

Leadership, decision-making and errors: cultural factors

Dinesh Bhugra¹ and Susham Gupta²

¹Professor of Mental Health and Cultural Diversity, Health Service and Population Research Department, Institute of Psychiatry, King's College London, UK, email dinesh.bhugra@kcl.ac.uk

²Consultant Psychiatrist, East London Foundation NHS Trust, Assertive Outreach Team – City and Hackney, London, UK

As clinicians, we are used to making often fast and life-altering decisions. As professionals, the clinical decisions we make depend upon our training, knowledge base, supervision, expertise and experience. Sociodemographic factors such as age, gender, ethnicity and cultural background can also influence our views. However, rarely do we step back to think about the mental processes behind our decision-making. In cognitive-behavioural therapy and in our general dealings with patients, we aim to help them identify their cognitive schema and attribution errors as a way forward; but we rarely reflect on our own cognitive schema and possible misattribution in making decisions. Both patients and healthcare professionals are affected by cultural norms, mores and expectations.

Leadership and management

As clinicians, we have responsibilities for developing our skills as leaders. Not all psychiatrists are born clinical leaders and not all have the role of or responsibility for being a team leader. However, the role of the leader in the clinical context goes beyond patient care and looks at service development, planning and delivery. More significantly, clinicians have to look both at patients' proximal contexts – such as family, employment and housing – and at the wider/distal contexts – like culture and society. The doctor-patient interaction is heavily influenced on both sides by cultures, healthcare systems and expectations of the therapeutic encounter. Under similar clinical situations, patients in one culture might wish to be equal partners in the clinical encounter and decision-making, whereas in another they may look up to the clinician for a much more directive approach. Therefore, it is inevitable that the leadership styles and components of leadership will differ across cultures. Even within the same culture, leadership styles depend upon organisational culture. The role of culture in the therapeutic encounter and in service development cannot be underestimated. Cultures dictate how patients are looked after, what resources are provided and what outcomes are needed. Cultures also influence caring as well as coping styles, although, in Hippocratic terms, the role of the professional remains paramount where patient welfare is crucial.

Leadership needs to be differentiated from management: the latter is about coping with complexity, whereas the former is about coping with change (Kotter, 1998). Leadership is not necessarily about having charisma or other exotic personality traits, but it has to do with having a broader vision, one which can be applied to service planning, delivery and evaluation. It

is definitely not about micro-management. Management is about responding to, and dealing with, complex situations and chaos, and the ability to bring about order and consistency. It is inevitable that management will be influenced by cultural patterns and cultural expectations. Administration, on the other hand, is about carrying out tasks set by someone else.

Leaders need to have a vision, a passion for the cause they are espousing, confidence (peppered with humility), curiosity, creativity, a sense of purpose, determination and courage. The ability to innovate and to be emotionally intelligent will help in certain circumstances. Leaders have to work with others collaboratively, by motivating, empowering and enabling teams and others to share in a vision. For a good and successful leader, vision, passion, focus and respect for opposing views are critical. Leaders must inspire others and, here again, cultural nuances become important. In socio-centric cultures, kinship is important and individual political dynasties are likely to emerge.

Although Kotter (1998) suggested that leadership is about coping with change (in business settings at least), it is also to do with the competitive volatile business environment, with ever faster technological change, international competition, deregulation, overcapacity and changing demographics of the workforce. Similarly, changes in healthcare across the globe – with increased connectedness through globalisation, internal and external competition in healthcare delivery, technological advances, increasing patient expectations and a decreasing doctor-patient power differential – will all contribute to changes in doctors' roles. This is where changes in leadership roles and styles come into play. Thus, good leadership skills must include the ability to cope with the complexities of healthcare delivery as well as associated change. More importantly, it is the overall vision of patient care and service delivery and how to deal with technical developments that marks out a leader.

Clinical decision-making: knowledge and error

Clinical decision-making comes with experience and expertise. However, within the broader field of leadership linked with decision-making, the role of the culture from which the clinician hails becomes important, as does the organisational culture in which professional practices are embedded. Knowledge, skills and competencies contribute only to a certain extent. The ability to deal with more complex cases differentiates a novice from an expert. Interestingly, knowledge and

error both flow from the same mental sources; only success can tell the one from the other (Mach, 1905).

Reason (1990, p. 9) suggested that 'error' be taken as a generic term to encompass all those occasions when a planned sequence of mental or physical activities fails to achieve its intended outcome and when these failures cannot be attributed to the intervention of some chance agency. Here the intention becomes important. Errors in clinical settings can be those of omission, commission, repetition or misordering, and can also be classified as cognitive (errors in planning, execution and storage) or primary (mistakes, slips, lapses) – similar to what Reason (1990, p. 10) has argued.

One of the tasks of the leader is to minimise the number of errors. This may involve regular discussions with peers to identify what could have been done differently, what lessons can be learnt, and how these can be employed and communicated so that others may learn. Self-monitoring with checklists, error suspicion, error detection and acknowledgment can be used to reduce the number of errors.

Factors such as depression and anxiety among clinicians can increase the likelihood of errors, and we as clinicians have to be aware of our own levels of stress and depression. Irritability and anger among doctors can lead to cognitive problems in decision-making and can increase clinical errors. Both personal and organisational factors can cause stress (Firth-Cozens, 2006a). Ghodse & Galea (2006) point out that doctors are 30–100 times more likely than the general public to misuse drugs and alcohol. Of these, general practitioners show the highest prevalence of addictive behaviours, followed by internists, psychiatrists, gynaecologists and emergency physicians. Social attitudes and the availability of alcohol will determine the rate of alcohol misuse.

Cognitive errors among clinicians will also influence the rates of clinical mistakes (Gibson *et al*, 2006). These errors may result from simple things like tiredness or from substance misuse. Firth-Cozens (1996b) suggests that positive attributes of leadership such as intelligence, benevolence, emotional stability, awareness of limitations, integrity, ability to delegate appropriately, good communication skills, creating a sense of justice and anticipating events can all contribute to better leadership and consequently better decision-making and lower levels of clinical errors. Negative attributes of a leader, according to Firth-Cozens (2006b), include being arrogant, dictatorial, hostile, boastful or *laissez-faire*.

Decision-making is affected by the way information is framed (Newell *et al*, 2007). A complicating factor in clinical decision-making is when the information provided by patients and carers is inadequate, inappropriate, of poor quality or poorly communicated, as this leads to deficient decision-making. Yates *et al* (2003) propose that good judgement depends upon discovering information, acquiring and searching through information and then sharing and combining information and feedback.

Reason (1990) suggests that there are three basic types of error: skill-based slips and lapses; rule-based mistakes; and knowledge-based mistakes. Both over-attention and inattention, as well as perceptual confusions and omission, among other factors, contribute to increased levels of error. Misapplication of good rules, information overload, rigidity and application of bad rules are types of problem related to rule-based performance. Also significant are knowledge-based performance, which is affected by selectivity,

confirmation bias, over-confidence, problems with complexity and the halo effect (Reason, 1990, p. 69).

Sometimes it is best to learn through trial and error, or from mistakes in one's decision-making, but in medicine the leeway for errors is small: whatever the level of error, it will cause a great deal of distress to all involved. Not all adverse events are due to poor decision-making, though. A blame culture and litigious societies have pushed medicine to a more prescriptive, defensive mode, which is not necessarily in the best interest of patients. For example, a 'number needed to treat' analysis in relation to people with mental health problems who are admitted against their will to prevent one injury will tell the story. However, few psychiatrists would want to be at the receiving end of the consequences of such an event. There is a great need for leadership within the psychiatric community to balance views on this sensitive issue.

Who should be responsible for making decisions? How much of this responsibility should be shared? The degree varies with each patient, with individual situations and with the cultural setting and wider society. Too much diffusion of responsibility can lead to chaos, while excessive narrowing is likely to lead to patronising attitudes and even arrogance. This is where leadership becomes important. It involves making decisions, often tough ones, using experience, knowledge and skills, while ensuring the participation of all involved and maintaining awareness of the culture and expectations of society in general.

No matter where in the world one practises, errors do occur. These may be complicated by cultural norms, expectations and resources. The interactions between the individual, the organisation or the healthcare system and society at large will determine how errors occur and how these are dealt with. There are lessons from Western Europe and the USA, where human errors in medicine have been studied for a long time; these lessons are applicable elsewhere.

Leadership involves learning from both successes and failures. Decision-making in the business context has been described in terms of five steps: establishing a context for success; framing the issue properly; generating alternatives; evaluating the alternatives; and choosing the alternative that appears best (Harvard Business School Press, 2006). Applied to medicine in general and to psychiatry in particular, this would be: establishing the criteria and the context for success (i.e. getting the patient better, whether that is symptom reduction or better social functioning); framing the issue (diagnosis and management, but going beyond that by discussing with patients their priorities); generating alternative diagnoses and management strategies; and regularly evaluating the diagnosis and outcome. Across cultures, the basic principles of diagnosis and management remain the same, even though the clinical presentation may be culturally influenced; but healthcare systems differ and the role of the leader is to influence and change systems in order to improve healthcare delivery.

Are leaders born or made?

Doctors are medical experts and are expected to be good at clinical decision-making. Their entire training is geared towards this prime objective. Leadership skills in medicine, on the other hand, are not a part of the medical curriculum and are often left to individual interests. Leaders in the

clinical world have traditionally progressed via the academic or clinical route, and often seemingly through seniority alone. For a long time, leadership was seen as 'management', a term equated with a challenge to medical authority and primarily aimed at cutting costs. Those clinicians who move into management roles, certainly in the UK, were seen as changing sides and giving up clinical duties. This scepticism and the resultant lack of involvement by clinicians in management and leadership roles led to a schism between the medical profession and those in charge of managing services, which only served to make both sides easier targets for the political agenda and the manipulation of public opinion through the media. This distrust has had a detrimental effect on some health services, especially when corporate models of services from other industries have been attempted with little involvement of clinicians. The resulting powerlessness felt by clinicians has affected the morale of the workforce and made medicine a less attractive career option.

Leaders are not born as leaders. They utilise their strengths for their purpose. Personality traits can be suppressed, weaknesses hidden and strengths can be played up. Understanding organisational culture is not always intuitive, although intuition may enable the individual to deal with challenges. For psychiatrists, certain skills required for leadership are inherent in training, such as understanding of human dynamics, dealing with groups and collaborating with teams. One can learn about business planning, assessing risks, dealing with others, identifying resources and being flexible, but inspiration and vision may not be learnt as such.

Conclusions

Medical training requires a high level of intellectual functioning. Confident decision-making and knowledge are important

aspects of one's clinical skills. These skills are central to being a leader, as is the ability to reflect on one's own decision-making processes. Psychiatrists are in an advantageous position of having skills they learn through clinical work which they can use to develop their own leadership abilities through reflective practice. However, there is a great need to provide opportunities for those clinicians with leadership abilities to develop. Greater say in how services function and deliver will lead to greater confidence among clinicians in general that patient care remains central to changes and longer-term planning and is not being hijacked by an external agenda.

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THEMATIC PAPERS – INTRODUCTION

Care for elderly people with mental illness: a global problem

David Skuse

Behavioural and Brain Sciences Unit, Institute of Child Health, London, UK, email dkuse@ich.ucl.ac.uk

As the median age of populations around the world increases, due to the provision of better diets and better medical care, the number of elderly persons vulnerable to mental illness will inevitably increase too. We are not good at providing high-quality geriatric care, even in high-income countries. For example, Age Concern (a UK-based charity) states on its website: 'Health and social care services have made some progress in tackling age discrimination, but older people still report feeling that they have had second class treatment and care simply because of their age' (www.ageconcern.org.uk/AgeConcern/ageism-in-healthcare.asp). How much worse these matters are in

low- and middle-income countries is the subject of our theme in this issue. We have drawn articles from three distinct geographic regions: India, Africa and South-East Asia. We often assume that cultural factors in lower-income areas lead to greater respect for, and better care of, the elderly than we experience in many parts of the Western hemisphere. This appears to be a misapprehension, and attitudes towards the elderly are changing as the impact of industrialisation increases.

Dr Henry and colleagues discuss the importance of supporting those caring for elderly people in India, and the services that could be provided for a geriatric population with