Psychiatric Bulletin (1993), **17**, 111–112

Personal view

Hospital staff culture, pathology and the patient

CHRIS GREEN, Consultant Forensic Psychiatrist, Stockton Hall Hospital, Stockton-on-the-Forest, York YO3 9UN

As psychiatrists, one might assume our professional lives are devoted to interviewing our patients, together with conducting and organising their treatment. During my years in psychiatry, however, I have spent an equivalent amount of time and energy reacting with the hospital staff culture as I have seeing my patients. In this context, I am sure I am no different from my consultant colleagues. The time we spend, and sometimes waste, attending meetings, developing initiatives, gossiping, and sometimes plotting, with our colleagues, can be very considerable. I would assert, however, that the staff culture in which we operate can be as potent a therapeutic or destructive factor upon our patients as the treatments we prescribe. Unfortunately, with the exception of those hospital malpractices which have erupted in scandal, relatively little attention is given to hospital staff cultures, their effects upon patients and when such cultures become pathological, and how they might be treated or ameliorated. This paper expands upon this theme.

Culture is a difficult concept to define. The culture of a hospital might be visualised as the 'hospital's personality'. I have considered hospital staff culture to comprise the various groups of staff, their attitudes and values, and their relationships. This culture operates not only through the official policies and procedures of the hospital, but often more importantly through unwritten 'norms' and codes of practice. Cultures appear to be accompanied by certain 'emotional tones' through which certain attitudes and behaviours are either encouraged or discouraged. In my experience, staff cultures are powerful and people new to an institution are rapidly under pressure to conform to the culture operant, following which they become integrated into the culture and in turn play their part in perpetuating it. Elements of hospital staff culture, which might be termed pathological, may present in a wide variety of formats. In my professional career I have come across numerous instances. I give three examples.

Cultural rituals and rules may be much more important in determining a patient's management than good practice. When I worked in a Special Hospital several years ago, the staff culture dictated that if a patient assaulted staff, a minimum of three days, possibly considerably longer, would be spent in seclusion. This was an unwritten, unofficial practice, which was reflective of that part of the Special Hospital culture which was disciplinarian and punitive. Administrative procedures were developed by the consultant staff to monitor the seclusion process, but these had the effect of making the seclusion 'tariff' respectable, not challenging the unwritten rule, as to have done this would have run the risk of provoking an angry nursing response. The final result was that the nursing staff continued to enforce lengthy periods of seclusion, while the consultant staff colluded with the process through ensuring that official authorisations and regular reviews were present in the patients' files.

Relationships between professional disciplines may be more influential in coming to a clinical decision than the facts of the clinical situation. I recall participating in assessing a patient for admission to a secure unit, which professed a strong multidisciplinary culture. Five different professional disciplines participated in the assessment. Regrettably, the unit was plagued by a number of inter-disciplinary rivalries and conflicts. At the resultant admission meeting, these various 'hidden agendas' and inter-professional rivalries were clearly in operation, although never openly admitted. The primary concern of the nursing staff was to keep as many patients as possible out of the unit. The consultant felt threatened because his overall responsibility for decisions on patient admissions was being questioned. The psychologist and occupational therapist resented the consultant's power and set themselves up to battle with him. The registrar felt he had to support his consultant and the social worker tried to pacify the warring parties. A decision concerning the patient's admission was reached, but this was more reflective of the pathology of the group dynamics than the patient's needs.

Once individual idiosyncrasies of practice become culturally accepted, there is a tendency not to challenge them, even if a patient's care or treatment may be suffering. We are all familiar with different therapeutic approaches made by different

consultants; one consultant may have a psychodynamic orientation and conduct psychotherapy sessions with his patients, while another consultant adopts a medical model and relies heavily on physical methods of treatment. The treatment a patient receives will depend on which consultant he is allocated to – perhaps related to who is 'on call' at the time of admission, rather than clinical considerations. In some instances, staff concerns may arise about the approach being taken with a patient's treatment, but if this only results in backroom gossip, as opposed to constructive discussion, resolution of the problem is unlikely to occur.

In the examples that I have given, the difficulties were not resolved. The underlying issues involved staff attitudes and values and their relationships. One may conclude that it was too threatening for those involved to examine and confront these issues in the open. This is why hospital pathology becomes perpetuated, and why also, in extreme cases, the nature of problems only becomes apparent following an independent inquiry. However, the primary purpose of a hospital is to provide good patient care and treatment. Cultural factors in the treatment of our patients should be examined properly and worked with in a constructive fashion, not avoided or denied, as often occurs.

If staff pathology is to be worked with, and positive aspects of hospital culture be developed, there has to be adequate communication between the individuals and groups within the hospital; particularly between individuals and groups where conflicts exist. Unfortunately, conflicts stop individuals and groups communicating and the establishment of a culture where there is an expectation that difficulties will be brought into the open can meet with severe resistance. It is also not without risk. Conflicts opened up, but not worked through, may end up having a greater destructive effect than when they were hidden.

The therapeutic community movement, originating with Maxwell Jones in the 1960s, provides in some of its elements a useful model which many hospitals could use to their advantage. Members of professional disciplines who work together should also meet together on a regular weekly basis for 'non-structured meetings' in which clinical, administrative or inter-personal issues can be raised. For the process to be successful, there has to be a clear commitment for regular attendance by all the key members of the team. Inevitably, clinical and administrative agendas will be seen, to some degree, as being related to personal and relationship issues which, as already illustrated, is frequently the case. An independent facilitator can be of much use in the above process. The role of the facilitator is, however, to endeavour to clarify some of the issues under discussion but retain a good degree of independence from the clinical group and not enter a decision-making capacity. The evolution of an effective group can be difficult and stressful, but if successful, combines the ability for individuals and different professions to be able to challenge each other constructively, while having respect for professional and individual boundaries.

The type of model described above can, without doubt, sometimes present itself as a threat to individuals, possibly particularly consultants in their leadership role. However, it is, I would argue, a more hopeful route towards tackling staff pathologies and establishing positive hospital cultures than the methods we more commonly follow of ignoring issues that remain too uncomfortable for us, or compensating for our inactivity and unease by gossiping with sympathetic colleagues.

Erratum

The Second International Conference of the International Association for Forensic Psychotherapy, 26–28 March 1993, *Psychiatric Bulletin*, January 1993, **17**, 24. The title in the main heading should have read International Association for Forensic Psychotherapy.