ASHRM Patient Safety Tip Sheet: Normalization of Deviance in Healthcare

AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Situation: Normalization of deviance is the gradual process of deviating from standard operating procedure (SOP) for various reasons and the deviation becomes the norm as no immediate adverse outcomes occur. Normalization of deviance in patient care has the potential for devastating outcomes. It plays a unique role in health care as the very safety practices and a larger culture of safety meant to prevent deviation from SOP are not as widespread as early patient safety movement proponents anticipated.

Background: Normalization of deviance is a term most notably described by sociologist Diane Vaughn in her analysis of the 1986 Challenger disaster. While the infamous "O-rings" were found to fail, extreme pressure to meet the launch date resulted in normalization of deviance across time, ranks, and disciplines and deemed the root cause of the disaster (Vaughn 1996). Vaughn further described the term as, "social normalization of deviance means that people within the organization become so much accustomed to a deviation that they don't consider it as deviant, despite the fact that they far exceed their own rules for elementary safety." An analysis of 245 closed medical specialty claims 2003-2012 found three common themes, (1) impaired culture of safety, (2) violations of standards of care, and (3) impaired patient safety and outcomes (Everson, Willbanks, & Boust 2020).

Assessment: Normalization of deviance is most prominent where a culture of patient safety is not fully established. As the Challenger disaster example portrays, the "groupthink" phenomenon that makes deviating from SOP acceptable across an organization can be readily applied to health care. One of many examples is the continued occurrence of wrong site, patient surgery. Its occurrence is often falsely attributed to the verification process being faulty (Vitale, Sethi, Wang 2020). Some accusations include the checklist being inadequate despite not being fully vetted or utilized and/or the "time-out' not working despite being performed without all team members in the room, and/or site marking failure despite it not being within the field-of-vision among other accusations. This group rationalization stems across all specialties and disciplines and so often normalization of deviance is the root cause and not faulty well-established processes.

Recommendation: To embrace a culture of patient safety that obliterates normalization of deviance as a root cause of adverse events, an organization must first analyze its current culture and act upon the results in a fully transparent fashion. By leadership first embracing the need to do so and being fully present on the journey while engaging the workforce to participate, transformation can occur. Use of change management practice allows for structured process improvement. Change management will identify principles and pillars to embrace a just, accountable, transparent, learning, and patient-engaged culture, all the necessary ingredients to omit the practice of normalization of deviation.

References:

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