FLO: The Solution to Knowing but Not Doing

COMMENTARY

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ABSTRACT

Dealing with the failure of many patient safety initiatives to positively impact patient safety is one of the most daunting issues healthcare systems now face. The concept of front-line ownership (FLO) and the research documenting the success of this approach is thus critical to all involved in the effort to make healthcare safer for patients. Focusing on why it is so important to involve front-line workers at every level in designing, implementing and evaluating patient safety initiatives is the subject of this commentary and, in the author's view, the only way to move from theory to practice, and from exhortation to the kinds of changes in behaviour and attitudes upon which patient safety depends.

ONE OF THE most vexing and frustrating problems in the effort to make patients safer in our high-tech healthcare systems is the gap between knowledge and action. In many areas, we know just what we need to do to keep patients safe. As Ross Koppel and I wrote in our book *First Do Less Harm: Confronting the Inconvenient Problems of Patient Safety* (2012),

we *know*, for example, that hand cleaning is one of the most effective methods to prevent the spread of infection. Yet, 50% of health-care workers do not wash their hands, even though they know they should. We know that the overuse of antibiotics leads to the development of hard – or even impossible – to control superbugs. Yet doctors routinely

prescribe antibiotics to people who don't need them (and doctors sometimes don't wash their hands because, "Well, what's the big deal? There are always antibiotics if a patient gets an infection"). We know that failures in communication and teamwork cause more than 75% of medical errors and injuries, yet most "teams" in healthcare are teams in name only (Koppel and Gordon 2012). Personnel who should be working together seem more often than not to be, as I have described it, "intimate strangers engaged in parallel play at the bedside" (Gordon 2006). We know ties, rings and jewellery – not to mention stethoscopes and white coats – are vectors for disease; yet North American healthcare professionals proudly continue to wear them. We know that surgery – and many other treatments and procedures – are safer when people use checklists and time outs; yet some surgeons adamantly refuse to institute these safety practices.

What else do we know that we don't do? We know that flattening healthcare hierarchies will lead "lower-level" healthcare workers to more effectively cross-monitor their so-called superiors, thus potentially preventing errors. Yet, many surgeons (to name only one category of clinician) still insist that their patients want them to be called "Dr. So-and-so" – even in the operating room, when the patient is usually unconscious (National Health Service 2009). We know patients are often so intimidated by their physicians or nurses that they fear to question them; yet we constantly outsource safety to patients, asking them to do everything from making sure that physicians, nurses, laboratory technologists etc. clean their hands, to expecting them to monitor which dose of which medication a harried doctor is prescribing and an equally harried hospital nurse is administering (Frosch et al. 2012; Gordon 2012a). We know the brain can't multi-task, but we ask those upon whom our lives depend in hospi-

tals and other healthcare institutions to do just that – juggle the care of four, five, maybe 10 or even 30 patients. We know the brain needs sleep in order to function and food to fuel it. Yet, particularly in North America, the sickest patients are dependent on physicians and nurses whose last good night of sleep may have occurred in their dreams and who go for more than six or eight hours without food (Kahneman 2011; Landrigan 2012; Trinkoff and Geiger-Brown 2012).

Sadly, this list is only a partial one. It could go on and on, which is why this model called FLO, front-line ownership, is so important. It identifies the gap that separates knowledge from practice and suggests how to address it so that we can turn scientific evidence into safe practice. That gap is made up of attitudes and behaviours that must change if patients and those who care for them are to be safe in our healthcare systems. As every major study about patient safety has pointed out, patient safety depends on a total top-to-bottom and bottom-to-top transformation in healthcare culture. But cultures do not change first, with behaviours following. Behaviours change; that change reshapes culture. To echo Zimmerman et al.'s quotation from Jerry Sternin, culture changes when people act their way into a new way of thinking.

Why is this lead paper so important? Because it hones in on what the great Canadian sociologist Erving Goffman wrote about more than 50 years ago – the fact that human life and activities are a series of performances. These performances occur not simply at the front of the stage, where experts explain what must be done to make patients safe and try to sell these techniques to staff (Goffman 1959). Where the rubber hits the road is in the backstage and private spaces where the messages, information and suggestions presented in such front-stage performances are either taken up and implemented or resisted, sabotaged and undermined. Today,

front-stage reports such as the US Institute of Medicine's *To Err Is Human* (1999) and *Crossing the Quality Chasm* (2001) have been trumpeted in the news media and have generated thousands – who knows? maybe even millions – of patient safety initiatives across the globe. Yet the stubborn statistics on patient harm quantify the equally stubborn persistence of the kind of behaviours and attitudes that I outlined above. Without some help from unusual suspects, such as theories of positive deviance or liberating structures, traditional medical science will continue to have a limited impact on the behaviours and beliefs of the front-line healthcare workers and leaders upon whose actions patient safety depends.

As we pointed out in *First Do Less Harm* and Zimmerman et al. brilliantly elaborate, you don't get people to change behaviour by throwing statistics at them or referring them to the latest report in a prestigious medical journal. Nor does behaviour change when high-level "champions" come in to "sell" the latest flavour-of-the-week (there are so many, that it's no longer even flavor-of-the-month) safety initiative (Lazes et al. 2012). Front-line workers will only act and change their behaviour when they are involved, not just in implementing the designs of "the experts" but when treated as experts themselves. Rajiv Jain and his colleagues at the US Department of Veterans Affairs (VA) proved this both, as the authors say, "socially" and statistically, in their successful attempts to reduce the rate of methicillin-resistant *Staphylococcus aureus* (MRSA) infections across the VA system (Jain et al. 2011). They used theories of positive deviance to find out who was cleaning their hands in a system in which so many others were not. These people – the positive deviants, not the high-level experts – led the focus groups and initiatives that helped to significantly reduce the rates of MRSA in the 152 VA hospitals. Yet, this kind of social

action did not make it into their *New England Journal* report on this amazing development. (Is this because it didn't fit the formula for scientific discussion and exploration? Or because it was the kind of "social proof" or "practice-based evidence" that Zimmerman et al. argue should also be included in our evaluation of safety measures?) To find out about what really happened at the VA, I had to read newspaper accounts and then go to Jain to discover how knowledge led to action in a complex institution.

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In my own work with healthcare professionals and other healthcare workers, I am constantly struck by how often backstage concerns and actions go unchallenged and, thus, defeat the best of intentions and the most well-thought-out initiatives that are sold to front-line staff. In the United States, the Agency for Healthcare Research and Quality has worked with the Department of Defense to craft an impressive team-training curriculum called TeamSTEPPS (Agency for Healthcare Research and Quality n.d.). In many places, the training has worked well to impact behaviour and practice. In others, it has been less effective. The theory and materials are not the problem. The problem should not be surprising: it is the resistance of healthcare leaders – nurse managers, physicians, higher-level administrators – some of whom consider themselves to be totally dedicated to patient safety.

I have sat in on meetings where staff reported that they fear retaliation if they put

TeamSTEPPS skills training into practice by challenging a superior to implement safe practice. I have observed chief nursing officers and hospital chief executive officers listen to this feedback and yet say nothing to reassure staff that if retaliation occurs, it will not be tolerated. What is so impressive in these meetings and in cases where a high-ranking – or high-earning – physician's behaviour is questioned is that hospital "leaders" often express a sense of powerlessness, even though they acknowledge that such bad behaviour has the potential to produce patient harm.

The same is true in institutions where the issue is a nurse manager's poor managerial practice. Similarly, in interviews I have done with nurse managers, many report that they feel equally powerless to intervene in the kinds of conflicts between nurses and nursing assistants that erode staff morale, encourage turnover and can also lead to patient harm. They lament their lack of training in conflict resolution, and confess that they have little support from their executive team (particularly when it comes to supporting a registered nurse [RN] who challenges a physician) on safety issues. Some have said that they even worry that intervening in a conflict between, say, an RN and a nurse's aide will result in someone reporting them – the managers – to human resources.

What these conversations, particularly with front-line staff, reveal is that many who work in healthcare do not believe their workplaces are "psychologically safe" environments (Edmondson 2003). They do not feel that they can constructively challenge a superior, or even colleagues or co-workers at their own level, without being "blown off" or, worse, humiliated or disciplined. This is in spite of the fact that we know that nothing will change in patient safety unless healthcare personnel at every level help one another to change behaviour, discuss mistakes and encourage positive deviance.

The concept of FLO and the techniques that Zimmerman et al. have used in their work in hospitals directly targets the need to transform human behaviour and attitudes so that knowledge can be put into action. It does this not by trying to convince front-line staff to listen to the experts but by acknowledging, enlisting and then engaging their own expertise. I have written about how this has been done at a major hospital in the United States – Maimonides Medical Center in Brooklyn, New York (Gordon et al. 2013). What the authors present in this lead paper is yet more proof that patient safety depends on effectively engaging the expertise of the people who know what is wrong and how to fix it.

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Although the authors do not use the term *psychological safety*, their FLO model implicitly depends on creating psychological safety in the healthcare workplace. The very fact of arguing that front-line staff – some of whom are regarded by higher-ups as doing little more than "mindless" work – have expertise and should lead, not simply follow, patient safety initiatives is an act of profound significance in the toxic hierarchies that often characterize the contemporary healthcare workplace (Gordon 2012b; Pronovost and Vohr 2011). Their model has implications that are both symbolic and concrete. By enlisting staff in identifying, crafting and then implementing solutions to serious patient safety problems, the model produces concrete results. On the symbolic level – a level at which humans function in the deepest sense – the fact that hospital leaders choose to explicitly

acknowledge staff expertise and implement their suggestions is the first step in transforming the behaviours that jeopardize patient safety.

> *On the symbolic level, the fact that hospital leaders choose to explicitly acknowledge staff expertise is the first step in transforming behaviours.*

Flowing logically from this model, the authors' argument that we must depend not only on gold standard randomized controlled studies to guide our patient safety activities but also on social proof is one that we must take very seriously indeed. Recognizing the value of social proof (such as creating and then mobilizing the kind of social networks they describe in their "social network mapping") acknowledges how important the generation of new conversations about patient safety is to turning it from aspiration to reality. The new affirmative safety conversations generated by the newly recognized expertise of staff at all levels replace the kind of negative conversations that all too often torpedo the most well-intentioned of initiatives. In a healthcare culture that too frequently relies only on statistical proof (and then, as in the debate about nurse-staffing ratios, sometimes denies the import of the data that prove the case for action), social proof is critical. We cannot, for example, wait for the definitive study that proves a connection between physicians' and nurses' ties, rings and bracelets and reductions in infections before we act on what anyone outside of healthcare would consider simple common sense. In a high-tech healthcare system that is producing horrific infections, if it might help, do it! Particularly when, as in the examples cited above, it costs the system absolutely nothing.

There is a lot of talk in healthcare about responsibility, accountability and ownership of patient safety. The authors of this lead paper should be thanked for helping us understand how to move from rhetoric to reality in this critical area.

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