Addressing Deficiencies in Professionalism and Communication Competencies: Changing the Culture

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Why Bother

- It’s a problem
- It’s dangerous
- It’s part of the surgical culture

"The nature of general surgery resident performance problems" Reed, et al Surgery 2009

1. Relationships with other Health Care Workers
2. Insufficient Knowledge
3. Communication

Communication and Outcome

- JCAHO and Sentinel Events
- “Silence Kills” study
- “A String of Mistakes:the importance of Cascade Analysis in Describing, Counting and Preventing Medical Errors”
- MGH handoff study of surgical residents

Disclosure - Wu et al.

* 2/3 of residents admitted making a fatal mistake
* Only 50% disclosed to attending
* Only 25% were disclosed to the patient
* 2/3 of physicians did not even feel comfortable discussing a medical error with a close friend

“Do house officers learn from their mistakes” JAMA 1991
“To tell the truth - ethical and practical issues in disclosing medical mistakes to patients” Journal of General Internal Medicine
“Medical error: the second victim” BMJ.

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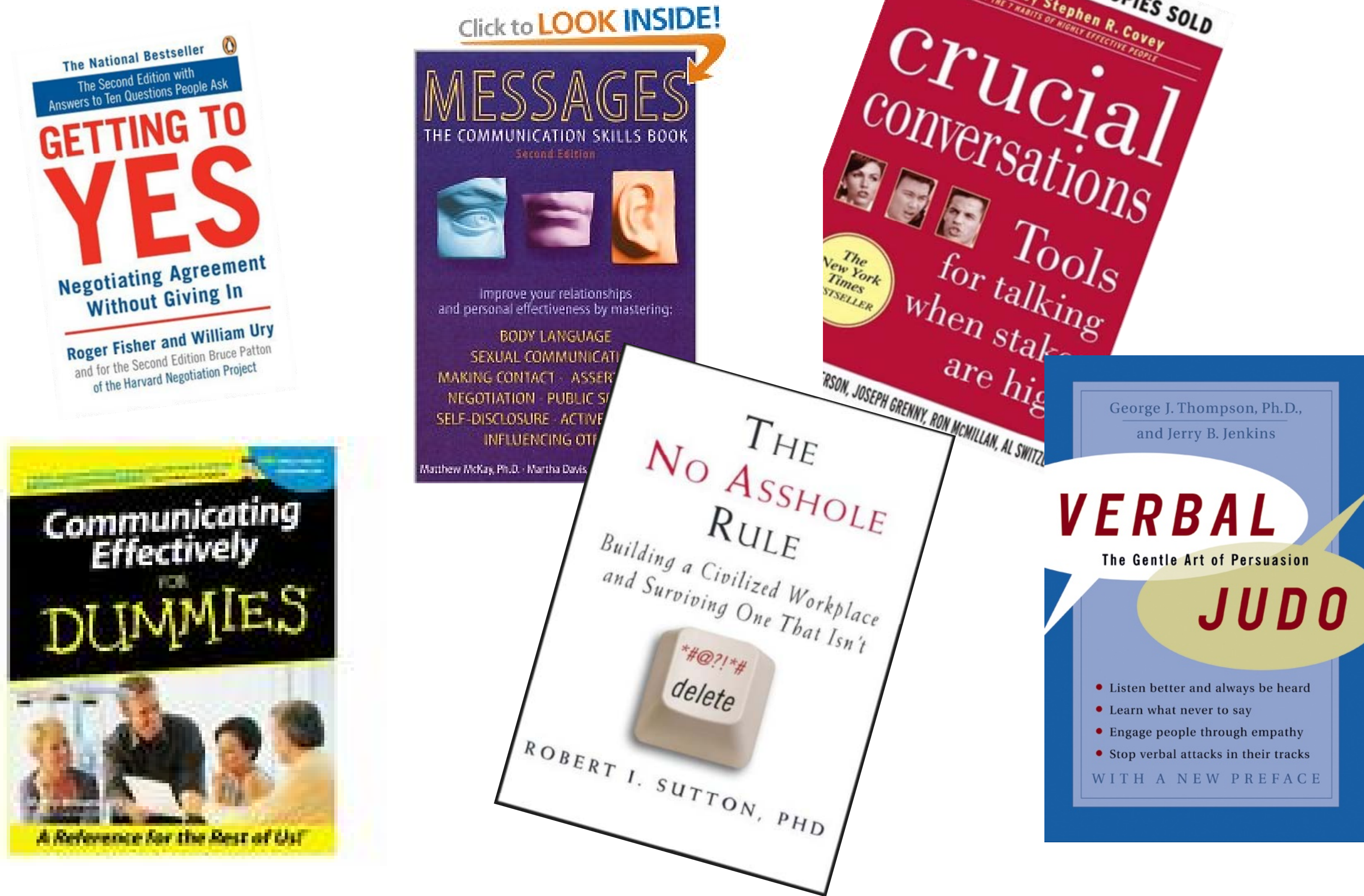
The Value of Communication to Corporate America

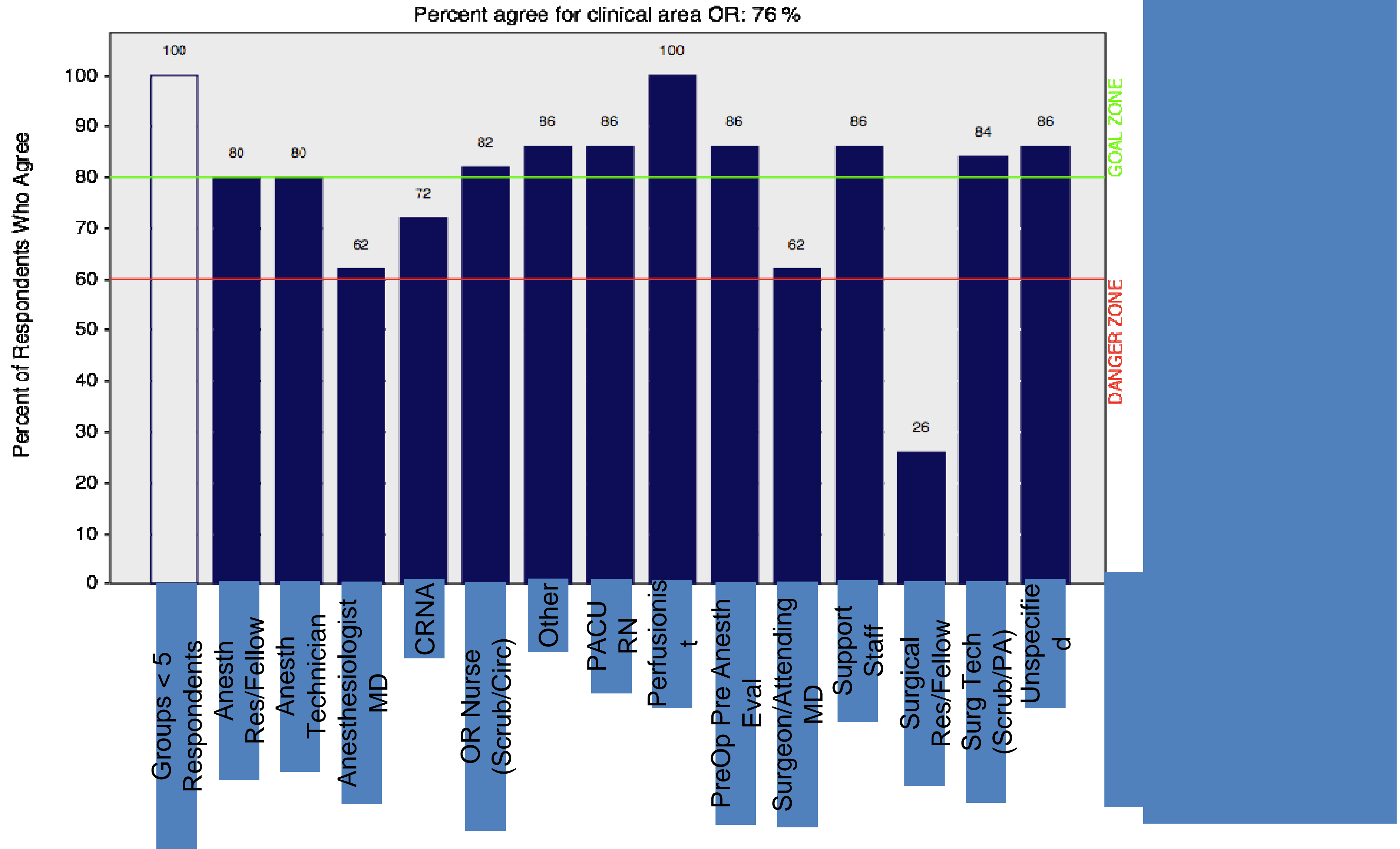


Hey, This is an ACGME Competency, right?

- Most of the time it’s focused on patient-physician communication
- Most of the time it’s evaluated by a box somewhere in the middle of an evaluation
- It’s almost never explicitly taught
- We have no idea how to remediate problems with it, heck we usually have trouble identifying problems with it
- We don’t interview and select for it

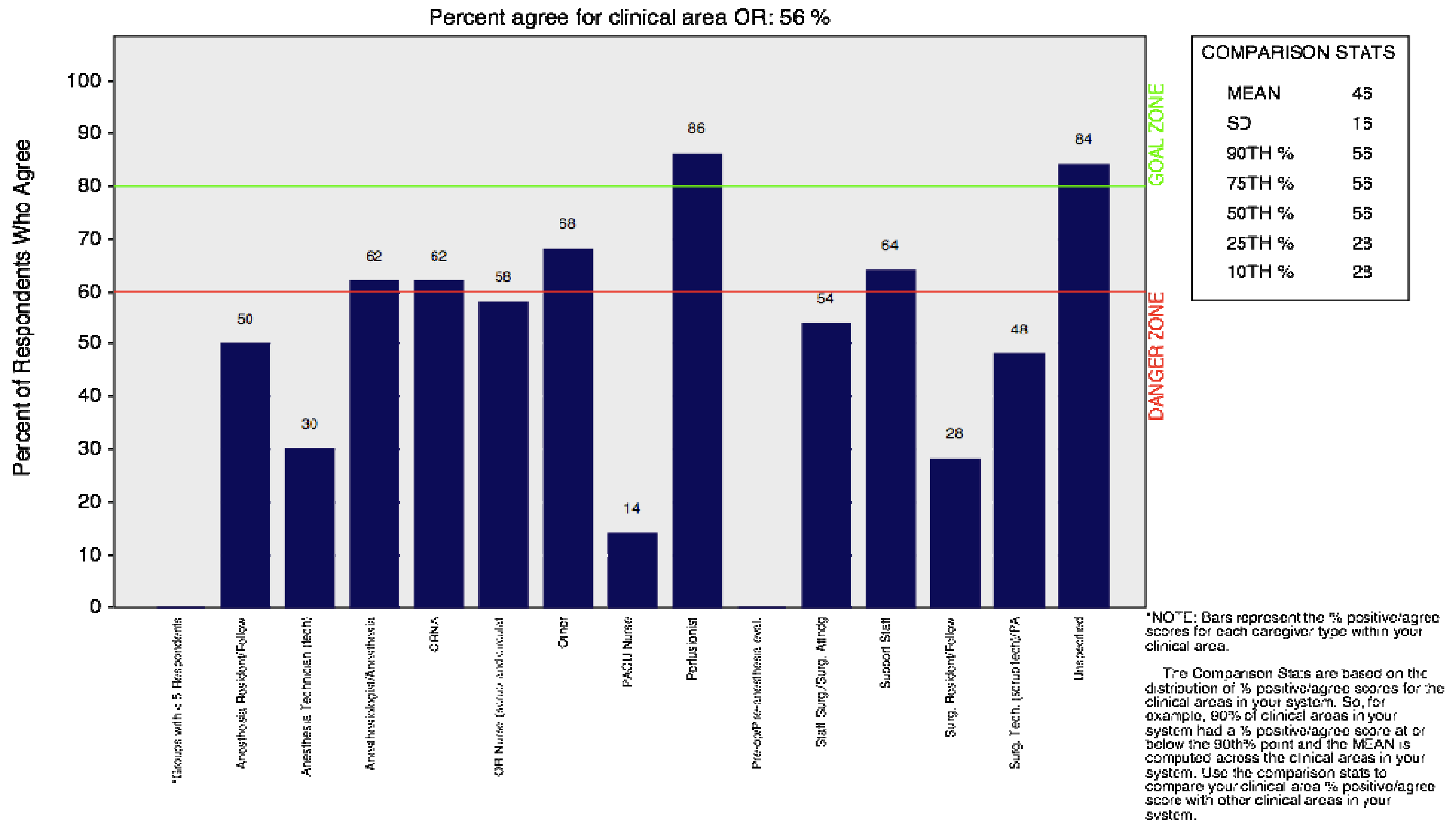
How did our residency come upon this?

I am encouraged by my colleagues to report any patient safety concerns I may have.



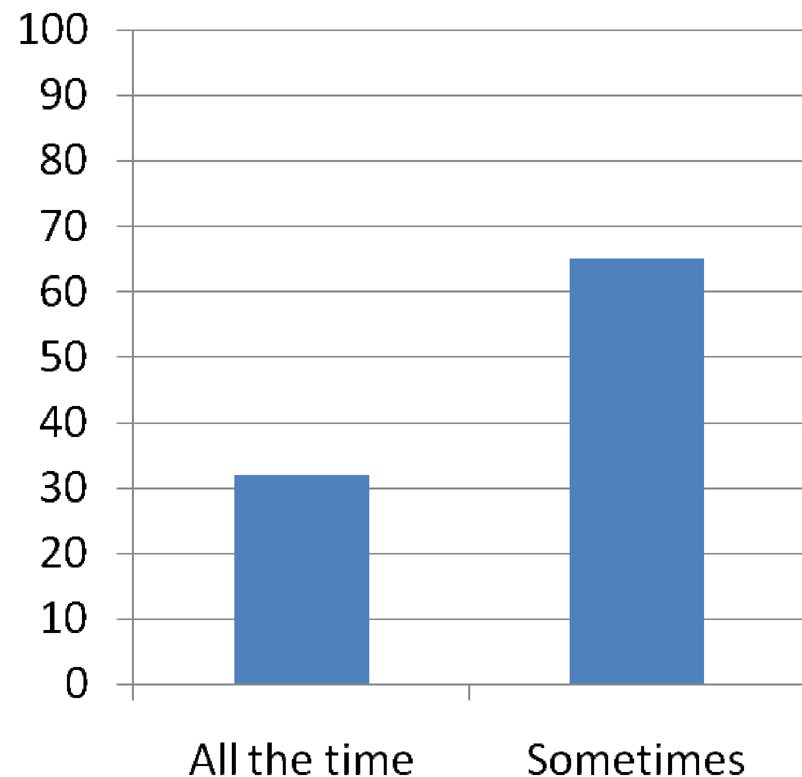
Disagreements in this clinical area are resolved appropriately (i.e., not who is right, but what is best for the patient).

This item is typically negatively correlated with annual nurse turnover rates.



ACGME Questionnaire

- Are mechanisms within the institution available to you so that you may raise and resolve issues without fear of intimidation or retaliation?



What to do?

- Large open session with attendings and residents led to…
- Focus groups
  - 16 hours with outside facilitator
  - Hundreds of pages of scrubbed transcripts
  - Analysis of the transcripts

Examples from the Transcripts

- J.What makes her good?
- She communicates, it doesn't matter when you call her, she' s there. She says "let's fix this". She works well with everybody. I have a lot of respect for her, she explains to families and sitting down and really discuss things with the family. I had a patient that post operatively was suppose to go back to SCU. His wife had been checking with us all night. We saw he was changed to SCU and the wife was getting more and more anxious. Janet walked the patient down and spent the time communicating to her. The wife was so appreciative because Janet explained what was going on. I think Janet communicates well with the nurses too. It's a team effort with her. Some residents view you as a means to an end, they don't articulate where they are going or how they are getting there, they just give the orders and walk away.

More Examples

- J.Who are those?
-
- Jane has been one for me. She does not communicate. She irritates me because she won't tell me what is going on. I call her and she's like "I know". If you know, let's fix it. So I go above her because she is not paying attention. Then she gets mad because I go above her. I am going to go above her if you're not communicating with me about your thought process. This patient is going bad, I need some help here and you are not giving it to me, so I am going to go above you. At the time, it was Mary. Mary sent her right over and that was fine. But still, she never communicated with me. Mary came over and she started to tell us and the next thing I know here comes the attending. Jane is all over it now, but she's not communicating with me, she's communicating with the doctors. She doesn't communicate with the nurses, just the physicians.

Themes from the Transcripts

- Example after example of dysfunctional communication
  - “cold shoulder”
  - Pager retaliation
  - “dressing down” in front of peers
  - Loss of emotional control
  - Behind the back gossip
  - “the sandbag”

“The Sandbag”

- I remember one incident when I was an intern and a test came back and now I would know that it wasn’t of any consequence but didn’t then. She saw it come back and encouraged me to call an attending about it who was on his way out of town. I called the attending and he said I was stupid. He was like you “Do you realize what you are saying is complete nonsense and does not make sense. Why are you calling me?” “Do you realize why this is completely unnecessary and stupid?” She set me up for it. She will do that; it’s a common occurrence. She will sandbag and withhold information from interns especially, so you are off course.

Two kinds of conflict

- Task conflict
  - a disagreement
  - common and necessary
- Relationship conflict
  - a dispute that leads to tension and anger
  - To be avoided or addressed

4 types of conflict management styles

Conflict Approach Style	Characteristics	Task Conflict	Relational Conflict
Problem Solving	Most effective	↓	↓
Forcing	Most expedient	↓	↑
Accommodation	When stakes are low	⇔	↓
Avoidance	Least effective	↑	↑

Change the focus to communication among health care providers

- Established 3 working groups
  - Code of conduct
  - Challenge Hierarchy
  - Nurse- Resident Interactions

Core Values

- Quality Patient Care
- Respect
- Responsibility (accountability)
- Teamwork
- Communication
- Education (lifelong learning, teaching, mentoring)

RESPONSIBILITY

- Doing the right thing
- Hold the crucial conversation
- Lean into your discomfort
- Hold each other accountable
- Accept responsibility
- Everyone takes ownership of the patient

Code of Conduct

- What is best for the Patient is the Ultimate Arbiter
- You have an absolute responsibility to speak up if there is a concern
- You have an absolute responsibility to listen when another provider speaks up

Challenge Hierarchy

Interpersonal Conflict

Micro-Negotiation

Listen carefully
Control your emotions
Indicate you understand (e.g. paraphrase)
State your position clearly (but be friendly)
Seek to dialogue and avoid debate
Work toward a “win-win”

Rogers & Lingard, AJS 2006

Phases

- Phase I- Set the foundation of behavioral values and principles
- Phase 2-Communication on the patient safety and concern pathway
- Phase 3-Specific feedback and conflict techniques
- Phase 4-Training and education on advanced interpersonal conflict techniques

What makes people change?

Patient Safety *Concern* Pathway

DRAFT 3/22/10

Follow these steps to resolve a conflict involving a patient safety or concern.

The protocol should be invoked when anyone has a patient safety concern. The protocol should not be invoked for personal education or convenience in the absence of a patient safety concern. If unsure whether to invoke the protocol, it is always acceptable to confer and get advice from another member of the team.

The protocol is invoked by saying…

1. "I'm Concerned…"

The appropriate response to this critical language statement is: "What's your concern?

Response should be acting on the concern or teaching the caregiver with a concern something they didn't know.

If concern persists, the response should be….

2. "I need more Clarity…"

Response should be acting on the concern or teaching the caregiver with a concern something they didn't know.

Still a concern….

3. "We need to collaborate…"

Nurse: "I will call (charge nurse/supervisor/senior nurse). Would you (resident) call (senior resident/attending)?" OR vice versa to initiate collaboration.

If still not resolved…

4. "Chain of Command" is initiated.

Usage of the chain of command must be verbalized to the parties involved before the end of the communication interaction.

Chain of command may be initiated for refusal to participate in a conflict pathway conversation.

• For nurse/resident or resident/resident interactions, collaboratively discuss going up chain of command and then present concern to next person in the chain.

• For resident/attending interactions, collaboratively discuss going up chain of command if comfortable doing so and make the call. If not comfortable, page ####.

Chain of Command

Nursing	*Residents*
Nurse Manager	*Chief Resident*
Director	*Program Director*
	Patient Safety Officer

• *Conflict must be resolved within 24 hours of interaction.*

• *Patterns of conflict can be addressed by chain of command.*

• *If same individuals re-clarify issue/s, an objective third party will be brought into the interaction.*

SPICE

I. Advanced Communication Skills for Surgical Practice
II. Admitting Mistakes
III. Delivering Bad News
IV. Interdisciplinary Respect, Working as a Team
V. Working Across Language and Cultures
VI. Self Care and the Stress of Surgical Practice