IT ADOPTION

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# Elephant in the Room

## The Role of Shame in Health IT Resistance

Forty years ago, management literature referred to a story demonstrating how organizations "frequently take actions in contradiction to what they really want to do and therefore defeat the very purposes they are trying to achieve." That story is now known as the "Abilene Paradox."

The story describes a Texas family who enjoys each other's company by simply sitting on the porch on a hot afternoon, but collectively decides to take a trip to Abilene, despite individual unspoken misgivings. When they return, each family member admits they really had a miserable time, but to please the others (or so they thought) each had agreed to a trip no one actually wanted to take, suggesting that people are often "very averse to acting contrary to the trend of a group where there is real risk of displeasure and negative consequences for not going along."[1]

The volume of social science research on organizational behavior in the forty years since its original publication may deepen the significance of the Abilene Paradox, especially in healthcare. Social work researcher Brené Brown poignantly described some of this research in a 2010 TED Talk.[2] Brown focused her research on the most powerful human desire – human connection. She discovered that the drive for connection is very often unmet. Her study subjects described disconnection as a major fear. And this fear then led to a deep sense of vulnerability. In Western society, we see vulnerability as weakness or failure. Given this, a person feeling vulnerable may then develop a deep sense of shame.

This TED Talk hit a nerve. In a subsequent 2012 TED Talk,[3] Brown said she initially thought "perhaps six or seven hundred people" would watch her original talk on YouTube. As of today, the video has over 16 million views. If Brown herself grossly underestimated the response to her talk—that her observations on shame and vulnerability resonated with tens of millions of people around the world—it seems obvious that we would also face this significant challenge in healthcare. In other words: are shame and vulnerability driving organizational forces in the healthcare environment? Are these forces that people working in these environments never admit or talk about? If so, what are the implications? Brown argues that equating vulnerability with weakness is a major misunderstanding. She proposes instead that vulnerability is not a weakness, but an act of courage. Our willingness to make our vulnerability open for all to see is necessary, even a requirement, for innovation, creativity, and change.

Most healthcare research looks at clinicians—individually and collectively. We know, for example, that during their training, physicians undergo an acculturation process where *in*vulnerability is a core theme. More importantly, we now know this cultural norm is a key factor contributing to medical error.[4] Similarly, research on physician-nurse relationships examines the "culture of blame and shame."

Bullying behavior between other clinical professionals—doctor to nurse and nurse to nurse—even clinician to patient—is well documented.

With an understanding of how shame and blame work for doctors and nurses, can we assume these emotional barriers also exist throughout our healthcare organizations? What about managers and executives? Those who work in health IT? Although we are not aware of any research in these areas, we propose that shame and vulnerability affect those beyond the bedside. Brown notes that shame is a universal human experience (an elephant in the room). This scope extends much further than focusing exclusively on physicians and nurses.

Assuming this is true, what is the significance to healthcare, particularly health IT? Few would disagree that our industry is in a dramatic state of flux that seems certain to introduce faster and more significant change in coming years. Daniel R. Masys, MD, former Professor and Chair of the Department of Biomedical Informatics and Professor of Medicine at the Vanderbilt University School of Medicine and now an Affiliate Professor of Biomedical and Health Informatics at the University of Washington School of Medicine, notes "Healthcare is being overtaken... by colossal changes in the environment in which it delivers its services and in the knowledge base of science upon which medical reasoning and health care decisions are made."[5] Of course, a primary driver of this change is the cost of care, but there are many other motivators, such as quality and access.

In general, the direction of this evolution suggests the system is taking shape: paying for value not volume, caring for patients from birth to death, coordinating care across the continuum, engaging patients as co-creators of health. The common thread is a need for data and information. With-

out robust, usable, interoperable health IT, none of this evolution is fully realized.

In the same way healthcare systems demonstrate increasingly rapid evolution, we've seen similar impressive changes in health IT. Twenty years ago, few had even heard of an electronic health record (EHR). Today you would be hard-pressed to find a healthcare worker who has never heard the term. Yet technology change of any magnitude is tremendously disruptive—to society, organizations, and individuals. We have many theories and models to predict and address the range of human reaction to change such as an EHR implementation, including applying Kubler-Ross' model of death and dying (denial, anger, grief, bargaining, acceptance).[6] We suggest considering adding Brown's model of vulnerability and shame to our thinking.

But how, exactly? Brown suggested that vulnerability is courage and the birthplace of innovation, creativity and change – all critical in our current environment of rapid change and an uncertain future. Brown further identifies an antidote for this vulnerability and shame barrier that we can apply to healthcare as well, and that is *empathy*.

Empathy and sympathy are commonly confused. Sympathy is the feeling of pity and sorrow for someone else's misfortune. Empathy is appreciating and sharing another's feelings (having shared the same, or a similar, experience). The distinction is critical. Sympathy requires minimal emotional investment. Empathy requires making visible *your own* vulnerability. Brown notes, "Empathy is about being present and wholly engaged without your protective armor" and "Empathy fuels connection."

Theresa Wiseman, a nursing scholar, proposed four qualities required to demonstrate empathy: perspective taking, staying out of judgment, recognizing emotion in other people, and communicating it.[7] In short, feeling *with* people not feeling *for* people.

What do we know about empathy in healthcare organizations? Again most of the research focuses on clinicians, and specifically on empathy's value in the provider-patient relationship. A 2010 study reported in the *International Journal of Medical Education* found that "empirical evidence... confirmed significant links [between physician empathy] and patients' satisfaction with their physicians, interpersonal trust, and compliance with physicians' recommendations."[8]

So empathy between physicians and patients is present and beneficial, but what about empathy for *fellow* caregivers and all other people who work in healthcare organizations? Is it possible that one reason health IT projects fail is the absence of empathy for each other? We believe that the industry attracts empathic physicians and nurses who often receive additional empathy training. We maintain that healthcare organizations must expand empathy training to its entire workforce. Embracing the courage of vulnerability by fostering empathy for and between caregivers may reduce resistance to health IT. If we expect to realize the changes embodied in health IT, we must require that the healthcare workforce overcome shame and embrace courage.

If we consider shame a deep and widespread barrier in our healthcare organizations, experienced by nearly everyone, not openly acknowledged or addressed, and we consider vulnerability as strength and therefore key to innovation, creativity and change, then and only then will we see our industry transform. Therefore, it is imperative that we find ways to enable and encourage our people to embrace vulnerability.

Empathy training must be more than just another burden on a severely strained industry. It must integrate into ongoing quality improvement, making it a byproduct of healthcare. Overcoming shame, embracing courage, and including empathy in quality improvement shifts our focus to what matters most: our patients and the health IT projects that benefit them while keeping our healthcare organizations from heading back to Abilene. **JHIM**

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