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Culture
What is it?
Who is it?
How is it formed?

I am making an assumption that everyone has read the document circulated with the Agenda,

As well as the documents circulated by Sam,

As well as the Vector report, and the E & Y report.

As well as the Engagement and Survey report.

I will not repeat what is already been said or circulated, but rather try to address the questions that arise out of it.

First, why should we bother about culture?



- Does it matter?


- Culture was positively associated with mortality rates, failure to rescue, readmission rates and adverse events / medication errors. ...well-being outcomes, notably, patient satisfaction, quality of life and patient mood.
- Patient mortality rates were nearly 48% lower in hospitals with better work environments, and surgical mortality rates were >60% higher in hospitals with poor work environments.

Braithwaite et al., 2017


The literature is clear: Culture has an effect on the care we deliver to patients, and these effects are mediated through the effects on provider's performance.

There is other literature that shows that team performance is a function of the context, the cultural context, in which the team exists.

Does this come as a surprise?



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Culture: What is it?

- The shared values, belief, or perceptions held by employees within an organization, ... the “social glue holding an organization together”, ... the underlying assumptions and beliefs that the members of an organization share and that operate unconsciously.

Korner et al: 2015


This is one definition of culture from the literature. It is much more sophisticated but the one that comes easily to mind: Culture is the way that we do business.

In my document I say that the plural of anecdote is not data, but that the plural of anecdote is culture. On reflection, this is not true. Rather, the plural of anecdote is our belief system, which is the underpinning of our culture.




Who is responsible?

- We all are



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Who is accountable?


- All the literature says:

The Leaders.


This is what the literature says.

I would ask you all, however, is there anyone in this room who has not had sometime been identified or self-identified themselves as a leader? If so, you are accountable for the culture that surrounds you.

HAMACIs supposed to be composed of medical leaders. What culture are we supporting?



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Leadership:

When people in authority want the rest of us to behave, it matters – first and foremost – how *they* behave.

This is called the “principle of legitimacy” and legitimacy is based on three things.


- People asked to obey have to feel they have a voice – if they speak up, they will be heard.
- The law has to be predictable – the rules tomorrow will be roughly the same
- The authority has to be fair.

Gladwell, 2013


Last weekend, I found this quote in Malcolm Gladwell’s book “David and Goliath”. I think it is important for us to remember that it is how we behave that will be seen and that will influence those whom we lead. Not what we say.

Unfortunately, I have been unable to find any guidelines in the literature about how to improve culture. There are commentaries about the characteristics expressed or demonstrated by High Reliability Organizations, or, indeed, High Performing Organizations, as I have outlined in the paper.

Unfortunately, the literature is silent as to how to get there. This is even true for the BC Patient Safety and Quality Council’s information on a “Culture Change Toolbox”. It simply says what is present in good cultures, without much in the way of guidance of how to get there, beyond common sense.



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High Reliability Organizations

Chassin & Loeb, 2017


Stages Of Maturity In Health Care Organizations' Path To High Reliability

Organizational characteristic	Stage of maturity		
	Minimal	Developing	Approaching
Leadership	Quality activities focused on regulatory requirements Strategic importance of quality improvement not recognized Metrics for quality goals not part of strategic plan or incentive compensation Information technology provides little support for quality improvement Physicians not actively engaged in quality improvement	Chief executive officer leads proactive quality agenda Board reviews adverse events Organization sets a few measurable quality aims Information technology supports some quality and safety initiatives Physician leaders champion quality goals in some areas	Organization commits to goal of high reliability for all clinical services Organization aims for near-zero failure rates in vital clinical processes Some services demonstrate near-zero failure rates in some vital clinical processes Reward systems for staff prominently reflect accomplishment of quality goals Information technology integral to sustaining quality improvement Physicians routinely lead quality efforts
Safety culture	No program to assess safety culture No assessment of trust or intimidating behavior Root-cause analyses limited to most serious adverse events; close calls not recognized or evaluated	Establishing safety culture accorded high priority by leaders at all levels First measures of safety culture deployed Beginning initiatives to encourage reporting and analysis of close calls	Safety culture is well established Measurement of safety culture is routine and drives improvement Regular reporting of close calls and unsafe conditions leads to early problem resolution
Robust process improvement	No formal quality management system External requirements are focus of improvement efforts No commitment to sustainable improvement	Organizational commitment to adopt strong quality improvement tools Training of selected staff beginning Improvement tools used to achieve gains in quality and safety in addition to routine business processes	Robust process improvement tools used throughout organization Patients engaged in redesigning care processes Mandatory training of all staff in robust process improvement Proficiency in robust process improvement required for career advancement

This is a more theoretical discussion by these authors from the United States.



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High Performing Organizations:

1. Shared (and clear) sense of purpose
2. Leadership style
3. Accountability system for safety, quality and service
4. A focus on results
5. Collaboration


The literature on high performing organizations in Canada, US and the UK all show similar defining characteristics.

It gives us only guidance on what we should be doing, not how to get there.

However, it does provide standards for us to measure ourselves against.



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HAMAC, culture and governance?

- Are we fulfilling our responsibility under the Bylaws?
- Are we exercising governance?
- Are we seen to be exercising it fairly?
- Are there changes that should be made in how we exercise our leadership and governance roles?
- What do we – all of us who sit in this room – have to do differently to make patients, providers and patient care flourish?

It is fine for us to talk about “them” changing culture. However, we must recognize that the organization is perfectly constructed to provide the results that it is getting. (Quote Some of the comments in the reports.) We cannot change others, we can only look at ourselves to change ourselves. There are many questions that should be answered.

Do we have the right number of people at the table. Several years ago, the number of Departments was reduced from 17 to 8, to make our meetings more efficient. Unfortunately, the number of departments heads, the content experts at the table for quality discussions, has gone down, our numbers have increased. In 2013, 5 years ago, we had more Department heads but only 35 people invited to the meeting. Now, with half the number of Department heads, our number has increased to a total of 45.

Do we have the right mix of people at the table?

Are we spending the right amount of time both in total and on serious topics? Apart from the organizational meeting, which is very much pro forma and has been canceled early twice in a row, we have a total of 10 hours in a year. Look at tonight’s agenda, and again I will ask if we are discussing the right topics for the right amount of time.

Similarly, I do not understand how we can not have the Nanaimo MSA not having a seat at the table whenever topics such as Vector or Ernst and Young are being discussed. I am told that recently the Board had a whole day meeting on culture. Not having representatives from the Nanaimo physicians, those who have struggled most with cultural problems, or any other MSA group sends a very poor message.. It is reflective of the problems.

Do we have committees that do not meet? If so, why?

Is the content of our agenda appropriate to monitor the standards of clinical care in the organization? Do we get appropriate data about the quality programs, the safety programs that will allow us to report appropriately to the Board on that which we should be reporting on.

Mme. Chair, I would turn the discussion and questions over to the members.