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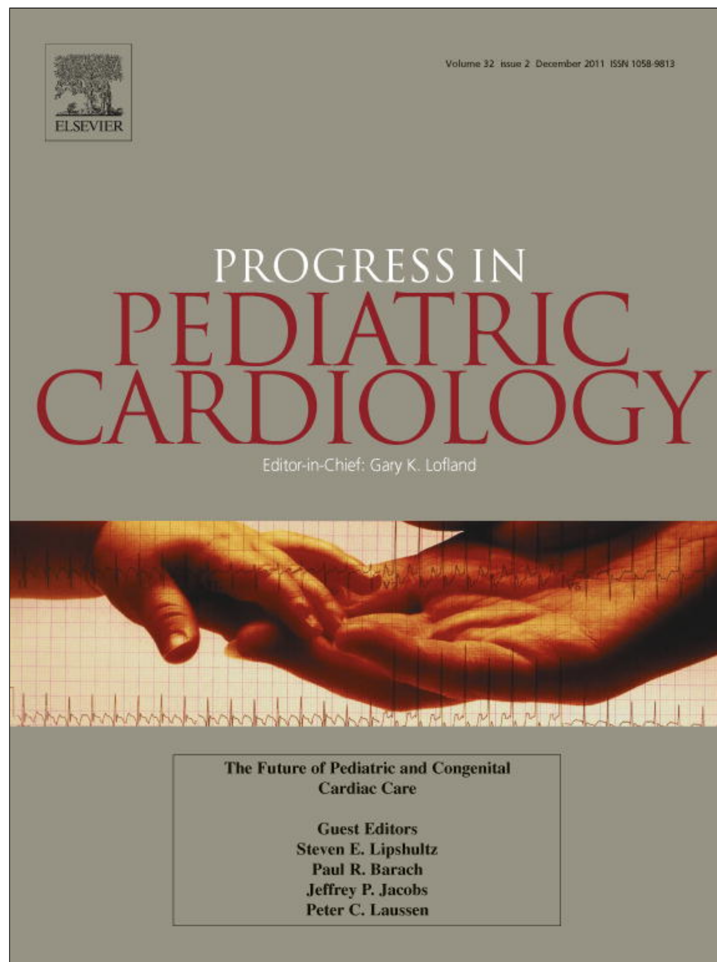

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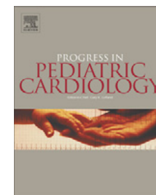

Improved quality and outcomes through congruent leadership, teamwork and life choices

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ABSTRACT

This manuscript evaluates how substantial improvement in quality and outcomes can be achieved by attention to intra and interpersonal factors that influence learning, growth, innovation and team function. It is difficult to quantify the improvement in outcome in terms of lives saved, errors prevented, morbidity reduced, but the literature on this topic as well as the experience of numerous providers suggests that it will be real and substantial. The recommendations in this manuscript will help you improve your practice.

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Through our various speaking engagements and in response to our articles, people keep sharing their stories with us. We can feel the frustration, the hurt, and the despair in the written or spoken words. (In order to protect actual people and programs, the stories that follow have been altered).

> A surgeon blames his ICU team for the death of a baby after a difficult heart repair. In the "interest of patient safety", he refuses to allow certain members of the team to ever touch one of his patients again. The Head of the ICU wants guidance.

By the time we have been contacted, the surgeon has been called to the hospital disciplinary committee and given a reprimand for unprofessional behavior. He maintains that he is acting in the best interests of his patients and if the hospital wants to support incompetent intensivists who 'destroy otherwise excellent operations', then he will find another job. The hospital has hired a new surgeon and is having better results than ever with the same ICU. The previous surgeon is still out of work. This article will discuss how to address these conflicts in order to pursue best practice.

> A new surgeon is hired and begins to have an affair with one of the cardiologists—apparent to everyone on the team. Together, they conspire to make decisions that are not always in the best interests of the patients. We are asked by a team member what to do to help bring this to a stop.

We are contacted by the hospital CEO who was willing to meet with us and who was previously unaware of what was going on. With his permission we perform interviews and share our findings with him. Both the surgeon and the cardiologist were suspended for unprofessional behavior. A more junior surgeon became the primary surgeon and is doing an excellent job. The chief of cardiology and the chair of surgery were admonished for lack of leadership and ability to intervene. The hospital CEO (who we thought demonstrated outstanding leadership) is sending them both to leadership development courses. The hospital is recovering. Both the surgeon's and the cardiologist's marriage have subsequently broken up. The hospital is unsure if they wish to reinstate either. This article will discuss the importance of leadership in turbulent times.

> A physician who has been practicing for 15 years and who is known for his "work ethic" and professionalism in the organization, gets a DUI coming to work one night to see a patient in the ER. Should he be dismissed from the hospital?

We work with the surgeon on the issues behind his unhappiness. He cites an empty marriage, mounting financial responsibilities, and a never-ending succession of sick patients whose complexity requires more and more from him, and he just doesn't have that much left to give. He feels "burned out." This article will describe some of what we talked about with him and the implications of "burnout" on patient safety.

> The head of the ICU yells at a nurse in front of the family, accusing her of incompetence and stupidity. The patient dies and the family files a lawsuit against the nurse and the hospital. The physician is asked to provide a deposition, which he does. Is this a violation of professionalism?

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Yes. The violation occurred when the physician chastised the nurse in front of the family. He demonstrated lack of self-management and it contributed to a mess. The nurse is still devastated (not by her treatment from the physician, for whom she has lost respect; but from the loss of a patient who she feels died "under her watch." She is still trying to learn how to reconcile loss when she works so hard to do the right thing). The family lost the lawsuit, and the intensivist is now looking for another job. This article will discuss the important link between professionalism and best outcomes.

> The wife of a successful surgeon writes to ask how to restore their relationship, which has become distant and non-connected. She wants to have their life back. She is also worried that he seems less engaged and dedicated to his work and she worries about the implications of his affect to patient safety and outcomes.

We offer coaching and counseling. The surgeon and his wife participate in some limited counseling (one of the authors, JDU, is a licensed mental health professional) and he is "burned out." Working harder, making less, under constant performance pressure to achieve unrealistic outcomes. He is depressed. The wife just wants to reconnect to the vitality and hopefulness she experienced early in their relationship before his life as a surgeon "wore him down." This article will discuss the link between this common scenario and best outcomes, and provide some tips for managing this looming problem.

> A respected surgeon kills himself. No one saw it coming. In his suicide note, he despairs over the loss of a patient and the impossibility of trying to be perfect. How can we help the team understand?

We suggest grief counseling for the team. The hospital tells us that they will just hire another surgeon (they already have) and that the team will "get over it." This article will discuss the implications of that kind of thinking.

> A cardiologist demands that a surgeon be dismissed due to "poor outcomes" and threatens to send patients elsewhere. What should the hospital do?

In this case, the hospital responded by dismissing the cardiologist for disruptive behavior. The surgeon continues to practice and is getting good results. The cardiologist is working at another practice in the same town, but his patients have not all followed him, and the original program continues to perform quite well. This article will discuss bullying and its consequences to patient safety.

> A family is happy that their child survived, but writes about the dismissive and occasionally nasty way the physicians treated each other. Is that necessary in order to provide good care?

No. In fact, from what you will read below, it is likely that the care from this group is consistently less than optimal. We simply respond to the family that we are glad their child is doing well and are sorry that they felt so uncomfortable with their physicians. We suggest that they send a letter to the CEO of the hospital.

> A surgeon shoves a cart with the computerized medical record across the ICU, accusing the ICU of incompetence. He storms out of the ICU leaving the family and the rest of the team wondering what to do next. He is considered to be a good surgeon. What can we do to help him?

In a private interview with the surgeon, a few months after the event, he admitted that he felt scared that his reputation would suffer if the patient didn't survive. When we asked him to imagine what it might mean to the family if the patient didn't survive, he began to cry. He later acknowledged that he had it all warped. He was placing his concern for his reputation above his compassion for the people he worked with (staff) and cared for (patients). He is one of the lucky ones and we are glad to say he is practicing now at a high level, more aware of stress and armed with tools to manage himself during those times. He is also better at harnessing the collective wisdom and help of his colleagues and is producing better results than ever before. And he is happy.

> A cardiologist suggests an option to the surgeon who scoffs and says he won't consider it. The cardiologist feels rebuked and is upset that his idea, which might be better for the patient, isn't even considered. The patient dies after a lengthy and complicated surgery. The cardiologist writes to us asking how he can get through to his surgeon and have his opinions considered.

This issue touches on a core element of good teamwork—the ability to accept influence from one another, and to create a culture of trust that is not dependent on outcome. We will discuss this in the article.

> Finally, one of us (RU) is rounding in an ICU as a visiting professor and observes sarcastic interactions between the intensivist and the surgeon—both trying to "one up" each other. The nurse appears "caught" in an uncomfortable situation. The patient, a neonate after a complex operation, is struggling and the two physicians are seemingly more intent on "being right" than on working out a collaborative solution. I feel uncomfortable and wish I could focus them on listening to each other's perspectives without summarily rejecting everything each has to say. I suspect the family, who is present, feels the same. The nurse tells me, in a separate interview, that the team functions fine when the patients are doing well and that the behavior I witnessed only surfaces when there are problems.

This article will discuss some of the easily recognized signs of poor teamwork that contribute to sub-optimal outcomes and how a system can be developed that gives everyone on the team permission to state what is real, even (especially) during times of stress. This group has not asked for help, so none was offered. I was glad to get away.

These stories are everywhere and cause us worry. Some of them may seem familiar to you. While these stories represent aspects of real scenarios, any similarity to real people or programs is unintended. Carl Rogers once wrote: "what is most general is most personal." It is through appreciating the common elements of experience, that we are provided with evidence for the ubiquitous nature of these issues. They beg a question: "How can we be the providers of outstanding team-based care, when we struggle with managing ourselves or our relationships with others?"

When we provide our talks and workshops to groups of cardiac surgeons, cardiologists, intensivists, nurses and perfusionists, we invariably encounter a consistent comment: "the only thing that matters is the patient and the outcome. That is our job—to provide good outcomes." Some have even said: "we don't really care about teamwork or how people take care of themselves. Our job is to get good results." The literature and experience are consistent on this fact (and we can reiterate; this *FACT*): good outcomes *require* teamwork, leadership (the kind that will be discussed below), and *engagement* by team members who show up *R*ested, *R*estored and *R*eady for work.

That is the focus of this manuscript. Good outcomes. And how they rely on the things we were never taught in our medical training. Not just *rely* on them. *Require* them. Good outcomes *require*

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excellence in medical knowledge, surgical/interventional skills, and judgment. We don't dispute that. It is the obligation of all providers of children's heart care that they continually develop their knowledge, skill and judgment. But medical knowledge, skills and judgment are not enough. Not even close.

In 2003, the IOM published their report on Health Professionals Education [52] and emphasized the importance of teamwork and communication in achieving *patient safety*. (In fact, patient safety is the title of their next report published in 2004) [53]. The concept had resounding implications in the field of health care. The ACGME introduced their "outcomes project" in which they emphasized the importance of competence in 6 areas which included, besides patient care and medical knowledge, interpersonal and communication skills, professionalism, practice-based learning (the importance of information and experience) and systems-based practice (appreciation for the interconnected relationships across the entire field of healthcare). The "outcomes project" forced education systems to begin teaching skills that many of the faculty had never (formally) received training to perform. For the first time, physicians were being held accountable for teaching (and learning) new ways of thinking, interacting and leading.

In the past decade, much has been written about the pressures inherent to the professional demands of becoming and practicing as a physician [22]. Some have described it as a lifestyle choice in which the professional demands leave little room for the balancing of relationships with one's self and others. The prevailing cultural value was that physicians must, of necessity, sacrifice the fulfillment of their own needs or the needs of their family in order to place all attention on the primacy of the needs of their patients. This has created the belief that: *we* (the health care providers) don't matter—the only one who matters is the patient.

Acceptance of this belief has helped normalize a culture that values certain behavioral expectations (listed below) that are not in our own or our patient's best interests and which are now being shown to contribute to poor quality and outcomes. Below each "unrealistic" or "misguided" expectation, (or sets of expectations), we have provided some discussion of alternative perspectives and the references that link these suggestions to quality and outcome improvements. The "expectations" are *italicized* to highlight that the statement is now one to be reevaluated.

The following statements (in italics) represent some of the unrealistic rules that physicians and their healthcare teams are expected to follow.

1. *Leadership must command and shouldn't trust others to do things right.*

Driven by fear that something might or could go wrong, the prevailing styles of leadership in medical organizations have been; a) *Commanding*, which used consistently, over time, is a *dissonant* leadership style that eventually drives people away. It produces resentment from or disengagement by team members who will eventually try to find a more inviting atmosphere where their needs and perspectives are appreciated; or b) *Pacesetting*, another dissonant style, which is perpetuated through doing everything one's self and not delegating. Pacesetters operate from the conviction that others cannot be trusted to do things correctly, which also deters some of the best people in an organization from wanting to participate, since their contributions or suggestions will be rejected [6,42].

In contrast to these dissonant styles, *resonant leadership* styles invite and consider the knowledge and experience of others [6]. Many exceptional organizations are creating leadership programs or sending potential leaders to national programs for leadership training to learn skills of engaging the entire workforce as a process that leads to best care [42,61,68,69,71,74,86–88,97]. As leadership styles change from dissonant to resonant, all members of the healthcare team become reengaged into a more collaborative framework that harnesses the collective skills and experience of the entire team, making individual weaknesses less relevant. These teams also embrace a shared accountability leading to the systemic change and awareness required for growth and learning in complex endeavors. In order for leaders to transition to this style of leading, their operative *mantra* needs to include courage, as well as, trust.

As will be discussed below, the complex adaptive systems in which we work will present some unsolvable challenges. If the expectation of the leader is that NO problems will occur, then they will either be disappointed (and how they deal with disappointment is paramount) or they will need to find ways to be "unaware" or dishonest—neither of which are desirable leadership traits. From the courage that it takes to accept the reality of conflict, challenge and occasional "failure" comes the opportunity to learn, innovate solutions that can help others and build the kind of organizational strength that produces progress and excellence. Major businesses have understood this for decades—and this kind of leadership is beginning to appear now in medicine [9,10,15,50,58,89,93].

2. *We cannot tolerate anything less than perfection.*

The demand for perfection stems from the high stakes of what we do—taking care of patients with life threatening illnesses—and from our hope that all patients will survive to have a normal life. For some, this intent gets entangled with their own sense of worth and esteem—more important than the patient doing well is how they are thought of by their peers and therefore they can only be valued if all their patients survive and their peers (many of whom barely know them and have likely never worked with them) believe they are exceptional. Perfectionism is also the norm demanded by patients, who may unrealistically wish to have a physician with god-like or indefatigable abilities. The concept that there is a "solution set" that will always create a successful outcome is not realistic in complex biological systems, in which no two patients or defects are exactly alike. And while it is important to demand and maintain high levels of personal and professional competence, it is not reasonable to deny the fallible nature of all human beings. Although mechanical systems are expected to perform in a consistently reliable and predictable fashion [51], biologic systems do not behave this way. That is why there is an occasional mortality after ASD closure or why some patients develop early pulmonary hypertension from lesions that should be safe to follow.

In his presidential address to the American Association of Thoracic Surgeons, Tom Spray lamented over the impossibility (and inappropriateness) of perfectionism, stating: "What we do is hard."[84] Unfortunately, when perfection is not possible, the delusion that it is achievable leads to dashed expectations, disappointment and a "culture of blame." [20] Many have suggested that the antidote to perfectionism that focuses on outcomes is to place more emphasis on the best *processes* [23,54,70,84]. In this system, quality and best outcomes would not be confined to monitoring mortality rates (which – given sample size limitations and variability of patient diseases and the way they are treated – is not a reliable indicator of quality [84,94]. Furthermore, mortality rates can be decreased (made more "perfect") by avoiding high risk cases, or by doing less than desirable procedures. Mortality rates are not reliable indicators of long term quality of life issues that might be influenced by operative or management strategies used to achieve survival). "Rather than focus on mortality as an outcome, we need to focus more on care process and appropriateness" [84]. This can be a criterion-based approach that defines best practice as those processes or procedures (including the strategies employed during the interventions) that correlate with the greatest likelihood of best long-term outcome. Our culture's present obsession with comparing surgical outcomes between surgeons, patient care teams and organizational systems has mistakenly channeled their energy and focus to one of competition among

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individuals and organizations, as opposed to channeling this energy towards defining the criteria that would enable all programs to achieve best patient outcomes. Organizations can all adopt the recommended processes (e.g. 24/7 in-house intensive care coverage by an attending physician) and by doing so, achieve "perfection" of process.

Another unintended consequence of the striving for perfection is the lack of forgiveness for oneself and for others when the results aren't perfect. The research on self compassion [57,63–65] has been impressive. The ability to have compassion for oneself is directly and positively linked to the ability to learn [26] and to the ability to be resilient and cope with difficulties. When contrasting high self esteem with or without self compassion, there is a distinct difference. Self esteem without self awareness and self compassion (recognition that the self is imperfect and still deserves kindness) is often associated with grandiosity and failure to acknowledge what is "real"—a potentially dangerous trait in a health care professional. When self esteem is tempered by awareness of limitations, and associated with the ability to be compassionate towards oneself, this can lead to more genuine (less grandiose) self esteem that is more appropriate because it is related to the ability to hear feedback (without defensiveness), while still maintaining kindness towards oneself as a learner. This is the challenge for us as lifelong learners—to accept that we are learners, meaning there will be times we "don't know" and have to "struggle" as we try to do new things or think in new ways. A system that insists on perfection makes it very dangerous to be a learner, and ultimately, that limits our ability to provide best practice.

3. *You should always be working hard ("are you busy?")*
4. *Disregard personal needs (people should be machines)*
5. *Self neglect with trivialization of emotions and denial of physical and social needs is the model to emulate:*

We have "invented" a unique culture that espouses the three values listed above. When the ACGME mandated a restriction on resident duty hours, decreasing them to 80 h/week, many of the physician leaders in our field reacted that this was unreasonable and might impair training. Like most Procrustean policies ("one size fits all"), the duty hour restriction has its limitations and consequences with respect to the training experience. It may be argued that a pediatric cardiologist, surgeon or intensivist needs more hours of training acquiring the experience needed for safe practice, compared to some other areas of lower risk medicine. That is not the issue that we wish to address. More insidious, and far more damaging, is the concept that we, as professionals, are unable to develop an *internal locus of control* to govern our actions and so we need to give that control over to something external—like a duty hour policy. We believe it would be more valuable to teach young physicians how to develop and value *mindful awareness* of their needs and capabilities, and that they can access help without implying weakness. (We will discuss some tools for this in the last section of this manuscript). This would be a major cultural transformation and would be more in line with what we would expect from professionals—*self-awareness* and *self-regulation*. It would also bring our culture into more alignment with the time proven benefits of emotional intelligence, mindfulness and congruence [11,21,23,40,41].

The problem with a culture of personal denial is that it is not sustainable. Over time, the physician who embraces the belief that he or she has no personal needs is at risk for burnout, depression, anxiety, chronic fatigue, substance abuse, divorce, or suicide [2,4,8,16,17,21,22,25,28,29,33,47,55,67,75,81,83]. The data documenting this lack of physician self-care (along with the consequences of burnout, depression, substance abuse and anxiety), are disturbing. A recently published study from the American College of Surgeons [76] reported information obtained from a sample of 24,922 surgeons who had been in practice for an average of 18 years (and therefore represented a group who had acquired the experience necessary for the level of expertise [14,39] that could be most beneficial to the public). For the most part, these surgeons worked 60 h per week, and were on call 2 nights/week. Overall, 40% were "burned out", 30% screened positive for the symptoms of depression, and 28% had a mental QOL (quality of life) score >½ standard deviation below the population norm. These data suggest that our medical culture either attracts people who are at risk for or encourages development of a lifestyle that results in self-annihilation. Regardless, our culture produces individuals who ironically may be less psychologically healthy than the general public they are supposed to care for and care about. We have inadvertently created a culture that emphasizes denial of the personal needs that make us truly human; while simultaneously requiring that we cater to the very real needs and demands of the humans we serve, work alongside and seek to heal.

Not only is it irresponsible to encourage people to enter a career that risks these outcomes, but *lack of self care, with its attendant consequences, has been definitively linked to errors and other forms of impaired outcomes for our patients* [7,22,25,27,48,77,91,95]. This is why we have been asked to write this manuscript. Physicians who are unhappy, unfulfilled and who have lost their energy and positivity are not capable of providing best outcomes [34–36,59]. They can only give what they have, and if they are suffering, so will their patients. The antidote for burnout relates to physicians prioritizing and pursuing opportunities for their own personal growth, wellness and renewal [5,22,25].

The link between physician wellness and quality [77,91] is becoming more apparent and increasingly more important. Physician wellness includes the process of learning to identify, honor and manage the needs of *oneself*, *others* with whom we are in relationship (personal and professional), as well as the larger medical *context* that creates our daily challenges [21,73]. This is the process we call congruence and we will describe it more fully in a later section.

Despite the preponderance of research linking physician wellness to quality, there are members of our specialty field who have ardently "argued" that the only thing that is important is "results" and that our needs and the needs of those with whom we work don't factor into that equation. We have yet to find any scientific evidence to support this type of thinking, and evidenced by the data cited above, perpetuation of this myth risks serious damage to patient safety and outcomes. We are human beings, not human doings, and are better doctors 48 weeks a year than 52 weeks a year [21].

Although held in disdain by some, encouraging work-life balance for health care providers is emerging as a major factor in improving outcomes [22,55]. One of the preeminent leaders of business transformation and growth, Peter Drucker, addressed this in his classic article on Managing Oneself [24] which is consistently reprinted by Harvard Business Review in their annual issues on leadership. Self awareness, self management and self regulation comprise the cornerstone of emotional intelligence [11,40] and are being linked to quality in every professional enterprise, including the practice of medicine and surgery. The journey to the self is an essential path to leadership [89] and may be the core work that can help us achieve the type of outcomes that are possible in our field. Stated succinctly, you cannot manage others if you cannot manage yourself; you cannot genuinely care for others if you do not find a way to genuinely care for yourself; and you generally can only give away to others what you yourself have to give—so if you have disdain for yourself and your needs, then you will likely give disdain to others for their needs. And who would ever want to work with or try to perform at their best for someone like that? Unless they have to.

6. *Hierarchical roles govern relationships and the person with the highest position will have the most correct information*:

Have you ever played the game where everyone in a group selects a playing card and without looking at it, places it facing out in a headband on their head? They then spend several minutes relating to one another according to the hierarchy of the cards, so that the person with an ace (ace is high) or a face card is treated differently than

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someone with a 2, 3 or 4. Seems ridiculous since it discounts all the unique talents and skills that each person might otherwise contribute to the team, yet this is how our organizations sometimes act. Karl Weick [92] has described High Reliability Organizations and High Consequence Industries as those which require peak performance by all individuals since the consequences of failure can be catastrophic. These organizations include nuclear power plants, aircraft carriers, airline cockpits, and, we would submit, pediatric cardiac care teams. Ironically, these organizations require strong leaders who know how to engage and encourage participation from all members of the team. Regardless of their role or title, the person with the most relevant information for a situation becomes the most important person on the team at that moment in time. In an effort to improve outcomes and reduce errors, methods of Cockpit Resource Management (CRM) [96] and checklists [37] have begun to invade our practices, especially our operating rooms. They are undeniably helpful and useful. But they will not function optimally if they aren't utilized in an environment that permits open and non-critical communication [60]. The risk to patient safety and best outcomes in hierarchical organizations is the suppression of bottom up and horizontal communication that is necessary to prevent errors or to introduce new ideas. The extreme side of poor communication is the reluctance of health care workers to speak up when the risk to them for doing so is admonishment, ridicule, or dismissal (being “waved off” or “waved out”) [1,19,38,62, 90]. In the airline industry, the reluctance of a team member, such as a first officer, to speak up, or the use of “mitigated speech” (language that is non-direct but less risky), has been shown to result in fatal crashes [39]. A checklist, even one that encourages speaking up when a team member is concerned, will only work when there is experience in the system that speaking up is safe. The importance of creating a work environment that is perceived as psychologically safe is paramount and is supported by research [30,66]. In organizations that lack psychological safety for speaking up, stress increases and individuals are more likely to make choices that are inconsistent with values that are in the best interest patient safety. Instead the individual team member's focus is on self-protection and self-survival. The risk of hierarchical relationships is the inhibition of some team members to speak up when they see or know something that might be important, and this can have devastating consequences. It is incumbent on the team leader to create an atmosphere of psychological safety (it is permissible to “not know” or to say something to anyone that might be important information). An excellent example of this occurs in the movie, *Master and Commander*. Russell Crowe is called to the deck because the lieutenant on watch thinks he sees an enemy frigate through the fog. But he is not sure. Crowe looks at another of the men on watch and asks: “Did you see it.” After hearing the reply of “No, Sir,” Crowe could choose to admonish the first lieutenant, but instead he says: “Very well. You did your job. Go back to your station.” In actuality, there is an enemy boat out there beyond the shroud of fog and by checking out this information, Crowe is able to save numerous lives on his ship. But imagine if instead, he rebuked or ridiculed (such as with the use of sarcasm, as we often see in medical settings) the person on watch. Even if there were not an enemy ship, would that person have felt safe speaking up the next time? How do you treat your teammates when they make a suggestion? Especially a suggestion you reject? And how do you reject those suggestions? Do you do so in a way that invites future participation? Research has shown several ways of improving relations among members of a team, and perhaps one of the most effective is to “accept influence” (as Russell Crowe did in the example above) from others. In a hierarchical organizational structure, it is easy to fall into a pattern of top down decisions, even though vital information may be trying to burst up from below—and is available to the trained leader who listens, invites engagement, and accepts influence so that all team members feel invested [45].

7. *Multitasking*
8. *Stress as a norm*

We have combined these two “values” of our current culture because they produce the same off-centeredness and dis-ease. Many of us have gotten inoculated with “hurry up” disease [82]. You may recognize the symptoms: you are in an elevator bay and the “up” button is already lighted, but you push it repeatedly anyhow. You believe that every stoplight is turning red out of sequence just to make you stop at every intersection. You get impatient with the recorded options being given to you on the phone call you have just made and you begin to push the “0” button repeatedly, or yell at the recorded operator expressing your frustration. You are having a conversation with someone (a spouse) and you walk away in the middle of their comments to you (or worse, yours to them) because you are trying to do something else simultaneously. You find yourself getting angry because the person in the grocery line in front of you is stopping to chat with the clerk. It goes on and on. Why do we choose to live like this? Yet, we have an operational “norm” in our work that states: “I handle stress well.” What we need is education on how to live life on life's terms.

How many of us have actually been trained to recognize when we are stressed, much less taught skills to manage it? The implication of this for quality and outcomes is that none of us can offer our best once we have gotten swept up in the amygdala hijacking of stress [43]. We fall into time worn patterns and often these are ones of blaming others, placating to try and make everyone happy (an impossible task), trying to outthink the problem (super reasonable) or just extracting ourselves from meaningful involvement (disengagement, which then makes us irrelevant).

Learning to recognize and manage our stress is a lifelong challenge. In the process, we move from *unconscious incompetence* (we don't even see how ineffective or out of control we are), to *conscious incompetence* (self awareness—which is the first important step for change), to *conscious competence* (we begin to learn and practice skills to manage ourselves), and eventually to *unconscious competence* (we have integrated new skills in a way that we have changed). This process is circular and continuous as we continue to learn.

Our field of pediatric cardiac care will never be devoid of stressful circumstances. In the words of the nurse mentioned at the beginning of this manuscript, most teams perform fine when there is no stress, but their ability to function well when there is stress can mean the difference between outstanding or simply average outcomes. Recognizing and managing stressful situations requires enormous practice, especially by the team leader, but there are numerous techniques available that can be learned [12,13,32,43].

9. *Be self-sufficient. Don't rely on others.*

There is an old adage that “none of us is as good as all of us.” Unfortunately, in our culture, asking for help is sometimes viewed as a sign of weakness. Best practice requires a transformation of this thinking. It isn't enough to know how to collaborate and harness the strengths and talents of others. At a foundational level, it is critical that our thinking expand to finding ways to be genuinely curious, open and accepting of the diversity of thought produced by our colleagues. As our business colleagues have taught us, when we are available to explore in a non-judgmental way the numerous perspectives of others, we open ourselves to learning and growing from them and consequently increasing the likelihood that our patient outcomes will improve [79,80]. In Einstein's words, “You cannot solve a problem with the same mind that created it.” Yet we often dismiss those who don't see the problem and solution our way as being incompetent, stupid or worse. The antidote to this kind of thinking is empathic openness to others [16]. Training for empathy has been linked to a higher level of physician wellness, which can improve outcomes [41,49,78–80,85].

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When systems lose control, we see the opposite end of this spectrum – an unfortunate occurrence that has received substantial press in the past year – bullying and mobbing. In these instances, organizations try to find a scapegoat for problems. Oftentimes these are deep-seated institutional deficiencies, but an individual is identified (usually by a dysfunctional few who are able to gain traction from leaders who are not able to truly look at a problem) and this individual is singled out as the "problem." The literature on mobbing, and some of the forces behind it, is chilling [3,18,31,56]. We have encountered increasing examples of this in the field of pediatric cardiac care and the stories that have been shared with us are heart-wrenching. The reason this is important in a journal related to outcomes and quality is that mobbing almost invariably robs a workplace of their most dedicated, diligent and competent performers [18]. Because it is becoming so prevalent, it is pertinent to list the Ten Key factors that define mobbing. If you find yourself experiencing or witnessing these in your workplace, then not only will you be at risk for poor performance (in fact, that has likely already occurred and is often the "trigger" that incites mobbing), but you may need to find a way to protect someone (including your patients) from harm.

Ten Key Factors of Mobbing [18]

1. Assaults on the dignity, integrity, credibility and professional competence of an employee.
2. Assaults that are negative, humiliating, intimidating, abusive, malevolent, and controlling communication.
3. Assaults committed directly, or indirectly, in subtle or obvious ways.
4. Assaults perpetrated by one or more staff members—vulturing.
5. Assaults occurring in a continual, multiple and systematic fashion, over some time.
6. Assaults portraying the victimized person as being at fault.
7. Assaults engineered to discredit, confuse, intimidate, isolate, and force the person into submission.
8. Assaults committed with the intent to force the person out.
9. Intent to represent the removal from the workplace as the victim's choice.
10. Assaults not recognized, misinterpreted, ignored, tolerated, encouraged or even instigated by the management of the organization.

The result of mobbing is *always* injury [18]. Although the literature is explicit that this is injury to the victim, in a field like pediatric cardiac care, there will also be injury to our patients. Organizations that tolerate or allow mobbing will not be centers of excellence. The people in the organization have gotten too out of control (usually from lack of leadership) to function as a safe team. In our opinion, patient safety in organizations that permit this behavior by a member or a few members of a team, depends on someone who is able to recognize the serious lack of leadership, dismiss the offending parties, and provide leadership training for people with leadership roles (as was actually done by a CEO we worked with, described in a scenario at the beginning of this article). Most importantly, is the huge impact that this behavior has on quality and outcomes [56]. And all of this is linked to our cultural value that tends to dismiss the value of others. (Although it should be clarified that bullying and mobbing is an extreme dysfunction along the spectrum of not counting others).

It is clear that we sacrifice enormous opportunities to improve our quality and our outcomes by refusal to change our cultural beliefs of what is expected of us in order to be an excellent practitioner. Although we agree that medical knowledge, experience, judgment and skill are essential, these factors are not enough to provide best practice and can be easily side railed by the numerous potential pitfalls discussed above. Our final piece in this manuscript is to provide a brief description of a *model* that might help you break old patterns and create an environment that can improve your system's quality, energy and performance.

1. Practice congruence: make choices that honor and value the needs of self, other and context

We have discussed the concept of congruence elsewhere [21,23] and we have based our model on the pioneering work of Virginia Satir [73]. All choices are driven by the (sometimes competing) needs of self, others and the context that is generating the need for action. When congruent, the needs of self, other and context are addressed in a manner that is flexible, adaptable, coherent, energized and stable. This is opposed to a pattern of rigidity in which only the needs of one or two aspects are met or of chaos in which none of the needs are thoughtfully and intentionally met [80]. This is illustrated in Fig. 1. A congruent action or choice honors each of these segments as important and valuable. The dynamics of a healthy, congruent system creates an integrated capacity to be flexible, adaptable and connected to all the needs in the system. Choices are neither rigid nor are they chaotic—they are aligned with the unique needs of each circumstance and the people involved. Regardless of what choices are made, all the elements have been considered and valued. As pointed out above, we have a culture that tends to emphasize context while diminishing the needs of self and others. When context becomes repeatedly and consistently overwhelming (Fig. 2), the needs of our selves and of others get minimized and over time, people in the system feel devalued. Although there are some contexts that can overwhelm the needs of the people in the system, over time, this is not a sustainable system for humans. It might work for machines, so we have termed this type of incongruence as *super reasonable.* In super reasonable systems, people are required to act like machines. Everything is logical and personal needs don't count. Continuous denial of one's own needs and the needs of others leads to depersonalization and burnout. In a congruent system, the patient's care always comes first (which is an important piece of context), *and* if you have a strong competing need, then the situation might be resolvable only by having a colleague take over for you to care for the patient while you care for yourself (which violates one of our cultural "rules" unless you are able to transform). Not making room for you or others to have needs is a recipe for burnout and diminished performance [5,17,21,22,76].

If you repeatedly count out your own needs, then you are at risk for an incongruent style that we term *placating* (Fig. 3) In super reasonable, you discount yourself and expect others to do the same. Placaters discount themselves and are also driven by the desire to meet the needs of others—frequently this translates into a need to make everyone happy or provide caretaking of others. This is done to the extent that they are willing to continually sacrifice or diminish their own needs. If this style is used consistently, the self diminishes to nothing and you are at risk for getting to the end of the road and no

Fig. 1. In a congruent system, the needs of self, others and the context are all valued and connected. These systems are integrated, flexible, and adaptive. They are neither rigid nor chaotic.

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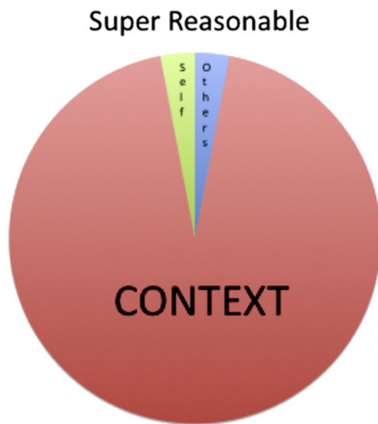

Fig. 2. When the needs of context overwhelm the needs of self and others, there is a risk for burnout as people begin to feel devalued and unimportant. A super reasonable system is not humanizing or sustainable and will not be associated with best outcomes since it negates the energy that can come from the people in the system. The "seed" in this style that is valuable is the ability to function strategically and logically.

one, including yourself, will really know who you are or what you stand for. It is also the position most frequently associated with depression and suicide, as the "self" message is "my needs don't count" [29,72]. As can be expected, placaters frequently make bad leaders because they are inconsistent and can't be trusted. They don't mean to be non-trustworthy. They just don't articulate values or a sense of self (since they may not have spent time figuring that out) and so they are inconsistent. With placaters, you never know what you will get—their leadership decisions reflect the last person they talked to. In medical systems, placaters can become so afraid to express their needs, opinions, values or beliefs for fear of displeasing someone that the system suffers from their inability to make important contributions. This is the risk for self-neglect and trivialization of oneself. There are no winners. The team, the individual and the patient all fail to benefit from the contributions that could be made.

Placaters are often attracted to *blamers*. This form of incongruence is well known in medical organizations. Blamers only count themselves (their needs, beliefs and values) and the needs of the context when the contextual needs further their personal and professional objectives (Fig. 4). Other individuals are simply not that important. Blaming is associated with narcissistism and the dissonant leadership styles of commanding, pacesetting and manipulating. The self needs to be protected, and often aggrandized. Research has documented that the factors that most quickly lead to destruction of relationships (including teams) include those tools that blamers, who have little use for others and little need to explore to understand their perspectives, are particularly skilled at employing: criticism, contempt and defensiveness (which is the "flip side" of blame: "I didn't do it—she did it.") [44–46]. Unlike placaters, who consistently try to please others, blamers don't genuinely care about others except as tools to further their own agenda or when another can be used in the service to attaining a goal [3]. They resist listening to the suggestions or perspectives of others while they assert that their way is the way things will be done or they disingenuously and deceitfully manipulate others in the service of their own agenda. Individuals who consistently discount the needs or perspectives of others make for dissonant leaders (drive people away over time) and destructive members of multidisciplinary teams. They are the ones who will likely refuse to collaborate, even to the point that they threaten to send patients elsewhere or refuse to allow someone to participate in patient care. At the most dysfunctional extreme, they can resort to bullying or mobbing and when this is recognized, their potential detriment to the health care team is enormous and without some form of remediation, they should be dismissed before their attitudes create harm. The long-term effect of managing stress with this style, where others don't count, is that you will get to the end of your road, and you will be alone.

There is a final form of incongruence that deserves mention, because it can also rob the system of excellence and best outcomes. When stress becomes overwhelming, it becomes more than some people can bear. Rather than blame, placate or adopt a super reasonable approach, they just "check out." This invitation to disconnect from the context or "check out" is particularly prevalent in organizations that encourage physicians to deny their own needs and the needs of other relationships in their lives in order to serve the context. The individual can become so overwhelmed with the contextual demands that distracting one's self seems like the only survival tool available. Unfortunately this can sometimes take a destructive form as in substance abuse or in leaving a job or marriage prematurely. In a professional setting, *irrelevance* is also a potential inhibition to good outcomes. These generally very competent and important team members are now detached from the context (they usually crack a lot of jokes when everyone else is trying to collaborate to solve a problem) and they aren't really checking into

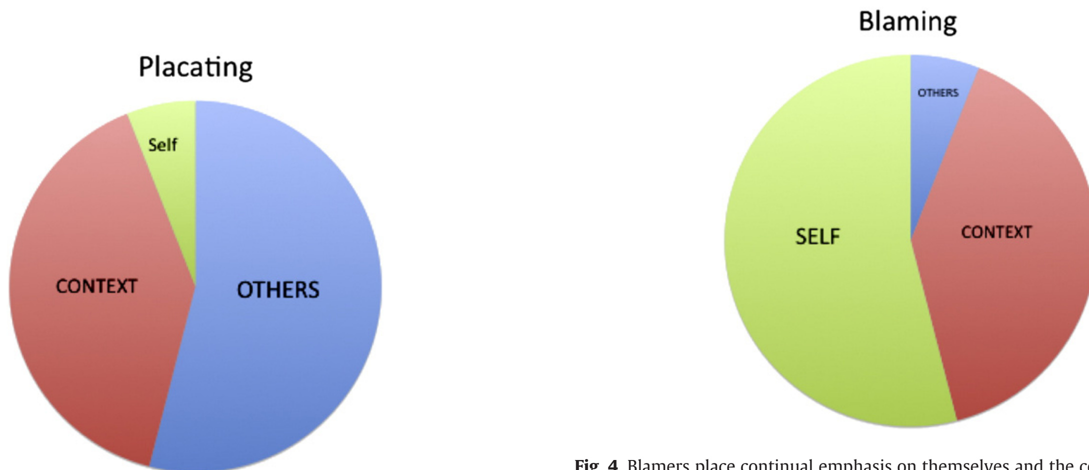

Fig. 3. Placating occurs when there is repeated emphasis on the needs of others and the context, while the needs of oneself are consistently diminished. Over time, placaters are at risk for depression or suicide. Their voice becomes a whisper in the system that is robbed of their potential contributions. The "seed" of benefit in placating is the ability to demonstrate genuine caring for others.

Fig. 4. Blamers place continual emphasis on themselves and the context. The needs of others are unimportant to them. They frequently have contempt for others and often will not listen to information that does not agree with their perspective. They may have so little respect for others, or narcissistic grandiosity, that they think little of manipulating, using or deceiving others to get their way. At the extreme, they will go to lengths to annihilate others, who may otherwise be of great value to the system. The "seed" of benefit from this style (when used appropriately) is the ability to be assertive.

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their own needs (which might be to get support) or the needs of others (which might be to honor their concerns). The entire dynamic of congruence is disassociated and disconnected (Fig. 5). Everything is just irrelevant.

These forms of incongruence described above become a problem when an individual chooses the same pattern repeatedly [21,23]. Each of these styles has a "seed" of value when used appropriately. Super reasonable demonstrates the ability to think strategically and logically. Placating demonstrates a seed for genuine caring and blaming reflects the ability to be assertive. Irrelevance carries the seed of creativity and innovation—of not conforming. We encounter so many unique challenges in the care of the pediatric cardiac patient and when we approach our contextual challenges in a way that can harness the perspectives, knowledge, skills, talents, experience and needs of the people in the system, we create an energy and engagement that results in enhanced performance. It is apparent that we are best served by recognition of the dynamic nature of congruent choice. There are times when individual needs must be sacrificed and there are other times when the context of the problem permits self and or others to be valued. Despite the unrelenting challenges of our profession, it is imperative that we find a way to integrate our pursuit of career excellence with our equally important pursuit of self-fulfillment and balance. When we are flexible, adaptive, coherent, energized and stable we are likely to know when to accept the influence of our professional colleagues and when we need to be assertive and stand firm in our own counsel. The nature of congruent choice-making is that we are constantly confronted with a new puzzle and each of the parts will need to be considered, and valued, differently. But none of the parts should ever be discounted. The congruent leader is able to recognize this and work with these pieces in a way that permits the flow of excellence.

In our work with pediatric cardiac teams around the world, where we have been able to evaluate the likely reactions of individual team members to stressful situations, we have encountered that the most common form of incongruence (same choice priorities used repeatedly when under stress) is *super reasonable*. We get into our heads and try to think our way out of the situation—reverting to our classical culture that people don't count—only the patient. There are certainly a fair share of people who blame or who placate, and some who

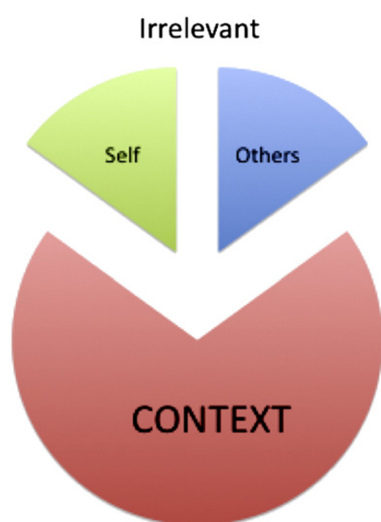

Fig. 5. Irrelevance can occur when the context is overwhelming or its demands are no longer bearable. Responding in a logical (dehumanized) way to context (super reasonable) is no longer an option and people "leave" the system. They can do this emotionally (burnout), physically (they quit), or chemically (substance abuse). The important "seed" in this style is the ability to be creative as you disconnect and see things differently.

immediately become irrelevant, but for the most part, our culture supports super reasonable. Unless you are without emotions or needs, you will eventually burnout in a system that is super reasonable, and as the research discussed above demonstrates, this will lead to medical errors, sub optimal practice and impaired outcomes.

We aren't suggesting that congruent choice making and leadership will solve your problems. "What we do is hard." And each situation unique. We simply hope this way of considering options may create more shared meaning among team members, open the door to more possibilities, and perhaps move you from unconscious to conscious incompetence—putting you on the threshold to achieve conscious competence. As good as you are now, and as well as your team functions at this time, imagine what you can achieve when you begin to practice the suggestions in this manuscript?

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