MISSION CRITICAL TEAM INSTITUTE

Green Paper: Critical vs. Routine Communication

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Problem Statement:

The COVID 19 pandemic is increasing the utilization of "Swarms," Cross-functional, or X-Teams (Ancona & Bresman, 2007; Ancona, Bresman, & Kaeufer, 2002). Unlike intact teams, which have already built trust, cohesion, and communication norms, swarms are coming together under extreme, and sometimes austere conditions, to rapidly execute a mission (resuscitation, intubation, etc.) and then quickly disperse to join another team. One of the challenges that these new swarms have been encountering is that some members are unclear/untrained on the differences between routine and critical communication, leading to unnecessary interpersonal conflict, which in turn decreases the effectiveness of the team.

Research Questions:

1. What are the optimal principles for Routine Communication?
2. What are the optimal principles for Critical Communication?
3. How can leaders let the team know when they are transitioning between Routine and Critical Communication?
4. What is one way for rapidly building trust and cohesion within a cross-functional/swarm/X-team that you have seen succeed?

Catalyst for Current Research: Research Notes from Dr. Preston B. Cline

Observation: Open Heart Surgery

Intent of Initial Observation

I had been asked by a Surgical Team, who specialized in open heart surgery, to help understand why they were experiencing high attrition with circulating nurses? While there are a number of contributing factors, such as a pay, lifestyle, stress, etc., the initial assumption was that it was primarily related to the manner in which Doctors communicated with Nurses. The current thinking was that if Doctors had better training on communication and empathy it would decrease nurse attrition.

Context

What I observed was that while the Surgeon is clearly the authority in the room, that authority is shared by consent/direction with the scrub nurse. While the Surgeon treats the patient, the scrub nurse is located at an elevated position, above and beside the patient. If you think of the actual surgery happening inside of an invisible bubble, the scrub nurse owns the inside of the bubble, and the circulating nurse, who is positioned at a station against the wall, manages all enabling functions and bubble security. Everyone who enters the surgical theater is greeted with

enthusiasm (it is a lot like being welcomed to someone home). The team say “thank you”, and “I love you” regularly to both their peers and visitors. A radio is playing prior to, and directly after the critical parts of the surgery, or the immersion event (Cline, 2017a).

Environment

If a typical Open-Heart Surgery last three hours, the first and last hour exists within a routine environment. **Routine Environments** are characterized by predictable, non-urgent, events that can be managed and mitigated using the principles of High Reliability Organizations such as; contingency planning, checklists and redundant systems (Weick, Sutcliffe, & Obstfeld, 2008). Effective communication in a Routine Environment is characterized by empathy, inquiry, active listening, etc. Once the patient is transitioned to the Heart/Lung machine, the Surgical Team crosses the event horizon into **Critical Environment** which is characterized by rapidly emergent complex events, which require improvisation, adaptation, and flow (Cline, 2017b). Effective communication in Critical Environments require a level of brevity that often ignore tone, tempo, volume and many of the accepted characteristics of routine communication.

Transmission or Reception?

As the Anesthesiologist was working the second surgical patient of the day, a few medical personnel began asking me about my research. As there was a lot of ambient noise in the room, and my hearing is not what it once was, my replies were louder than they needed to be. In response, the Anesthesiologist stepped out from the patient and in the nicest, and kindest, way possible asked “Preston, could you tone down the volume a bit.” Given the context the Anesthesiologist would have been right to ask me to leave or scold me, instead they remained extremely kind and courteous.

As a professional researcher I have very high standards regarding my work behavior and pride myself on staying out of the way during observations. So, upon receiving the feedback (Again, the transmission could not have been kinder) I experienced a cascade of negative emotions and a raging inner monologue of embarrassment, annoyance, shame, etc. Due to years of experience, however, I have developed a “thick skin” and was able recover pretty quickly. Yet, I could not help but wonder: How I had developed that “thick skin?” How did I learn to understand the difference between someone providing me feedback (where I was being asked to change my long-term behavior) versus someone using direct communication toward me (to improve the teams immediate performance) in service of an urgent mission? How did I learn to separate myself from my role?

My working assumption going into this research observation, was that if there was a communication problem within the surgical team, it was due to how Doctors learn how to **transmit** information My experience, however, demonstrated that while there may be doctors who lack empathy and communicate poorly, we also must consider how competent and talented individuals learn to **receive** information. (Note: to be absolutely clear this argument is NOT an excuse for disrespectful, boorish, or immature behavior, as the best leaders remain calm and courteous even in the most chaotic environments). Furthermore, even if we are able to train

people to identify, and differentiate, between routine and critical communication, who do leaders let their teams know when they are transitioning between routine and critical communication?

Next Steps: Collaborative Inquiry

Given the speed of the COVID pandemic, we no longer have the time to do exhaustive studies, on how to better prepare medical staff for framing routine and critical communication, as well as transitioning between them. Instead, we are going to crowd source the solutions in real time. Below is a both a link to a survey, and the results of the survey. We ask that you pass this email to the rest of the Mission Critical Team community have them click the link and fill out the survey. The report will update immediately and thus medical workers can immediately have access to effective practices. The staff at MCTI will curate the survey, and from time to time, publish summaries of effective practices as they emerge.

Questions:

1. What is your profession? (Medicine, Military, Fire, Academia, etc.)
2. Please share 5 words, or phrases, describing your principles for optimal ROUTINE communication (Active listening, respect, empathy, etc.)
3. Please share 5 words, or phrases, describing your principles for optimal CRITICAL communication (Clear, Concise, Non-Emotional, etc.)
4. In a sentence, describe how you team knows when you transition between routine and critical communication.
5. What is one way for rapidly building trust and cohesion within a cross-functional/swarm/X-team that you have seen succeed?

Test Survey Link:

https://corexmsdff4qgcml5by2.sjc1.qualtrics.com/jfe/form/SV_e3PZMm6UzA323el

Test Report Link: *

will take a few minutes for the server to update with your answers, but it will stay live so you can see evolve.

https://ql.tc/Ftv5QA

References

Ancona, D., & Bresman, H. (2007). *X-teams: How to build teams that lead, innovate, and succeed*: Harvard Business Press.

Ancona, D., Bresman, H., & Kaeufer, K. (2002). The comparative advantage of X-teams. *MIT Sloan Management Review, 43*(3), 33.

Cline, P. (2017a). *Learning Event Review Process (L.E.R.P.)*. Langley, VA: Air Land Sea Application Center

Cline, P. (2017b). *Mission Critical Teams: Towards a University Assisted, Mission Critical Team Instructor Cadre Development Program*. Dissertation for Doctorate in Education. University of Pennsylvania Graduate School of Education.

Weick, K. E., Sutcliffe, K. M., & Obstfeld, D. (2008). Organizing for high reliability: Processes of collective mindfulness. *Crisis management, 3*, 81-123.