Is workplace culture an excuse for poor care?

In this article...
- Why nurses should take responsibility for their own behaviour
- Is “I was following orders” an acceptable excuse for poor care?
- Why nurses fail to maintain professional standards of behaviour

Is it ever acceptable to blame workplace culture for poor care, or should nurses take responsibility for their care regardless of this?

1. How does workplace culture affect how we practise?
2. Why do some nurses perform well in a particular environment while others do not?
3. Can external factors be given as a reason for lower standards of care?
4. How can we follow our own moral compass in all circumstances?
5. What does the NMC code of conduct say about personal responsibility?

Author
Steve Mee is senior lecturer, University of Cumbria and author of Valuing People With a Learning Disability.

Abstract

This article looks at the issue of nurses’ own responsibility for their actions. Negative behaviour can be explained by external factors, such as culture and the influence of others, or by internal ones, including a person’s own moral compass. Within the context of the Francis report, this article raises questions about how we can ensure that nurses adhere to their code of conduct.

The Francis report (Francis, 2013) describes shocking abuse and neglect of patients, with some nurses responsible for poor care. It is difficult to comprehend how nurses can behave like this. The report suggests that culture was the problem and proposes changes to management and leadership, with an emphasis on clear guidelines and education. It advises there should be a move from a financial to a care focus.

However, the code of conduct (Nursing and Midwifery Council, 2008) is clear – as nurses, we are responsible for our own behaviour. Many nurses in the Stafford hospitals did manage to perform their duties in a caring and professional way, although they of course did not make the headlines.

This is just one example from more than 300 pages of similar stories that took place over four years. This is a sorry tale of nurses lacking knowledge, not carrying out basic monitoring and even refusing to speak to families. These can be seen as directly contradicting two introductory standards of conduct for nurses (NMC, 2008):
- Work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community;

What happened at Mid Staffordshire?
The following account was reported to the Francis inquiry:

“The patient was then transferred to Ward 6 earlier than his family felt appropriate. On the ward his fluid levels were not monitored, the buzzer was placed out of reach and his colostomy bag leaked regularly. The patient required his chest to be suctioned regularly yet many nurses admitted they did not know how to carry out the procedure.

“His family tried to find out about his treatment but… a nurse refused to leave her office to speak to the family. After eight days on the ward the patient contracted MRSA and was returned to the Intensive Care Unit, where he deteriorated rapidly and died” (Francis, 2013).
Provide a high standard of practice and care at all times. The following account must have been unimaginably harrowing for the family: “On one occasion she attended the hospital at around 6am to find her mother in a side room calling ‘please help me, please help me’. The patient was covered in dried faeces and was completely naked. She ran down the ward to find the staff ‘chatting and laughing’. She assisted in washing her mother and it was ‘awful’. Her ‘hands were absolutely caked’ and it ‘was dried and it was up her arms and it was round her neck’.” (Francis, 2013).

The patient died later that night. This shocking vignette makes a mockery of the standard:

- Make the care of people your first concern, treating them as individuals and respecting their dignity (NMC, 2008).

The Francis report has an astounding number of similar stories, with instances of patients being asked to soil the bed because there was “no time to give them a bedpan”; nurses being directly rude, callous and mocking; frail people being left on commodes for hours; buzzers being ignored or disabled; and general incompetence. There were instances of very poor hygiene, inadequate record keeping, poor organisation, poor communication, falsifying notes and wrong administration of medication.

Culture, causal attribution and behaviour

Attribution is a theory from cognitive psychology that attempts to understand the human tendency to attribute motivation and cause of behaviour. Heider (1958) suggested that there are two main types of attribution – dispositional and situational.

One makes a judgement about a behaviour according to whether the causes are perceived as dispositional, that is within the person, or situational, which is external to the person. Heider said that one tends to perceive negative behaviour in another as dispositionally caused (they are like that) whereas one’s own negative behaviour is likely to be described as situationally caused (I had no choice, the manager told me to do it, the ward culture was like this, I was following orders and so on). If culture is being blamed in the Stafford hospitals, then a situational attribution is being made for causality.

What of the nurses in such a culture? Davidhizar and McBride (1985) suggested that student nurses saw the tasks they had to do as externally located and stable and their effort as internally located and unstable. This has implications for the confidence they will have as nurses when they rely on their inner unstable resources to challenge what they see as stable cultures.

On the other hand, Meurier et al (1998) offer some hope. They suggested that, although people generally explain unpleasant events or their role in them on external (situational) attribution and are therefore less likely to learn, nurses are more likely than is typical to blame the error on internal (dispositional) factors. This suggests a strong professional ethos and some hope for being able to care in the context of uncaring cultures.

Obedience to authority

Milgram’s famous experiment (Milgram, 1965) explored the extent to which people were prepared to hurt others simply because they were told to do so. He found that 65% of participants were prepared to inflict pain so severe that it caused a stranger to scream in pain or pass out because a man in a white coat told them to do it. Many of the participants felt extremely uncomfortable but, as far as they were aware, inflicted the pain anyway. An extract from transcripts of the experiment (Box 1) shows a participant giving a situational attribution to their own negative behaviour. It can be reduced to “I was only following instructions”.

One story in the Francis report (2013) described nurses’ lack of action. “On three occasions when the patient was due to be discharged the nursing staff failed to prepare her and discharge was postponed. When her family complained, a nurse commented she was ‘just going with the flow’.” (Francis, 2013)

If part of the human condition is to follow orders and “go with the flow” then nurses can appear like mindless puppets in the health cultures imposed upon them. As nurses, we get accustomed to a steady stream of exposures and reports of neglect and abuse, with nurses at the heart of all that has gone wrong. This seems to happen in all areas of nursing and the more vulnerable the patient/client, the more callous the abuse appears to become.

The reverse side of the coin

Each time there is a report, recommendations similar to those proposed by Robert Francis QC are made. However, there is one obvious point of hope. If 65% of Milgram’s participants were prepared to inflict pain on a stranger, then it is also true that 35% were not prepared to do so. What did that one third minority have that the two thirds majority did not?

First, they had a sufficient sense of right and wrong and the assertiveness to behave accordingly. It is not all despair with the Francis report either. The shocking stories will rightly take the headlines and dominate the discussion; however, for example, the Francis report lists 31 stories from the first quarter of 2005 and, of these, 15 are negative and 16 are positive. In other words, whatever the culture, half of the nurses managed to behave as nurses should and half did not. For example: “Having visited A&E, the Acute Cardiac Unit, Ward 1, Ward 10 and the Shugborough Unit at Stafford Hospital, a patient cannot ‘speak highly enough’ of the care he has received in all areas. Everyone who dealt with him was passionate and caring and the staff often worked ‘above and beyond’ the call of duty. He thinks that the constant barrage of criticism is ‘counterproductive and unnecessary’.” (Francis, 2013)

This team were not just good but working “beyond the call of duty”. Similarly, the shocking account that opened this article began with the following: “Following a colostomy operation at

FRANCIS ON... CULTURE

All those working for the NHS must adopt and demonstrate a shared culture in which the patient is the priority in everything that is done. This requires:

- A common set of core values and standards shared throughout the system
- Leadership at all levels from ward to the top, committed to and capable of involving all staff with those values and standards
- A system that recognises and applies the values of transparency, honesty and candour
- Freely available, useful, reliable and full information on attainment of those values and standards
- A tool methodology such as a cultural barometer to measure the cultural health of all parts of the system

There should be an emphasis on the culture of caring and compassion in nurse training, education and professional development. This will include a selection procedure that requires recruits to show evidence of the appropriate values, attitudes and behaviours.


**Stafford Hospital the patient was treated on the Intensive Care Unit where the care was ‘second to none’ and he slowly began to recover.” (Francis, 2013)**

In the same hospital, nurses on one ward provided care that was “second to none” and, on another ward, nurses carried out serious neglect and abuse. The code of conduct (NMC, 2008) states: “As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions.” Within the same hospital culture, it seems that some were able to take that responsibility and some were not.

One vignette describes the despair of a nurse who was trying to take responsibility for her actions:

“[A patient] was concerned by the lack of staff. He found one nurse crying as she had worked for 12 hours without a break and at the weekend.” (Francis, 2013)

It is probably the case that many nurses of all branches feel that they work under conditions and in cultures where it is difficult to truly perform the duty of care. Some of us believe that conditions are worsening, with cuts and fragmentation, to create an environment in which such scandals are more likely.

It can be instructive to consider a time in which the care was very much worse. What did nurses do then? Strauss (1987) described the use of theoretical sampling to give a perspective when attempting to understand the meanings in a given situation. Theoretical sampling involves taking an extreme example of the situation and considering what might be learned. One example is Nazi Germany.

In Nazi Germany doctors and nurses fitted in to the system and “went along with it”. It is the same human tendency in operation but under extreme conditions. In Germany in the 1930s and 1940s “going along with it” entailed knowingly giving lethal doses of barbiturates to children, performing experiments on live human beings and allowing others to starve to death. In the concentration camps, such as Auschwitz, there were particularly horrific experiments such as deliberately infecting individuals with gangrene to test different treatments. These were often done without anaesthesia. Nurses took part in all of these activities and, when tried at Nuremberg, used situational attribution such as being under pressure for taking part in these activities.

The cliché “I was only following orders” was used by many, including Erna Elfriede, a nurse who was found guilty of killing 200 patients.

She said: “I was ordered to do it. When I am asked again, why I didn’t refuse, although I realised that it was an injustice, I can’t give an answer to this question. I do and did in the past have a strong feeling of guilt, but it is impossible for me to give a reason for the fact that I didn’t refuse. It simply was ordered and I had to execute orders” (Evans, 2010).

At this same time in the same culture is the story of someone who worked according to his inner moral compass. Helen Lewis (1992) was incarcerated in Auschwitz. She described how on a daily basis one of the guards, a conscripted teacher, would save some of his own food, single out a prisoner who looked frail and throw them a sandwich. Had he been caught, he would have been shot.

**Conclusion**

The Francis report made recommendations for a change in culture and service to ensure that the events at Staffordshire Hospital are not repeated. Changing nurse training, greater transparency, mission statements making expectations clear, putting patients first in planning services and developing leadership are all critical tools of culture change.

What about us, the foot soldiers? There is not much we can do to effect these changes. As a nurse with nearly 40 years’ experience, I have become weary of scandals and inquiries followed by fine words and insufficient action and resources to prevent the next scandal. What can we do as individual nurses? The only access most of us have to these strategic changes is to use our vote carefully. Is our party of choice the most likely to fund and action these changes? An answer to what we can do as individuals is to be found in the code of conduct: “As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions” (NMC, 2008).

We can all draw a personal line in the sand. “I will never ask a patient to soil the bed” is easy. “I will never shout at a patient” perhaps a little harder at the end of a long shift. “I will always respond to a request for a bedpan made quickly” perhaps a little harder still, particularly if you attribute patients’ behaviour as dispositional and that they are just making a fuss.” “I will have my own moral compass and be prepared to go against team practice if the standards are not acceptable” is even harder. “I will whistleblow if I see bad care” is very difficult, particularly if systems are unsupportive, as they often are in these cases.

Few of us like to stand out and be unpopular but some nurses are prepared to do so. Some did at Stafford and should be saluted. Some people did in Nazi Germany, such as the man who saved food for prisoners at the risk of being shot. We can all decide where we stand on this continuum and draw our own line. In the end, cultures are only collection of individuals.

**References**


---

**Discussion**

**Box 1. OBEDIENCE TO AUTHORITY FIGURES**

Below is an extract from Stanley Milgram’s experiment:

**Participant:** “I don’t like what happened to that fellow in there [the victim]. He’s been hollering and we had to keep giving him shocks. I didn’t like that one bit. I mean he wanted to get out but he [the experimenter] just kept going, he kept throwing 450 volts. I didn’t like that.”

**Interviewer:** “Who was actually pushing the switch?”

**Participant:** “I was, but he kept insisting. I told him ‘No’, but he said you got to keep going. I told him it’s time we stopped when we get up to 195 or 210 volts.”

**Interviewer:** “Why didn’t you just stop?”

**Participant:** “He wouldn’t let me. I wanted to stop. I kept insisting to stop, but he said ‘No’…. I figured the voltage we were giving him was quite a bit. I wanted to stop but he [the experimenter] kept insisting not to stop.”

Milgram (1965)