Instituting a Culture of Professionalism

Jo Shapiro, MD
Director, Center for Professionalism and Peer Support
Chief, Division of Otolaryngology
Brigham and Women’s Hospital
Boston, MA
Disclosures

Consultant for Safe and Reliable Healthcare, LLC
Deep Bow

Lois Margaret Nora, MD, JD, MBA
Academy for Professionalism in Health Care
Team Sport

Allan Frankel
Paul LeSage

BWH Provider Services

CRICO/RMF

BWH CMO

Tony Suchman

Medical Staff Credentialing Committee

BWH Human Resources

Office of General Counsel

PPS Team

Risk Management
My story

Evolving understanding
Institutions are...

“where the human heart either gets welcomed or thwarted or broken.”

This is, fundamentally, a *culture* change
This is, fundamentally, a culture change

“The organization's culture consists of patterns of relating that persist and change through ongoing interaction.”

- Tony Suchman, MD
Brilliant Diagnosis
How many of you want to talk to Dr. Mills?

Why would you dread this conversation?

Why have we tolerated this for so long?
Organizational accountability barriers

- Conflict avoidance/fear of retaliation
- Person is competent/valuable in other domains (e.g., technical skills, content expertise)
- Loss of revenue
- Behavior not exhibited toward all groups
- “Subjective” data
- Patient harm not proven
- Intent vs. impact
- Accountability seems harsh to individual
Why this is so crucial for us to deal with

• Culture drives safe care delivery
• Culture is about behavior
• A core domain of behavior is professionalism
You can’t just send a memo
Brigham and Women’s Hospital

- 793-bed tertiary care facility
- Major teaching hospital for Harvard Medical School
- Physician and scientist faculty: 2,738 (60% male, 40% female)
The Center's mission is to encourage a culture that values and promotes mutual respect, trust and teamwork.
the CENTER for PROFESSIONALISM and PEER SUPPORT

- Professionalism Initiative
- Teamwork Training Communication
- Peer Support
- Disclosure Coaching
- Defendant Support

Wellness
Reporting Concerns
Data (n=352)

- Repeat FPs (31)
- Teams (17)
- New FPs (304)

<table>
<thead>
<tr>
<th>Year</th>
<th>Repeat FPs</th>
<th>Teams</th>
<th>New FPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>77</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>65</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>2014</td>
<td>35</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>2015</td>
<td>38</td>
<td>4</td>
<td>15</td>
</tr>
</tbody>
</table>
Building a program

Making the Case
To get leadership commitment we have to make the case

- Culture drives safe care delivery
- Culture is about behavior
- A core domain of behavior is professionalism
PROFESSIONALISM
That's not my job.
Professionalism

- Ethical
- Respectful
- Altruistic
- Honest
- Knowledgeable
- Collegial
- Cultural competence
- Resource stewardship
- Integrity
Trustworthy relationships

Unifying concept
Executive Patient Safety Committee

Can’t separate professionalism from safety
Communication & patient outcomes

• 300 surgical cases: pts whose surgical teams exhibited less teamwork behaviors were at higher risk for death and complications (Am J Surg. 2009 May;197(5):678-85)

• Reported levels of positive communication and collaboration with attending and resident MDs correlated with lower risk-adjusted morbidity (J Am Coll Surg. 2007 Dec;205(6):778-84)
Professionalism and patient care

• 3-5% of MDs demonstrate behavior that interferes with patient care

• National survey 3900 MDs/RNs/staff in 102 hospitals
  – 51% saw disruptive behavior correlate with compromises in patient safety
  – 71% with compromises in quality
Communication failures

Root Causes of Sentinel Events
(All categories; 1995-2005)

- Communication
- Orientation/training
- Patient assessment
- Staffing
- Availability of info
- Competency/credentialing
- Procedural compliance
- Environ. safety/security
- Leadership
- Continuum of care
- Care planning
- Organization culture

Percent of 3548 events

Joint Commission
Sentinel Event Alert

End intimidating and disruptive behavior among physicians, nurses, pharmacists, therapists, support staff and administrators

“behaviors that undermine a culture of safety”
“Behaviors that undermine a culture of safety”

- Verbal or physical threats
- Intimidation
- Reluctance/refusal to answer questions, refusal to answer pages or calls
- Impatience with questions
- Condescending language or intonation
Just Culture

Human Error

Product of Our Current System Design and Behavioral Choices
Manage by changing:
• Choices
• Processes
• Procedures
• Training
• Design
• Environment

At-Risk Behavior

A Choice: Risk Believed Insignificant or Justified
Manage through:
• Removing incentives for at-risk behaviors
• Creating incentives for healthy behaviors
• Increasing situational awareness

Reckless Behavior

Conscious Disregard of Substantial and Unjustifiable Risk
Manage through:
• Remedial action
• Disciplinary action

Consistency in Rules and Response

Balanced Accountability

Console
Coach
Discipline
ABMS/ACGME competencies: professional standards

- Patient care
- Medical and clinical knowledge
- Practice-based learning and improvement
- Interpersonal communication skills
- Professionalism
- System-based practice
Burning platform: Society, TJC, ABMS, ACGME

- Patient safety
- Patient experience
- Learning environment
- Litigation risk
- Retention
- Morale and productivity

*Not doing this is costly on many levels*
Building a program

Making the Case

Education
Code of Conduct

State your expectations

Code of Professional Conduct Policy 5.2.2.1
Brigham and Women’s Hospital
Brigham and Women’s Physicians Organization
Interactive training sessions
Think of ourselves as potential…

victims, perpetrators or bystanders
Evaluation of sessions

• 2,738 evals completed from 2011 – 2015
• Evaluation range:
  1 = strongly agree
  5 = strongly disagree

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean Score (n=2,738)</th>
</tr>
</thead>
<tbody>
<tr>
<td>objectives achieved</td>
<td>1.5</td>
</tr>
<tr>
<td>awareness increased</td>
<td>1.6</td>
</tr>
<tr>
<td>will enhance professional practice</td>
<td>1.7</td>
</tr>
</tbody>
</table>
Building a program

Making the Case

Education

Accountability
Handling concerns process

- High level concerns process
- Director gives feedback to FP
- Director coaches reporter to give feedback
- Listen only
High level handling concerns process

• Confidential discussion w/ Director
• Assessment: multisource interviews
• Discussion w/ supervising MD, chief/ chair, CMO, OGC, ELR
• Professionalism Advisory Committee
• Meeting w/ disruptor
• Retaliation prevention/mitigation
• Document all interactions

Monitoring
Principles of hearing concerns

• Confidential; Timely; Fair/thorough
• Protect against retaliation
• Intent vs impact
• Focus on behavior, not dx
• Balance of personal accountability and systems issues
• Effector arm
We are not expecting perfection
This is not about minor issues
Not about snitching

The focus is on patterns of behavior
or a single egregious incident
Critical skill

Your facility with leading difficult conversations
Frame-Based Feedback

Trying to learn the other person’s perspective through genuine curiosity and exploration.

Frame-based feedback: algorithm overview

My Frame
- Setting context
- Specific behavior(s)
- Concern or appreciation

Their Frame
- Short open-ended question (for starters)

Match your discussion to their frame

- Rudolph, et al.
Key points

- Focus on behavior, not diagnosis
- Prevent harm to reporter
- Monitoring
- Everyone held to same standards
Back to Dr. Mills ...

Let’s think of his response to feedback
<table>
<thead>
<tr>
<th>Common responses</th>
<th>Appropriate feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inadequate data</strong></td>
<td>Not a court of law</td>
</tr>
<tr>
<td><em>Exactly who said this?</em></td>
<td></td>
</tr>
<tr>
<td><strong>Personal sabotage</strong></td>
<td>Not an isolated incident</td>
</tr>
<tr>
<td><em>Dr. X is trying to discredit me</em></td>
<td></td>
</tr>
<tr>
<td><strong>Other people like me</strong></td>
<td>You shouldn’t have a disruptive working relationship with anyone</td>
</tr>
<tr>
<td><strong>I am special and talented</strong></td>
<td>Not a performance evaluation</td>
</tr>
<tr>
<td><em>I do work that no one else is qualified to do</em></td>
<td></td>
</tr>
<tr>
<td><strong>This is a systems problem</strong></td>
<td>Yes, and …</td>
</tr>
<tr>
<td><em>If this whole system functioned better...</em></td>
<td></td>
</tr>
<tr>
<td>Common responses</td>
<td>Appropriate feedback</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Unfair process</td>
<td>We hold everyone to the same standards</td>
</tr>
<tr>
<td>I’m being singled out because …</td>
<td>Disruptive behavior is a safety risk</td>
</tr>
<tr>
<td>Patient advocacy</td>
<td></td>
</tr>
<tr>
<td>Others aren’t responsible for patients the way I am</td>
<td></td>
</tr>
<tr>
<td>Prove harm</td>
<td>We don’t need to</td>
</tr>
<tr>
<td>Give me one example …</td>
<td></td>
</tr>
<tr>
<td>Personal style</td>
<td>Impact not intent</td>
</tr>
<tr>
<td>I don’t mean anything by it</td>
<td></td>
</tr>
<tr>
<td>I am no worse than others</td>
<td>We are focusing on your issues right now</td>
</tr>
<tr>
<td>I am certainly not the only one</td>
<td></td>
</tr>
</tbody>
</table>
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A word about the rogue elephants
Other tools

• Feedback training
• Coaching/advising
• Relational Coordination
• Conflict resolution
Our data

Shapiro J, Whittemore A, Tsen LC.

Instituting a Culture of Professionalism: The Establishment of a Center for Professionalism and Peer Support.
Interventions

Jan 2010 - Jun 2013 (n=159)

- Feedback by CPPS*: 103 (65%)
- Coaching: 23 (14%)
- Formal evaluation: 19 (12%)
- 360: 11 (7%)
- Other+: 3 (2%)

* Involves: CPPS director, CMO, OGC, EAP, Pt Relations, div chief, dept chair
* Residential referral, empathy training, emotional intelligence
Outcomes: Behavioral

Jan 2010 - Jun 2013 (n=149)*

- Some improvement: 52 (35%)
- Significant improvement: 34 (23%)
- Insignificant improvement: 8 (5%)
- Need f/u info: 36 (24%)
- Work in progress: 10 (7%)
- Not a professionalism issue: 9 (6%)

Total: 86 (58%)

Excludes: left institution, demoted, did not investigate
Outcomes: Change in job status or institutional role

Jan 2010 - Jun 2013 (n=201)*

- 157 (78%) Remain in role
- 23 (11%) Left due to professionalism issue
- 11 (5%) Demoted
- 10 (5%) Left for other reasons

*Excludes groups/teams
How can we expect people who are feeling unsupported and isolated to deliver high quality patient care?
Peer Support
Disclosure Coaching
Defendant Support
OUR HOUSE RULES

I WILL........

1. DO EVERYTHING I CAN TO GO HOME SAFE
2. NEVER FORGET RULE #1
3. RESPECT MY WORKMATES
4. COMMUNICATE POSITIVELY WITH THOSE AROUND ME
5. CHALLENGE MY MATES TO DO THE RIGHT THING
6. PRESENT FIT FOR DUTY & READY TO DO MY BEST
   - NEVER TAKE SHORT CUTS AT THE EXPENSE OF SAFETY
7. LEAD BY EXAMPLE & BE PROUD OF MY WORK
8. SPEAK UP IF I SEE SOMETHING NOT QUITE RIGHT
9. STEP UP & HELP MY WORKMATES IF I SEE THEY NEED HELP
Hope

"Not the conviction that something will turn out well, but the certainty that something makes sense, regardless of how it turns out. The hope of fellowship, and kindness, and service."

Vaclav Havel
This is difficult but so important. It takes great leadership, courage and skill.

Thank you for your commitment to this work.