In Pursuit of Professionalism, Respect, and Safety
Gerald B. Hickson, MD

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Reliability

"Failure free operation… effective, efficient, timely, patient-centered, equitable"

- **Vision/goals/core values**
- **Leadership/authority**
- **A *safety* culture includes:**
  - Psychological safety
  - Trust

Nolan et al., Institute of Medicine, 2001; Nolan et al., Boston: Institute for Healthcare Improvement, 2004; Hickson et al., Joint Commission Resources, 2012.

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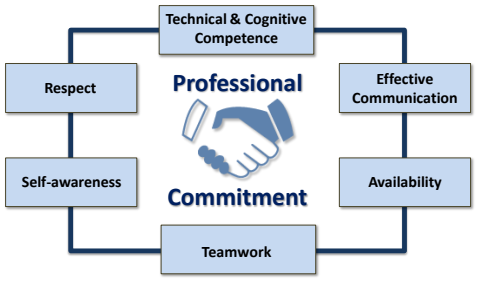
Professionalism and Self-Regulation



Joint Commission Resources — Hickson et al., Joint Commission Resources, 2012.

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But you know, I don't always feel so special

5

A Challenge… Burnout

"Psychological harm is common… when team members are not treated with respect…A culture of fear and intimidation (not being listened to) saps meaning… drains motivation."

And, it makes it hard to be professional…

Lucian Leape Institute. Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care. Boston, MA: National Patient Safety Foundation; 2013.

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Modern Healthcare

The leader in healthcare business news, research & data

When physicians burn out, solutions are elusive. Support groups can't counter the root causes of a crisis "*and no happy talk*"

October 29, 2016
http://www.modernhealthcare.com/article/20161029/MAGAZINE/310299983

Burned-out doctors

- Don't collaborate as well with colleagues
- Make more mistakes
- Exit the profession

http://www.modernhealthcare.com/article/20161029/MAGAZINE/310299983

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So how do we address burnout?

A warning…

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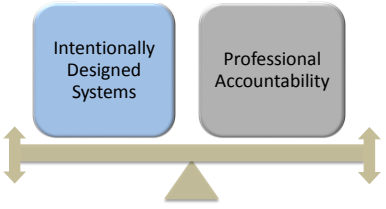
Pursuing the Right Balance

A compact between administration and the professional group



Joint Commission Resources — Hickson et al., Joint Commission Resources, 2012.

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Case: John

- Orthopedics
- Male/42 y/o
- Regional - Suburban
- High RVU generator… a "machine"

Nurse reports:

"Dr. John refused to do a time out before surgery… said, 'can't we just get started…we're on the same page here.'"

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Continued: Why are we so hesitant to act?

Why bother acting?

Failure to act impacts outcomes of care

And if we act, most colleagues improve

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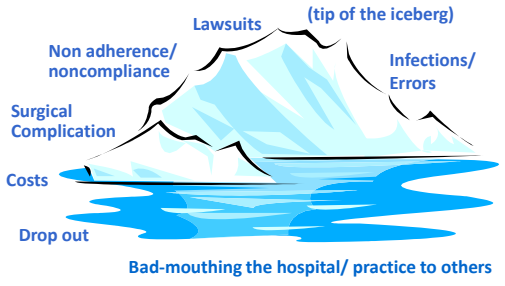
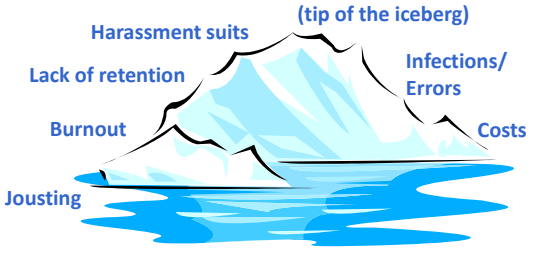
Consequences of Unsafe Behavior: Patient Perspective



Hayden et al., *Joint Commission Journal on Quality and Patient Safety*, 2010.

Consequences of Unsafe Behavior: Healthcare Professional Perspective



Felps W, et al., Research and Organizational Behavior, 2006.

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So do patients and families observe or experience similar disturbances in the force?

"While asking Dr. John about my diagnosis, he responded that my questions were annoying… wouldn't listen and kept speaking over me."

"Asked to sign a consent… for another patient (same last name) and for surgery on the opposite leg."

"Dr. John performed surgery last Thursday, and hasn't been back to see me since then… not being seen by ANY physician."

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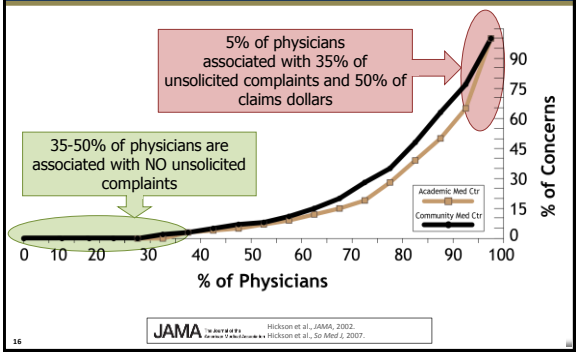
Patient Complaint Distribution



JAMA Hickson et al., *JAMA*, 2002. Hickson et al., *So Med J*, 2007.

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Incurred Expense By Risk Category

Predicted Risk Category*	# (%) Physicians	Relative Expense*	% of Total Expense	Score (range)
5 (high)	51 (8)	73	50%	>50
4	52 (8)	42	29%	41 - 50
3	76 (12)	4	4%	21 - 40
2	147 (23)	6	13%	1 - 20
1 (low)	318 (49)	1	4%	0
Total	644 (100)		100%	

* In multiples of lowest risk group

Moore, Pichert, Hickson, Federspiel, & Blackford. *Vanderbilt Law Review*. 2006.

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Failure to Address Behaviors that Undermine a Culture of Safety

Leads To:

- **Adoption of unprofessional conduct**
- **Lessened trust, lessened task performance** *(always monitoring disruptive person)*
- **Threatened quality and patient safety**
- **Withdrawal**

Felps W et al. How, when, and why bad apples spoil the barrel: negative group members and dysfunctional groups. Research and Organizational Behavior. 2006;27:175-222.

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Surgical Outcomes Research Collaborative

32,125 operations by 817 surgeons

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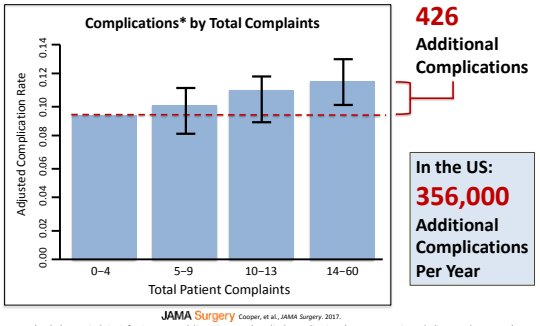
Surgical Complications and Patient Complaints



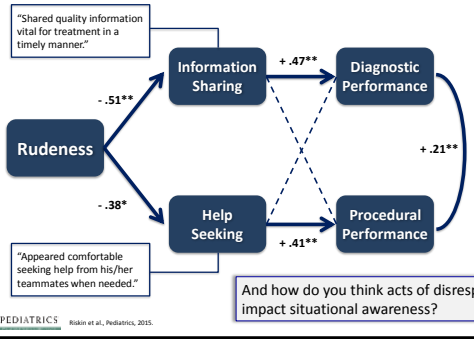
426
Additional Complications

In the US:
356,000
Additional Complications Per Year

JAMA Surgery Cooper, et al., *JAMA Surgery*. 2017.

20 *Includes surgical site infections, wound disruptions, and medical complications (e.g. pneumonia, embolism, stroke, MI, UTI)

The Impact of Rudeness on Medical Team Performance



And how do you think acts of disrespect impact situational awareness?

PEDIATRICS Riskin et al., Pediatrics, 2015.

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To "do something"
requires more than a commitment to professionalism and personal courage.

It requires a plan
(people, process and systems).

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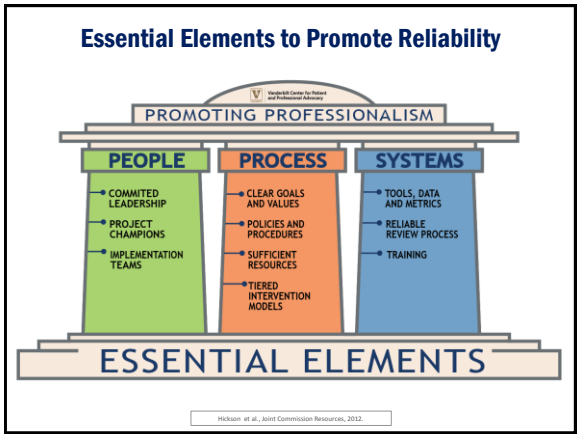

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Leadership

- Who are the key leaders?
- How do you engage?

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Our Credo Journey

The year: **1995**

A focus group of **900** team members

In an effort to define **Who We Are.**

Used hand-drawn art exercises to illustrate **What Professionalism Looks Like.**

Were distilled into six core principles that Became the Vanderbilt **Credo** in 2005*.

The six principles are broken down, in turn, into more than 30 behaviors The complete list can be found at http://www.mc.vanderbilt.edu/root/pdfs/elevate/8_5credo.pdf.

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VUMC Values

VANDERBILT UNIVERSITY MEDICAL CENTER

Credo

it's who we are

- I make those I serve my highest priority.
- I respect privacy and confidentiality.
- I communicate effectively.
- I conduct myself professionally.
- I have a sense of ownership.
- I am committed to my colleagues

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What Are "Surveillance Tools"?

Hickson, Joint Commission Resources, 2012.

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Case: John

- Orthopedics
- Male/42 y/o
- Regional - Suburban
- High RVU generator… a "machine"

Nurse reports:

"Dr. John refused to do a time out before surgery… said, 'can't we just get started…we're on the same page here.'"

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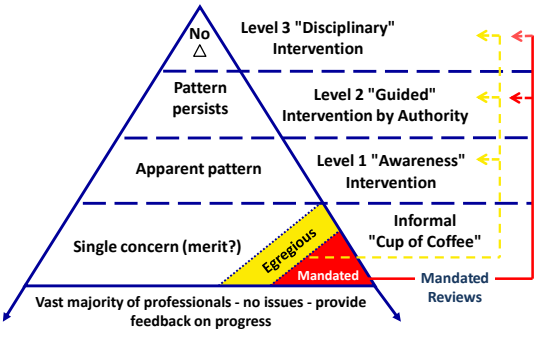
Promoting Professionalism Pyramid



Webb et al, 2016; Talbot et al, 2013; Pichert et al, 2013; Hickson et al, 2012; Hickson & Pichert, 2012; Pichert et al, 2011; Stimson et al, 2010; Mukherjee et al, 2010; Pichert et al, 2008; Hickson, Pichert, Webb, Gabbe, 2007; Ray, Schaffner, Federspiel, 1985.

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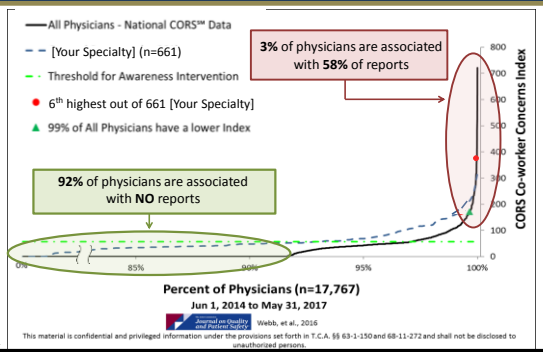
CORS Index



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For a single "event"…

Informal Conversation
Regular (Cup of Coffee)

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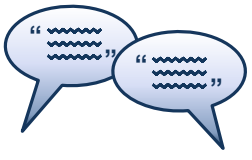
What might an informal intervention sound/look like?



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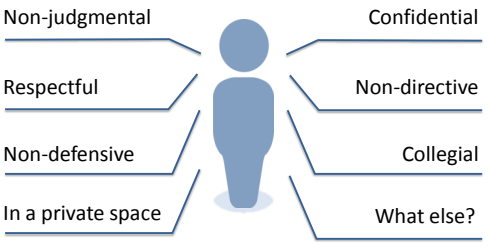
If you were on the receiving end…

You would want the conversation to be:



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Elements for "Informal" Conversations

Goals

- Deliver a single story/observation.
- Let the recipient know the behavior/ performance was observed.

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Having the "Informal" Conversation

Opening

- I am here as ____ (peer, safety committee, or leader, etc.)
- You are an important team member…
- I observed/received a report…
- We are committed to sharing…

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Having the "Informal" Conversation

Review Data

- Review story with sufficient specifics
- "I know there are two sides…"
- Avoid seeming judgmental
- Avoid "you" word
- Pause

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Having the "Informal" Conversation

Respond

- Pushbacks
- Questions
- Emotions

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Having the "Informal" Conversation

Close

- Express appreciation
- Ask to reflect
- Encourage alternative response

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Having the "Informal" Conversation

But It's Not a Control Contest

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Types of Pushback

- Deflection
- Dismissal
- Distraction

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Pushback: Deflection

Deflection

It's not me, it's the…

- Patients (unique, difficult)
- System
- Reporter's mistaken perception
- Report – "that just didn't happen"

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Pushback: Dismissal

Dismissal

"Do you know who I am?"

"I don't believe…"

- Observation
- Seriousness
- Messenger's (Committee's) Authority or process

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Pushback: Distraction

Distraction

"We should really be focusing on…

- System/other team members
- Fix or Help me
- Body language/Emotional response

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Stay on Target

Your responses should reflect the Goals of the conversation

- An observation/ report was made
- Deliver the message

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Responses to Pushback

What are some potential responses?

- **Remind:** This is a part of who we are
- **Reflect:** Back to receiver
- **Reinforce:** Expectations

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Potential Responses

- **Remind:** This is a part of who we are
- **Reflect:** on…
- **Reinforce:** Expectations, majority respond

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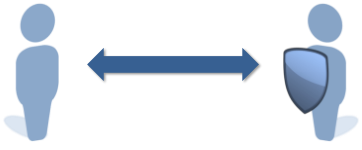
Now it's your turn…



- Remind
- Reflect
- Reinforce
- Deflection
- Dismissal
- Distraction

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Another complaint…

RN reports:

"Dr. John said, 'I've had it with you and the other 'time out police.' Can we just get going?'"

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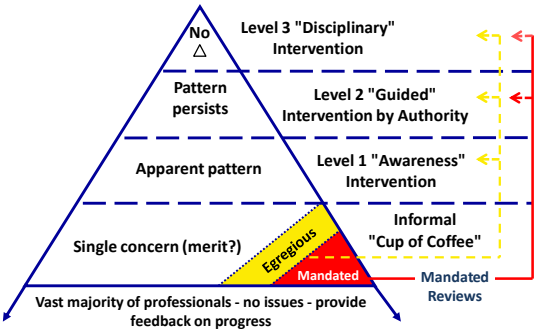
Promoting Professionalism Pyramid



Webb et al, 2016; Talbot et al, 2013; Pichert et al, 2013; Hickson et al, 2012; Hickson & Pichert, 2012; Pichert et al, 2011; Stimson et al, 2010; Mukherjee et al, 2010; Pichert et al, 2008; Hickson, Pichert, Webb, Gabbe, 2007; Ray, Schaffner, Federspiel, 1985.

Shortly there after…

More complaints received:

"Dr. John asked me if I hated my job because I did it so badly."

"He does not properly alert staff members when he needs equipment opened to the field…"

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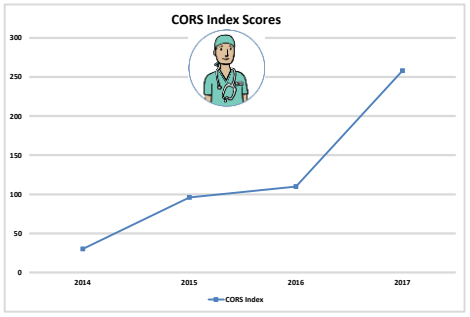
Dr. John's Complaint Curve



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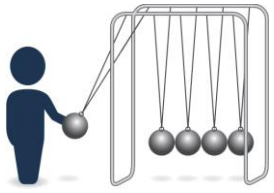
ABC Analysis

- **A** **Antecedents**
  - Anything which precedes and sets the stage for behavior
- **B** **Behavior**
  - An observable act
- **C** **Consequences**
  - Anything which directly follows from the behavior

53 Thomas Krause, PhD, Presentation at the National Patient Safety Foundation Board of Governors Meeting June, 2007

Consequences



- Consequences **control behavior**
- Antecedents **influence behavior** only to the extent that they **predict consequences…**
- Timing, consistency and significance of consequences **affect their impact**

54 Thomas Krause, PhD, Presentation at the National Patient Safety Foundation Board of Governors Meeting June, 2007

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In John's case, is burnout contributing?

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Could be…

We surveyed physicians…

2013

Wellness Survey
☑ Burnout
☑ Emotional Exhaustion
☑ Interpersonal disengagement
☑ Sleep impairment
☑ Low professional fulfillment

… then tracked their patient complaints for the subsequent 3 years

Stanford University Department of Psychiatry, Stanford Risk Authority

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Burnout has a strong association with patient complaints

	2013 Wellness Survey	2014-2016 Patient dissatisfaction
☑	**BURNOUT**	+++
☑	Emotional Exhaustion	+
☑	Interpersonal disengagement	++
☑	Sleep impairment	+
☑	Low professional fulfillment	++

Stanford University Department of Psychiatry, Stanford Risk Authority

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Remember there are lots of possibilities…

May there be other problems facing Dr. John?

But does it matter? Is there a safety issue here?

And how will you know unless you engage?

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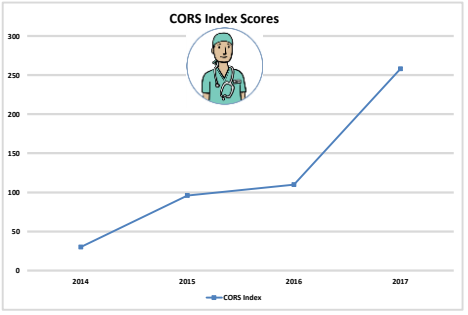
Dr. John's Complaint Curve



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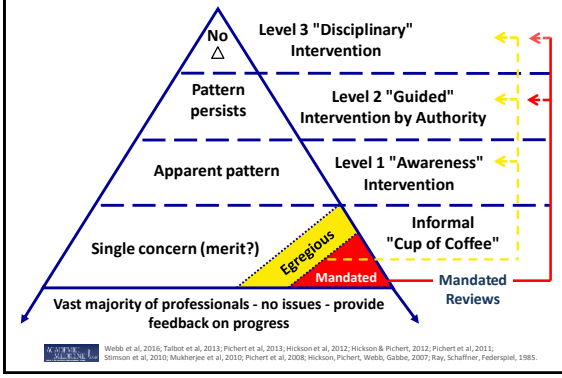
Promoting Professionalism Pyramid



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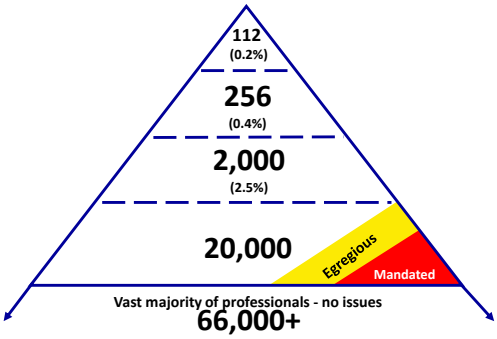
Let's put this in perspective…



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EDICTS: Elements

- **E** — Expectations
- **D** — Discrepancies from expectations
- **I** — Intervention options
- **C** — Consequences
- **T** — Timeline
- **S** — Surveillance

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Resources for Authorities

EVALUATION/ ASSESSMENT	SKILLS-RELATED ASSISTANCE	PRACTICE CHANGES	FINANCIAL
▪ Personnel resources ▪ Physical, mental health ▪ Physician Wellness Program ▪ 360° team evaluations	▪ Coaches, counselors ▪ Training education ▪ Chair review of care, systems	▪ Reduce RVUs, volume ▪ Adjust schedule ▪ Personnel	▪ Adjust incentives ▪ Eligibility for increases ▪ Liability ins. Surcharge

Hickson GB, Moore IN, Pichert JW, Benegas Jr M. Chapter 1: Balancing systems and individual accountability in a safety culture. In: Berman S, ed. *From Front Office to Front Line*. 2nd ed. Oakbrook Terrace, IL: Joint Commission Resources;2012:1-36.

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But what about burnout?

How do we address?

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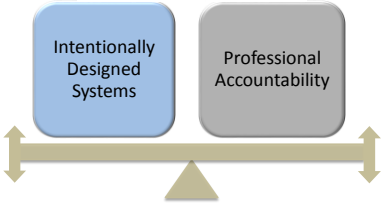
Pursuing the Right Balance

A compact between administration and the professional group



Joint Commission Resources — Hickson et al., Joint Commission Resources, 2012.

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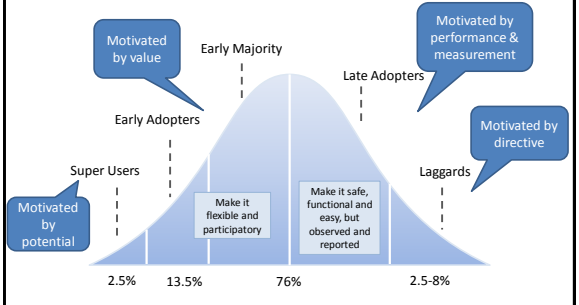
The Human Condition



Adapted from Rogers, Everett M. Diffusions of Innovation. New York, Free Press of Glencoe, 1962.

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How to Create a Joyful, Engaged Workforce

Outcome:
↑ Patient experience
↑ Organizational performance
↓ Staff burnout

4. Use improvement science to test approaches to improving joy in your organization

3. Commit to making *Joy in Work* a shared responsibility at all levels

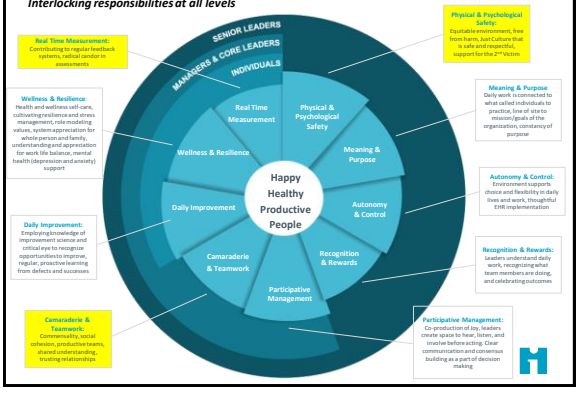
2. Identify unique impediments to *Joy in Work* in the local context

1. Ask staff "what matters to you?"

28th Annual National Forum on Quality Improvement in Health Care IHI s Joy in Work Framework: The Antidote to Burnout Stephen Swensen, Andrea Kabcenell, Shaun Maher, Jessica Perlo Sunday, December 4, 2016

Critical Components for Ensuring a Joyful, Engaged Workforce

Interlocking responsibilities at all levels



Critical Components for Ensuring a Joyful, Engaged Workforce

- Real Time Measurement
- Physical & Psychological Safety
- Wellness & Resilience
- Meaning & Purpose
- Daily Improvement
- Autonomy & Control
- Camaraderie & Teamwork
- Recognition & Rewards
- Participative Management

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Let Us Hear Your Comments and Questions

Now or Later

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