Nurse Education Today 38 (2016) 5–8

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/nedt

Care erosion in hospitals: Problems in reflective nursing practice and the role of cognitive dissonance

Jan de Vries *, Fiona Timmins

School of Nursing and Midwifery, Trinity College Dublin, Ireland

ARTICLE INFO

Article history:
Accepted 10 December 2015

Keywords:
Cognitive dissonance
Nursing
Care erosion
Critical reflection
Nursing values

SUMMARY

Care erosion – gradual decline in care level – is an important problem in health care today. Unfortunately, the mechanism whereby it occurs is complex and poorly understood. This paper seeks to address this by emphasising problems in reflective nursing practice. Critical reflection on quality of care which should drive good care instead spawns justifications, denial, and trivialisation of deficient care. This perpetuates increasingly poor care levels. We argue that cognitive dissonance theory provides a highly effective understanding of this process and suggest for this approach to be incorporated in all efforts to address care erosion. The paper includes a detailed discussion of examples and implications for practice, in particular the need to restore critical reflection in nursing, the importance of embracing strong values and standards, and the need for increased awareness of signs of care erosion.

Introduction

Recently, this journal has seen a fierce polemic (Paley, 2014a,b; Darbyshire, 2014; Rolfe and Gardner, 2014a,b; Timmins and de Vries, 2014; Darbyshire and McKenna, 2013) on issues around deficient care, compassion deficit and other problems discussed in the Francis Report (Francis, 2013). The shocking decline in care in the Mid Staffordshire Hospital Trust confronted us with many issues which were, and still are in great need to be addressed. The authors involved in the polemic have all contributed in different ways. Some of us have highlighted how healthcare organizations as a whole need to be reformed. Others, including us (Timmins and de Vries, 2014), have emphasised that in addition to systemic issues we need to improve our understanding of the psychological mechanisms that lead to what we indicated as 'erosion of care' (p. 1270) (Timmins and de Vries, 2014). In this paper we will put the polemic aside in order to expand on our contribution: how failing critical reflection and self-correction in health care workers and management lead to care erosion. Using cognitive dissonance theory (Festinger, 1957; Cooper, 2007) as an explanatory model we will discuss the often not well understood mechanisms. The specific objective of this paper is to provide health care staff, management, and educators with a new understanding and ways of addressing decline in care levels.

Care Erosion

Deficient levels of care are often the result of unnoticeably gradual decline. Like a frog will be boiled because the frog does not respond to a *gradual* increase in temperature of the water, troubled health care institutions fail to react to signals of gradual decline in care. The result is *erosion of care* or *care erosion*. We first introduced the term (Timmins and de Vries, 2014) as an indicator of failing care. To be more precise, we mean: a gradual decline in the quality of care in vital sectors, a gradual increase in violations of standards and regulations, growing inconsistencies between values of health care and actual practice, and a decrease in levels of compassionate care delivery as demonstrated by health care workers.

Before we go any further we should acknowledge that care erosion does not take place in a vacuum. Many factors influence it. Perhaps most importantly, policy makers and hospital management generate the climate for it. Specifically efforts to economise affect the ability of staff to perform as well as they would like. In addition, autocratic or incompetent leadership, excessive stress and lack of training are often incompatible with care and safety in organisational culture (Reason, 1990; Reason, 1993). Furthermore, a poor safety and reporting culture (Reason, 1997; Hayter, 2013) means that minor slips and concerns are left unreported and unaddressed. Thus they can gradually become the norm and escalate. And finally, social psychological factors such as conformity (Asch, 1956), obedience (Milgram, 1963), loss of perspective (Zimbardo et al., 1974) and group think (Janis, 1982) suggest that social pressure can make us do things against our better judgement. However, to understand the core of what goes wrong we must analyse the internal process whereby health care staff reflect on their care delivery. Normally, this reflective process ensures self-correction whenever practice becomes inconsistent with values and standards of care. When it fails, care erosion becomes likely.

Critical Reflection

Reflection and reflective practice are well described in the nursing literature (Jasper, 2013). Indeed almost every modern professional

* Corresponding author at: School of Nursing and Midwifery, Trinity College Dublin, 24 D'Olier Street, Dublin 2, Ireland.
E-mail address: jan.devries@tcd.ie (J. de Vries).

http://dx.doi.org/10.1016/j.nedt.2015.12.007
0260-6917/

espouses the notion of reflection on practice (Hargreaves and Page, 2013). The processes are well understood and their articulation, such as by Schön (1983) has informed much of its development. Nonetheless, its effectiveness has been questioned recently. Of particular concern has been whether personalised reflection, which is often focused on feelings (Høyrup and Elkjaer, 2006), provides enough direction to optimise practice. Specifically, Jasper (2013) has advocated that taking action needs to be a more explicit part of reflection. Others advocate very clearly for reflection as a functional process: 'Nurses should adopt the role of the sentinels of yesteryear and systematically 'watch' for occurrences of substandard care (Darbyshire et al., 2015) (p. 2). Our perspective echoes this sentiment. Reflection should be 'critical' in nature and focus on consistency and inconsistency of actual care delivery with values, standards, and regulations. It should also be a touchstone for our effectiveness in getting work done and the belief in ourselves as good health care workers. Inconsistencies are to be used as signals to adapt practice (see Fig. 1). In hospitals in trouble, such as the Mid Staffordshire Trust, neither reflection levels nor the response were adequate to avert care erosion. Why and how this happens is best explained by cognitive dissonance theory.

Cognitive Dissonance

Cognitive dissonance theory (Festinger, 1957) deals with how we experience and respond to inconsistencies within our thinking and between behaviour and thinking. When we become aware of inconsistencies we experience discomfort or dissonance. This motivates efforts to reduce it and regain consistency by adapting our attitudes, perceptions, or behaviours until they are again consistent with one another. The more pronounced the inconsistency, the more unpleasant we feel (Cooper, 2007). Mild dissonance may be felt as an annoyance or a 'mental itch', but strong dissonance can take the form of embarrassment, shame, regret, or anger with oneself.

If we apply this mechanism to critical reflection, it follows that picking up inconsistencies between practice and standards, regulations and values must be experienced as unpleasant. This is essential because it forms the aversive drive to improve practice. Without dissonance discomfort there is no incentive to seek ways of reducing inconsistencies. However, dissonance research shows that we would not necessarily favour change in behaviour over modifications of perceptions or attitude (Cooper, 2007). For instance, when we have done something inconsistent with our values that we cannot take back, we may reduce the dissonance by decreasing the extent to which we see ourselves as responsible or culpable. Typically we tend to conjure up justifications that seem to let us off the hook, such as 'there was no time to do it correctly' or 'it was somebody else's fault'. Once we've convinced ourselves that it was not our fault, our dissonance will be reduced and we will feel better. Empirical research has consistently demonstrated the effectiveness of justifications in dissonance reduction (Shultz and Lepper, 1996). Other ways to reduce dissonance without addressing the inconsistency come in the form of trivialising the inconsistency (Martinie and Fointiat, 2006), denial or seeking distraction (Steele, 1988). Each of these strategies we see when care erosion takes place. In fact, in the Mid Staffordshire Hospital signs were consistently ignored, denied, trivialised and justifications were made to defend it, which created a smoke screen obstructing the reflection process.

Most problematic is that whatever is effective in reducing dissonance discomfort tends to be used again the next time the same violation occurs. We've emphasised this crucial aspect before:

> *The insidiousness of this shift is that once these justifications or excuses have been established by a person, future lapses in care will not lead to the same level of discomfort.As a result a gradual erosion of the quality of care is likely and a vicious cycle of increasingly deficient care may emerge* (Timmins and De Vries, 2014, p. 3).

While Festinger's original perspective is still widely supported, the massive body of empirical research on dissonance has led to several revisions of the theory. Aronson's self-consistency perspective (Aronson, 1969) suggests that dissonance discomfort is at its strongest when we behave in ways that violate beliefs that we are smart, good, correct, etc. Frequent incidences of poor clinical practice would specifically threaten the belief of oneself as a good practitioner. Reduction of this kind of dissonance is a matter of self-protection and carries particular urgency, hence its inclusion in Fig. 1.

Other modifications of the theory have emphasised that dissonance theory is also applicable to mechanisms to guide our actions (Harmon-Jones et al., 2003; Harmon-Jones and Harmon-Jones, 2002). In this case dissonance discomfort is perceived as a signal that a course of action is inconsistent with a plan or goal and motivates adjustments until the discomfort is reduced. This facilitates consistency of actions with a plan or goal (Beckmann and Irle, 1985). This perspective on the theory emphasises that dissonance will emerge whenever we sense that we won't get the job done (in time). This is an important element – sometimes implicit – in how nurses reflect on their performance (see Figs. 1 and 2) and, as we will demonstrate, a crucial aspect in care erosion.

Examples

How the dissonance mechanism applies to the reality of care erosion will be illustrated with three examples which are representative of occurrences in clinical practice.

Example 1. : After a procedure with a patient that carries a high risk of infection a nurse realises he or she forgot to wash hands.

Fig. 1. Critical reflection in nursing focussing on adapting practice if needed.

Fig. 2. Reflections in nursing perpetuating care erosion.