System operators might disagree on whether or not a rule or standard applies, e.g., reporting an X to the physician or to pharmacy (but is that really an X?)
- Where judgment is corrupted by bias (e.g., confirmatory or availability) or **narcissism**

Narcissism as Arrogance



- “The rules don’t apply to me. I don’t bother to acquaint myself with them.”
- Responsibility for rule following (and rule violation) is denied or deflected

Narcissism as Self-Protection: System operators don’t speak up



- System operators fear speaking up because they fear retaliation
- Disbelieve the possibility of meaningful system change—nothing will happen if I speak up
- Fear tarnishing the image of the organization

Yet, ignoring process variations or deviations will encourage their normalization



Some recommendations

Speaking Up

- Develop a culture that:
 - Understands the inevitability of deviance or nonconformity
 - Appreciates both the benefits and burdens of a culture of non-retaliation (i.e., a “just” culture)
 - Protects system operators who do speak up
 - Promotes a culture of responsiveness
 - Realizes that protecting deviant system operators risks harming the consumers of our services

This is tough because you're going against human nature!!

- Putting risk aversiveness and vigilance into action might mean:
 - Going against your intuition: "But this is such a low probability event and nothing bad has ever happened"
 - BUT SUPPOSE IT HAPPENS! HOW BAD WOULD IT BE?
 - Expending energy into *enabling nonevents*

Develop Mitigation and Vigilance Strategies

- Identify system deviations through frequent rounds, survey of incident reports, RCA, focus group research
- Develop mitigation strategies
 - Pay attention to weak signals and early warnings: They are "free tuition"
 - Beware of excessive optimism: "But nothing bad has ever happened!"

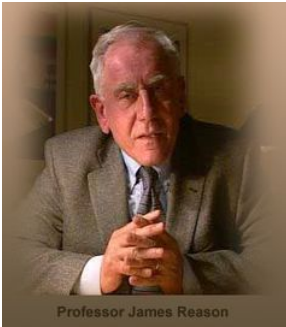


The Great Challenge: Continually ask and study how we make system operators feel safe in discussing and calling attention to unorthodox behaviors and process variations so as to reduce system based threats to patient safety.

Realize this is a never-ending project

- Systems always run in a degraded mode;
- Human beings like to experiment, and trying out new intervention strategies is often an expression of a caring employee who wants to do a job better or who wants better results
- The system is always witnessing change, which invites new harm opportunities

“The only attainable safety goal



Professor James Reason

... is not zero accidents, but to strive to reach the zone of maximum practicable resistance and then remain there for as long as possible.” (Reason, *The Human Contribution*, p. 285)

Vigilance Leading to Resilience: We take a licking, but we keep on ticking

