Collaboration for Leadership in Applied Health Research and Care
Northwest London

How knowledge of patterns of influencing in AMU can inform Quality Improvement work.

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BACKGROUND

Acute medicine is a young specialty. The methods for delivering care in the AMU and during the medical tasks are developing.

A key part of the role of leader in the AMU is the introduction of new ways of working to continuously improve performance.

Safe reliable care, good patient experience and efficiency are chief elements of healthcare quality.

Trainee doctors are influenced to adopt approaches, knowledge and behaviours by their colleagues.

In order to control the spread of innovations introduced to the AMU, it is useful to understand how influence spirals in the team.

Previous research has shown different patterns of social networks of influence among acute medicine trainees for technical, patient-centred and organisational behaviours (below).

METHODS

Trainee grade doctors working full time in AMU were interviewed. Interviews sought information on determinants of influence in three domains: technical care, patient-centred care and organisational work.

A simple framework, an inductive-deductive grounded theory method was used with questions exploring themes that emerged in earlier interviews.

Participants were asked to consider influences throughout their career, not just in the current post.

Thematic analysis was done using NVivo software.

Participants: ranged from FY1 to SpR; they were selected from 4 different rotations over a 2 year period using convenience sampling.

All gave informed consent and approval from HRA was obtained.

Interviews continued until thematic saturation was achieved.

Influence networks for clinical (left) and patient centred actions (right) in an AMU team (amalgamated advice seeking and role modelling).

RESULTS

Influence relating to technical care

Trainees described they were much more likely to ask advice from, or emulate, people they considered to be kind, and particularly when the kindness was absolutely consistent.

“someone who is kind to patients and kind to everyone on the ward … that’s the kind of person I would copy”

This was partly because they felt less threatened, and more likely to have a positive experience and get a good explanation when asking advice.

Trainees described generally trainees valued kindness in patients highly, and had greater respect for colleagues who acted in this way. There was crossover, or halo effect, between perception of being patient centred or giving an extra; extra role for patient experience and technical competence.

The visible success of an action was important when deciding whether to adopt it in future practice. This might mean a diagnostic approach picking up a diagnosis or a treatment working, especially a very sick patient recovering. Actions were more likely to be emulated if accompanied by a comprehensive explanation. When trainees were unsure of the reasons for an action, and explanation was not offered, many assumed that there was no thinking behind the decision and doubted the competence of the person observed.

Influence relating to providing good patient experience

Trainees initially interpreted this as meaning selectively picking up phrases used by consultants during ward rounds, situations such as end of life care, DNR and breaking bad news. When encouraged to think beyond this, trainees stated that they would then copy the approaches of others, feeling that this domain of behaviour was something personal. All said they had not asked for advice on dealing with patient communications, and felt they would not in the future.

“I don’t think I have. it’s easier to frame your own way. I don’t think I’ve ever…”

Where they emulated behaviour, this was from role models who were chosen because they had similar approaches to themselves. They felt their values came from external sources, mainly parents, but not from colleagues.

“I went to a school where religion was very, like, central …”

“parents yes, definitely similarities between how I act and how my parents would act”

Trainees valued colleagues who made an effort to improve experience, and many gave examples of times they had acted positively after observing good practice.

“I came to it with a kind and caring nature and I think for that in someone else and one of the things I look for in someone is do they have that too”

“People who mirror you, you’re more likely to copy”

Influence relating to ways of organizing work, such as prioritizing discharge letters

There were no personal characteristics that would make someone an influencer. Trainees were willing to try different ways of working if asked to, but only by someone local and doing a similar job; there was resistance to changing practices in response to managers. A practice would be assessed on its merits, whether it made things easier, and adopted or rejected.

There was a sense that nothing the trainees did could make any difference in this respect; care was so complex and other people could negate any gains from efficient working.

Conclusion

All of the determinants of influence that we describe are well known.

Psychological safety is an enabler for knowledge transfer and this was clearly important when learning about technical care.

Homophily, how similar people are, is known to contribute to social network structure and trust.

Stickiness of an action is known to be key to its chance of adoption.

What this study adds is the finding that these different mechanisms for influencing are weighted very differently for the technical, patient-centred and organisational work.

This is useful knowledge for those wishing to improve care by influencing colleagues – whether in formal QI work or day to day work.