Caring Courageously

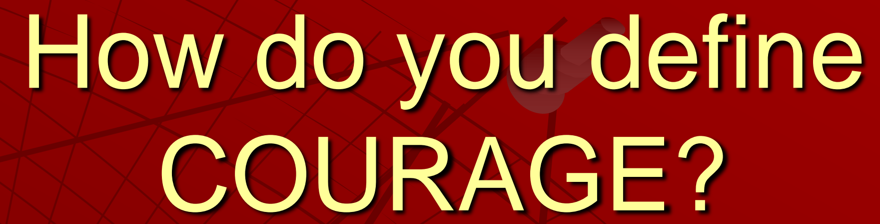
September 6, 2019

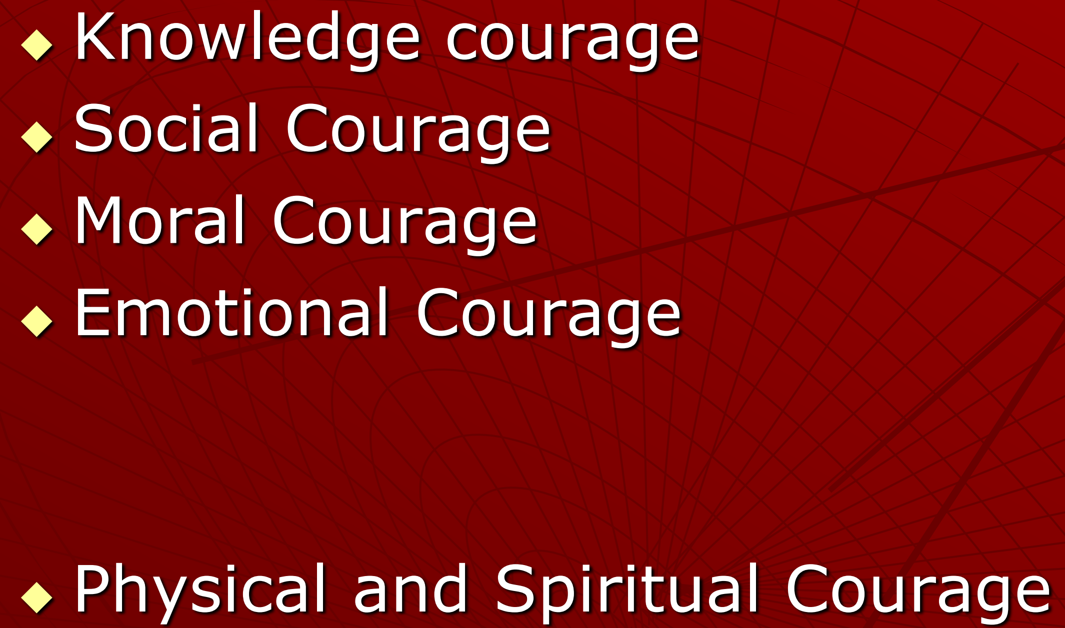
California Healthcare Insurance Company

Opima Healthcare Insurance Services Owner's Retreat

Della M. Lin, M.D.

dlinmdconsult@yahoo.com


How do you define
COURAGE?



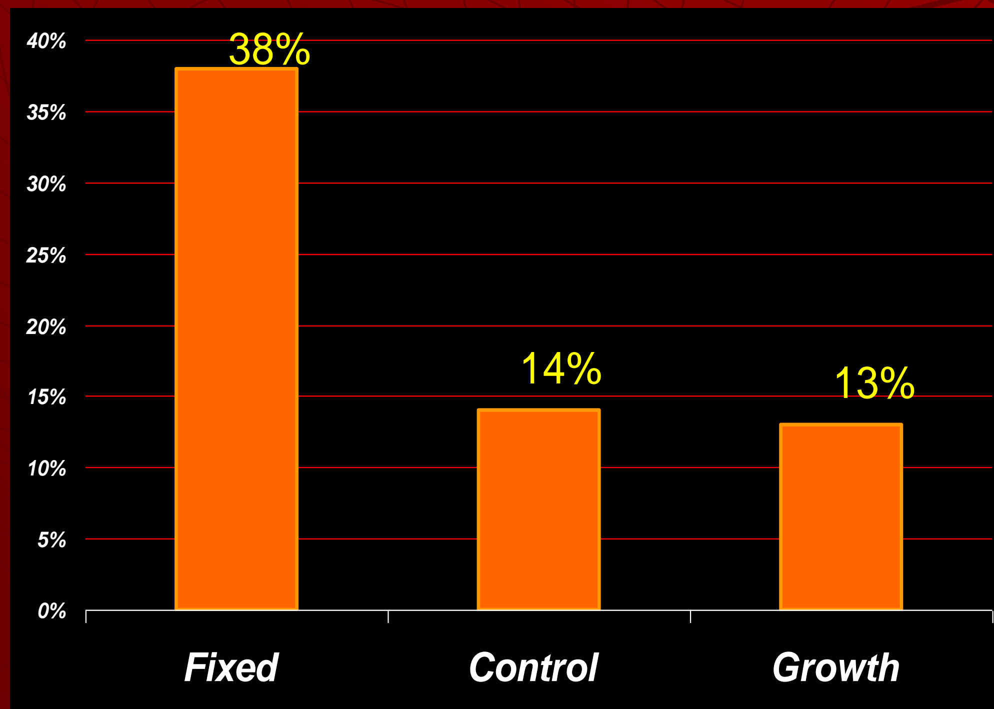
- Knowledge courage
- Social Courage
- Moral Courage
- Emotional Courage

- Physical and Spiritual Courage

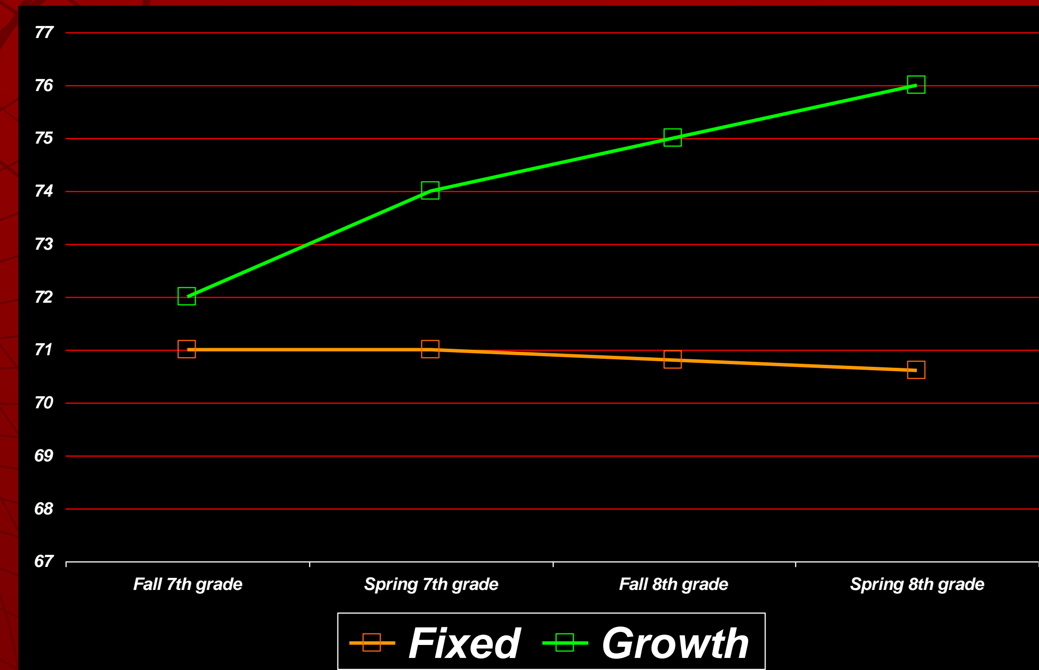
Knowledge Courage

Fixed Mindset Pitfalls

Misrepresenting Scores



Performed Less Well Over Time



Mueller and Dweck J of Pers and Social Psych 1998 Vol 75, No1, 33-52
Blackwell et. al. Child Dev 2007, Vol 78, No 1, pp 246-263

I can learn anything I want to.
When I'm frustrated, I persevere.
I want to challenge myself.
When I fail, I learn.
Tell me I try hard.
If you succeed, I'm inspired.
My effort and attitude determine everything.

I'm either good at it, or I'm not.
When I'm frustrated, I give up.
I don't like to be challenged.
When I fail, I'm no good.
Tell me I'm smart.
If you succeed, I feel threatened.
My abilities determine everything.

Patient Safety

"Many continue to believe in the myth of Marcus Welby…the unbridled benefits of technology

and the assumption that competence and safety are spread evenly and consistently throughout the health-care system"

"If passengers were asked to fly with a commercial airline organized like most health care, they wouldn't get on the plane."

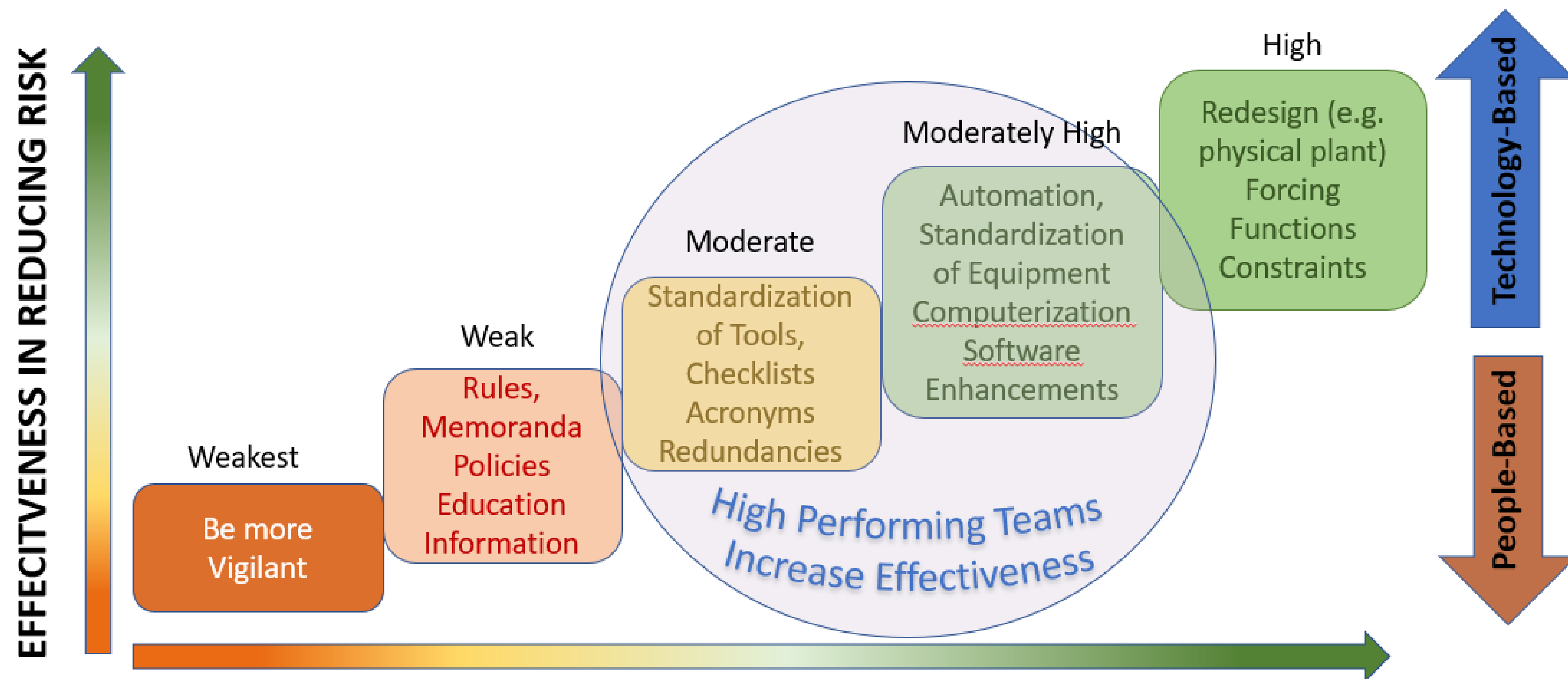
…David Lawrence M.D.

National Press Club

That's not who we are…

That's not what we do…

We don't know how to do that…


Hierarchy Effectiveness of Risk Reduction
EFFECITVENESS IN REDUCING RISK
Weakest
Be more Vigilant
Weak
Rules, Memoranda Policies Education Information
Moderate
Standardization of Tools, Checklists Acronyms Redundancies
Moderately High
Automation, Standardization of Equipment Computerization Software Enhancements
High
Redesign (e.g. physical plant) Forcing Functions Constraints
High Performing Teams Increase Effectiveness
Technology-Based
People-Based
COST AND EFFORT
Della Lin, M.D.
Adapted from John Gosbee, MD; Dept of Veteran Affairs and Institute for Safe Medication Practices

#1 Health Priority for 87% of American Retirees: "Staying Mentally Sharp"

- The most common complication in the hospital, affecting > 2.6 million adults/year
- ~50% of cases, there is an iatrogenic contributor
- The complication causes significant harm well after discharge from the hospital

Incident Delirium during hospitalization has been a blind spot of harm

Odds Ratio = 4.19

Impact of Incident Postoperative Delirium on Mortality

Hamilton, GM et. Al. Anesthesiology 2017: 127:76-88

Re-orientation

- Family Presence
- Hearing Aids
- Glasses

Avoid Drugs

- Opioid Sparing
- Avoid Drugs on Beers List
- Non-Pharm for Agitation

Enhanced Recovery

- Untether
- Hydration
- Nutrition
- Mobilization

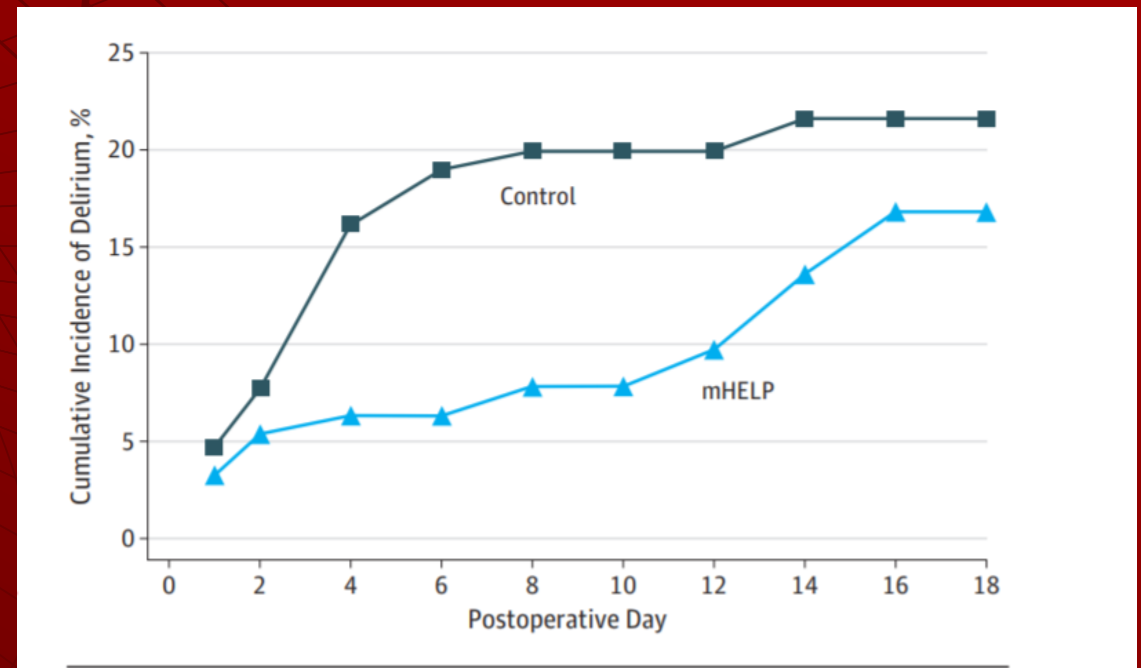
Sleep Hygiene

- Group tasks at night/minimize disruption
- Turn off TV
- Bed by window
- Activities during the day

Multi-Component Prevention

- Meta-analysis:
  - Surgical Patients: Odds Ratio 0.71 (0.59-0.85)
- Modified HELP program:
  - Reduced Delirium Chen et. Al. JAMA Surg 2017

56% Risk Reduction



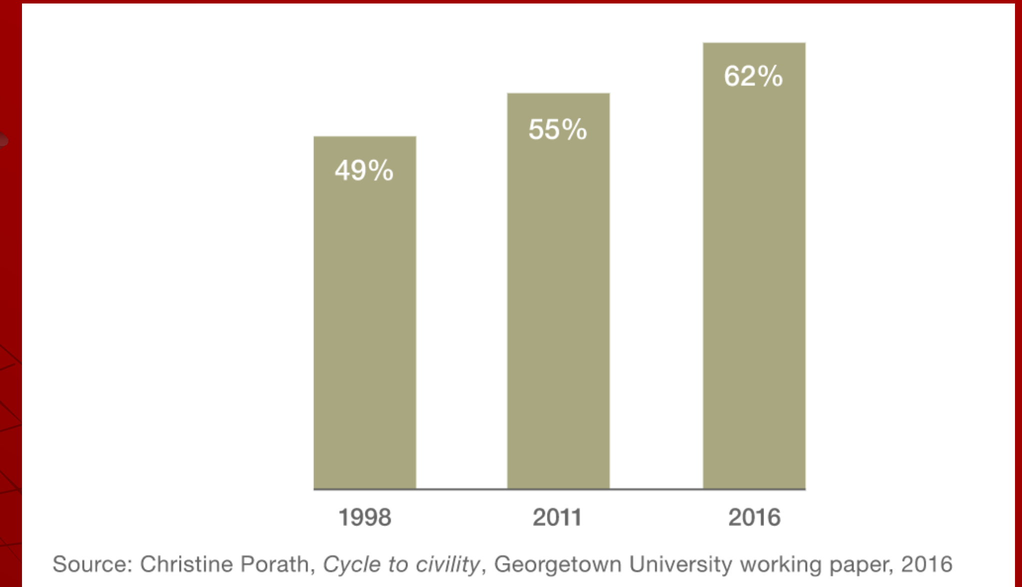
KNOWLEDGE COURAGE

Social Courage

Thai Boys Cave Rescue

Incivility and Rudeness Rising…

- Impact on performance
  - 47% spent less time at work
  - 38% deliberately decreased quality
  - 63% lost time trying to avoid offender
  - 66% lower performance
  - 78% lower commitment to the organization
  - 25% admit taking frustration out on those they serve



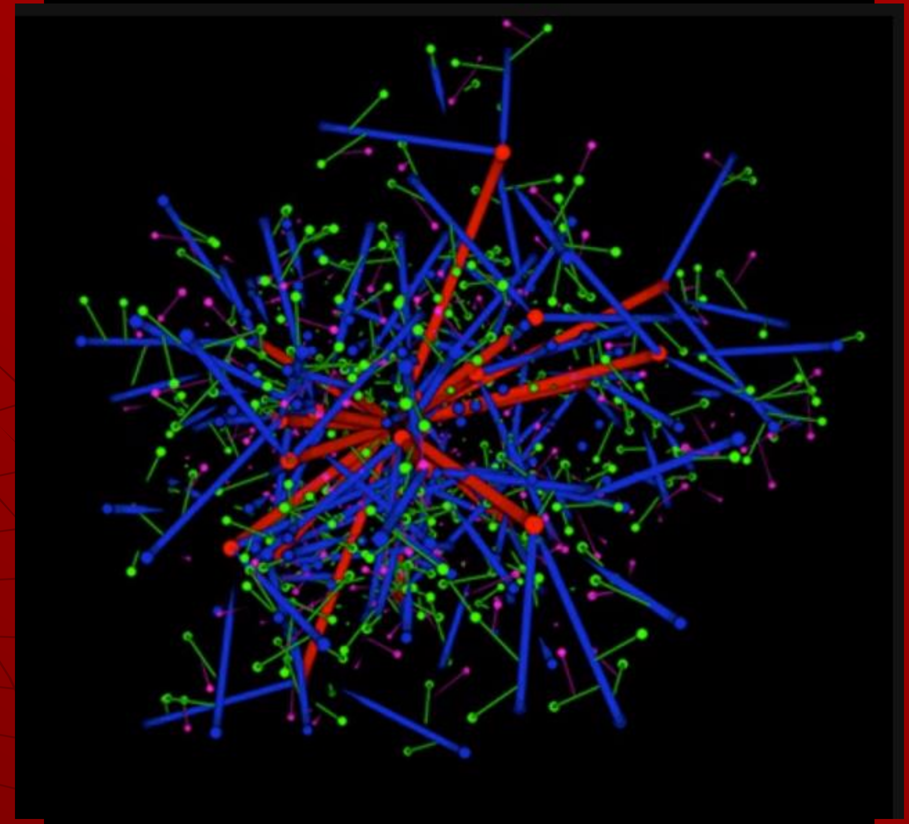
… and contagious

Overlooked but not untouched

..Porath, C. Org Behav Hum Dec Proc 2009

Incivility Spiral

… Rosen, C, Appl Psychology 2016



Myth: Violence is part of the job
Reality: Rates significantly outpace other industries

- Health care workers account for **11%** of the US workforce, but experience **57%** of the nonfatal workforce related injuries involving days away from work. (Bureau of Labor Statistics, 2015)

- ~ 24,000 workplace assaults per year… **75%** occur in the healthcare industry (OSHA 2015)

Phillips, James. N Engl J Med 2016;374:1661-9

It's not just in the ED or Psych Units

Workplace Violence Against Anesthesiologists: We are not Immune to this Patient Safety Threat

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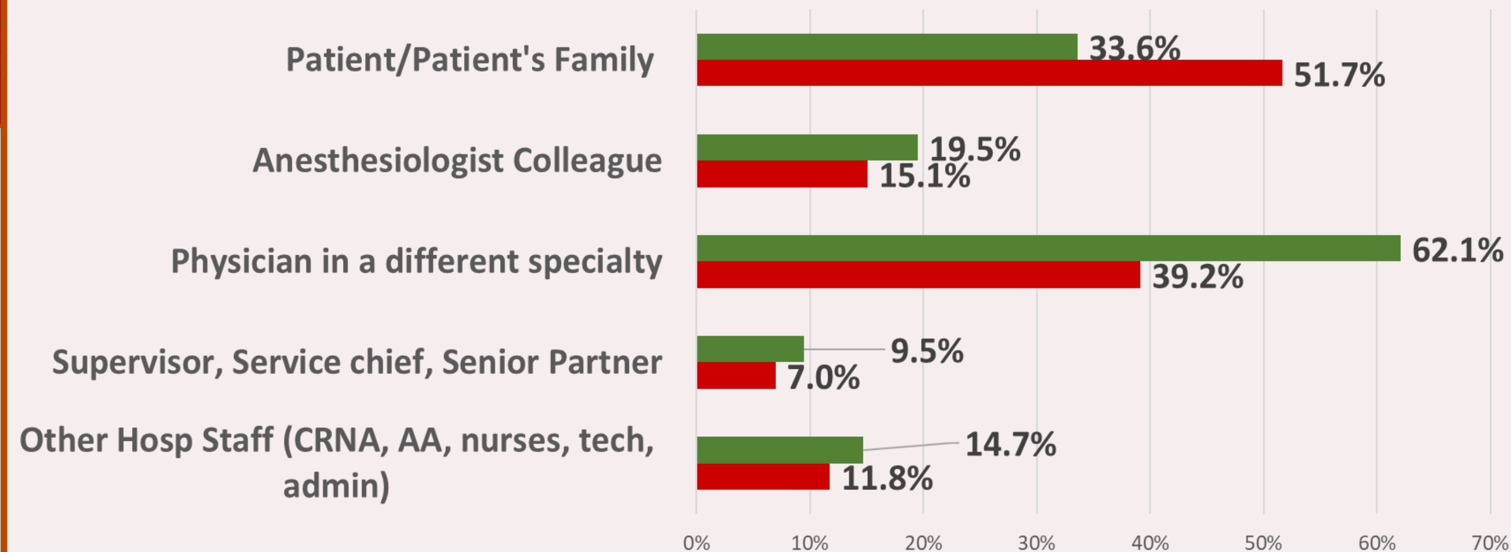
Violence against health care workers is not a novel phenomenon. The Occupational Safety and Health Administration (OSHA) defines workplace violence as "violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty."[1]

Health care workers are more susceptible to violence in the workplace than any other group of workers in the United States. From 2002 to 2013, the Bureau of Labor Statistics data indicate that workers in

	Physical Workplace Violence (Responding Yes) (%)	Nonphysical Workplace Violence (Responding Yes) (%)
Have you experienced physical violence or nonphysical violence in the workplace during your career?	20.1	69.0
Did you report it to supervisor, human resources, law enforcement, senior partner?	42.6	38.7
Did it result in time away from work?	4.6	3.6
Did you feel the situation was addressed and resolved to your satisfaction	40.1	31.4
Have you received any training on deescalation of a threat in the workplace?	25.0	
Have you received any training on what to do during an active shooter (eg, Silver Alert) threat in the workplace?	39.3	



69% of anesthesiologists report experiencing non-physical violence in the workplace

Udoji, M. et. al. International Anesthesiology Clinics July 2019

Rudeness impacts diagnostic and procedural performance

The Impact of Rudeness on Medical Team Performance: A Randomized Trial

Arieh Riskin, MD, MHA[a,b], Amir Erez, PhD[c], Trevor A. Foulk, BBA[c], Amir Kugelman, MD[b], Ayala Gover, MD[d], Irit Shoris, RN, BA[b], Kinneret S. Riskin[a], Peter A. Bamberger, PhD[a]

DOI: 10.1542/peds.2015-1385

Accepted for publication Jun 22, 2015

Rudeness and Medical Team Performance

Arieh Riskin, MD, MHA,[a,b] Amir Erez, PhD,[c] Trevor A. Foulk, BBA,[c] Kinneret S. Riskin-Geuz, BSc,[d] Amitai Ziv, MD, MHA,[d,e] Rina Sela, CCRN, MA,[e] Liat Pessach-Gelblum, MBA,[e] Peter A. Bamberger, PhD[a]

abstract

OBJECTIVES: Rudeness is routinely experienced by medical teams. We sought to explore the impact of rudeness on medical teams' performance and test interventions that might mitigate its negative consequences.

METHODS: Thirty-nine NICU teams participated in a training workshop including simulations of acute care of term and preterm newborns. In each workshop, 2 teams were randomly assigned to either an exposure to rudeness (in which the comments of the patient's mother included rude statements completely unrelated to the teams' performance) or control (neutral comments) condition, and 2 additional teams were assigned to rudeness with either a preventative (cognitive bias modification [CBM]) or therapeutic (narrative) intervention. Simulation sessions were evaluated by 2 independent judges, blind to team exposure, who used structured questionnaires to assess team performance.

RESULTS: Rudeness had adverse consequences not only on diagnostic and intervention parameters (mean therapeutic score 3.81 ± 0.36 vs 4.31 ± 0.35 in controls, $P < .01$), but also on team processes (such as information and workload sharing, helping and communication) central to patient care (mean teamwork score 4.04 ± 0.34 vs 4.43 ± 0.37, $P < .05$). CBM mitigated most of these adverse effects of rudeness, but the postexposure narrative intervention had no significant effect.

CONCLUSIONS: Rudeness has robust, deleterious effects on the performance of medical teams. Moreover, exposure to rudeness debilitated the very collaborative mechanisms recognized as essential for patient care and safety. Interventions focusing on teaching medical professionals to implicitly avoid cognitive distraction such as CBM may offer a means to mitigate the adverse consequences of behaviors that, unfortunately, cannot be prevented.

WHAT'S KNOWN ON THIS SUBJECT: Rudeness is routinely experienced by medical teams. Medical professionals exposed to rude behavior performed poorly on diagnostic and procedural tasks related to the medical treatment they provided. Reduced information sharing and helping mediated the effects of rudeness on their performance.

WHAT THIS STUDY ADDS: Rudeness had adverse consequences not only on therapeutic components of medical teams' performance, but also on collaborative team processes essential for such performance. Cognitive bias modification as a preventative intervention mitigated most of these negative consequences of rudeness.

DOI: 10.1542/peds.2016-2305

Riskin, A Pediatrics Sept 2015
Riskin, A Pediatrics Feb 2017

Impact on performance may not be *self*-evident…

ORIGINAL RESEARCH

Exposure to incivility hinders clinical performance in a simulated operative crisis

Daniel Katz,[1] Kimberly Blasius,[2] Robert Isaak,[2] Jonathan Lipps,[3] Michael Kushelev,[3] Andrew Goldberg,[1] Jarrett Fastman,[1] Benjamin Marsh,[1] Samuel DeMaria[1]

► Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136bmjqs-2019-009598).

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Check for updates

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To cite: Katz D, Blasius K, Isaak R, *et al*. *BMJ Qual Saf* Epub ahead of print: [please include Day Month Year]. doi:10.1136/bmjqs-2019-009598

ABSTRACT

Background Effective communication is critical for patient safety. One potential threat to communication in the operating room is incivility. Although examined in other industries, little has been done to examine how incivility impacts the ability to deliver safe care in a crisis. We therefore sought to determine how incivility influenced anaesthesiology resident performance during a standardised simulation scenario of occult haemorrhage.

Methods This is a multicentre, prospective, randomised control trial from three academic centres. Anaesthesiology residents were randomly assigned to either a normal or 'rude' environment and subjected to a validated simulated operating room crisis. Technical and non-technical performance domains including vigilance, diagnosis, communication and patient management were graded on survey with Likert scales by blinded raters and compared between groups.

Results 76 participants underwent randomisation with 67 encounters included for analysis (34 control, 33 intervention). Those exposed to incivility scored lower on every performance metric, including a binary measurement of overall performance with 91.2% (control) versus 63.6% (rude) obtaining a passing score (p=0.009). Binary logistic regression to predict this outcome was performed to assess impact of confounders. Only the presence of incivility reached statistical significance (OR 0.110, 95% CI 0.022 to 0.544, p=0.007). 65% of the rude group believed the surgical environment negatively impacted performance; however, self-reported performance assessment on a Likert scale was similar between groups (p=0.112).

Conclusion Although self-assessment scores were similar, incivility had a negative impact on performance. Multiple areas were impacted including vigilance, diagnosis, communication and patient management even though participants were not aware of these effects. It is imperative that these behaviours be eliminated from operating room culture and that interpersonal communication in high-stress environments be incorporated into medical training.

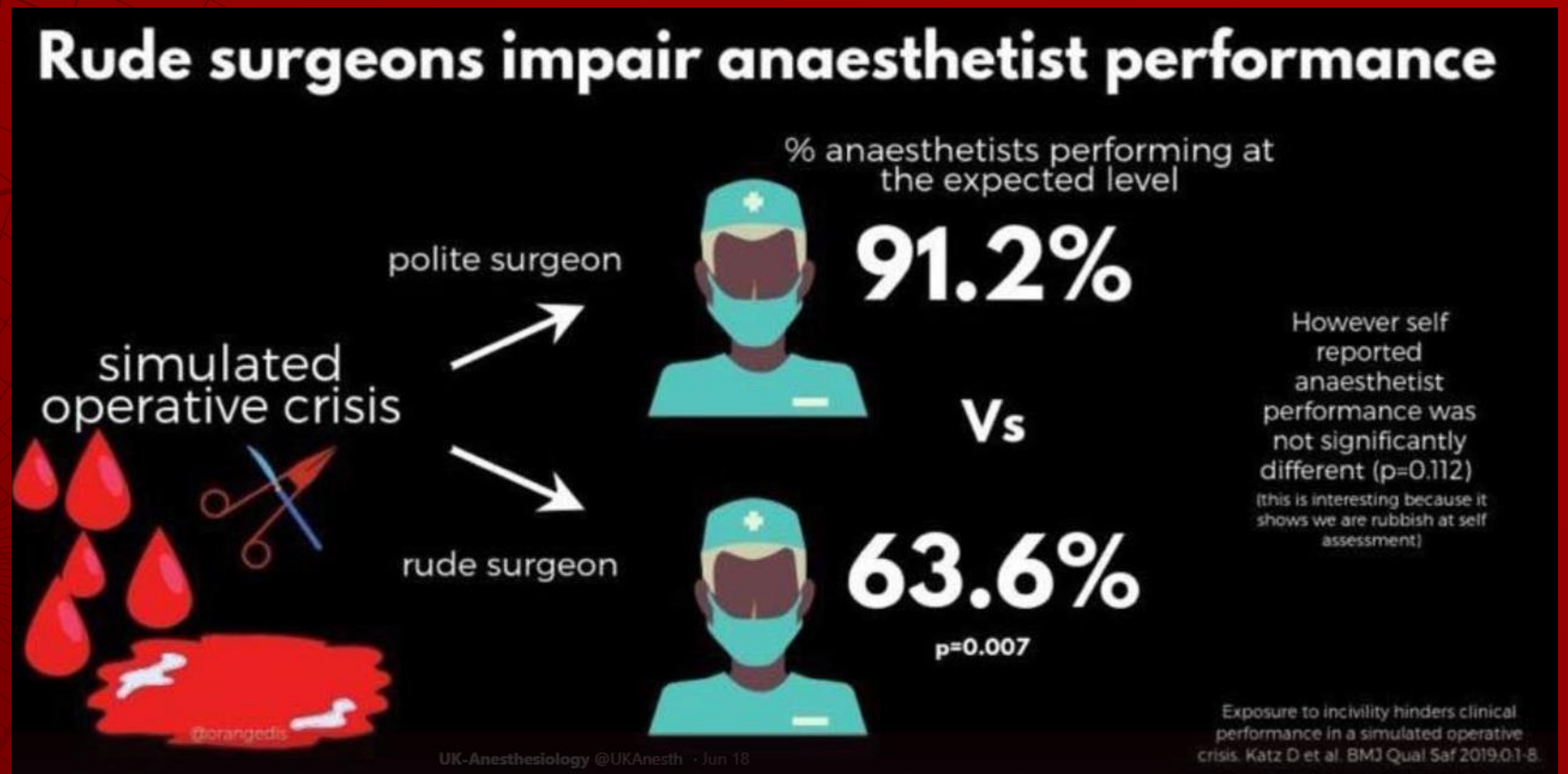
INTRODUCTION

Effective communication is a cornerstone of safe patient care, along with clinical excellence.[1] This is particularly true in

lapse in communication between team members can permit rapid precipitation of adverse events.[2 3] One potential threat to communication and medical/technical skills in the operating room (OR) is incivility, defined here as rude, dismissive or aggressive (RDA) behaviour(s) that impede professional relatedness.

Incivility creates interpersonal conflict and can impair diagnostic and technical performance,[4 5] thereby increasing patient safety risks.[2 6] The negative consequences of incivility have been well described in non-medical industries as well,[7] where researchers have shown that even witnessing workplace incivility impairs performance and attention.[8 9] Incivility is a pervasive issue for anaesthesiologists; 98% of anaesthesiologists in one survey reported being exposed to disruptive behaviours,[10] and trainees have reported being subjected to RDA behaviours several times per week.[6] The hierarchical structure of surgical teams may engender an atmosphere of intimidation and impede residents' likelihood to challenge superiors (in their own specialty or otherwise), even when something unsafe or medically deleterious is occurring.[11 12]

The vast majority of attending anaesthesiologists believe that residents are comfortable voicing concern and communicating with surgeons on their own. However, only half of residents surveyed report that this is the case.[13 14] Efforts to provide residents with tools for challenging OR hierarchy and dealing with difficult communications have varied in their effectiveness, but the presence of these efforts is a clear display of need.[15–17] Indeed, struggles among team members in the OR have been a known issue in anaesthesiology for decades. Gaba *et al*[18]



Katz, D. et. Al. BMJ Quality and Saety epub ahead of print May 31 2019

Impact on Surgical Complications

Research

JAMA Surgery | Original Investigation

Association of Coworker Reports About Unprofessional Behavior by Surgeons With Surgical Complications in Their Patients

William O. Cooper, MD, MPH; David A. Spain, MD; Oscar Guillamondegui, MD, MPH; Rachel R. Kelz, MD, MSCE, MBA; Henry J. Domenico, MS; Joseph Hopkins, MD, MMM; Patricia Sullivan, PhD; Ilene N. Moore, MD, JD; James W. Pichert, PhD; Thomas F. Catron, PhD; Lynn E. Webb, PhD; Roger R. Dmochowski, MD; Gerald B. Hickson, MD

Invited Commentary

Author Audio Interview

IMPORTANCE For surgical teams, high reliability and optimal performance depend on effective communication, mutual respect, and continuous situational awareness. Surgeons who model unprofessional behaviors may undermine a culture of safety, threaten teamwork, and thereby increase the risk for medical errors and surgical complications.

OBJECTIVE To test the hypothesis that patients of surgeons with higher numbers of reports from coworkers about unprofessional behaviors are at greater risk for postoperative complications than patients whose surgeons generate fewer coworker reports.

DESIGN, SETTING, AND PARTICIPANTS This retrospective cohort study assessed data from 2 geographically diverse academic medical centers that participated in the National Surgical Quality Improvement Program (NSQIP) and recorded and acted on electronic reports of safety events from coworkers describing unprofessional behavior by surgeons. Patients included in the NSQIP database who underwent inpatient or outpatient operations at 1 of the 2 participating sites from January 1, 2012, through December 31, 2016, were eligible. Patients were excluded if they were younger than 18 years on the date of the operation or if the attending surgeon had less than 36 months of monitoring for coworker reports preceding the date of the operation. Data were analyzed from August 8, 2018, through April 9, 2019.

EXPOSURES Coworker reports about unprofessional behavior by the surgeon in the 36 months preceding the date of the operation.

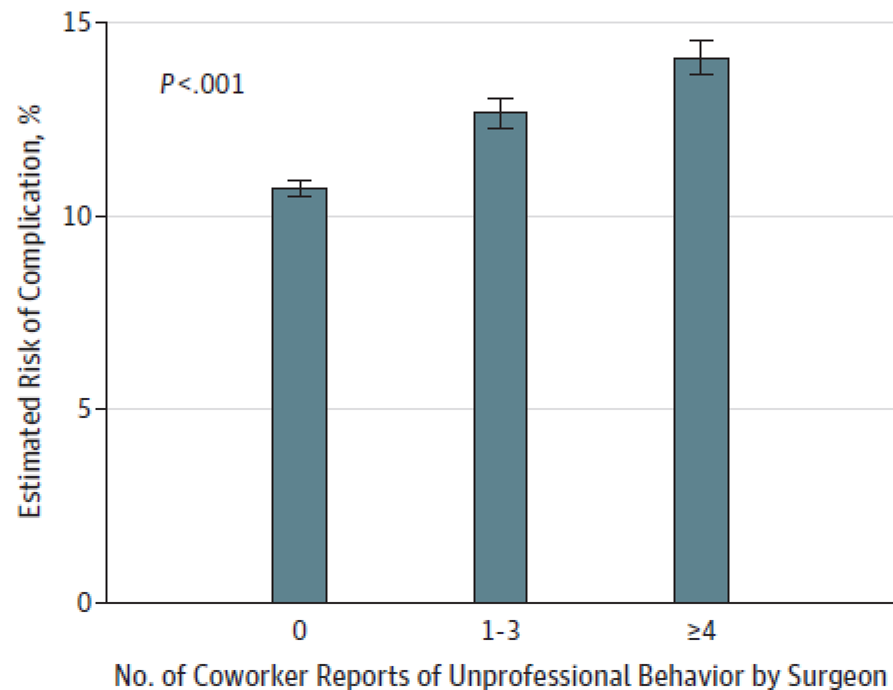
MAIN OUTCOMES AND MEASURES Postoperative surgical or medical complications, as defined by the NSQIP, within 30 days of the operation.

RESULTS Among 13 653 patients in the cohort (54.0% [7368] female; mean [SD] age, 57 [16] years) who underwent operations performed by 202 surgeons (70.8% [143] male), 1583 (11.6%) experienced a complication, including 825 surgical (6.0%) and 1070 medical (7.8%) complications. Patients whose surgeons had more coworker reports were significantly more likely to experience any complication (0 reports, 954 of 8916 [10.7%]; ≥4 reports, 294 of 2087 [14.1%]; $P < .001$), any surgical complication (0 reports, 516 of 8916 [5.8%]; ≥4 reports, 159 of 2087 [7.6%]; $P < .01$), or any medical complication (0 reports, 634 of 8916 [7.1%]; ≥4 reports, 196 of 2087 [9.4%]; $P < .001$). The adjusted complication rate was 14.3% higher for patients whose surgeons had 1 to 3 reports and 11.9% higher for patients whose surgeons had 4 or more reports compared with patients whose surgeons had no coworker reports ($P = .05$).

CONCLUSIONS AND RELEVANCE Patients whose surgeons had higher numbers of coworker reports about unprofessional behavior in the 36 months before the patient's operation appeared to be at increased risk of surgical and medical complications. These findings suggest that organizations interested in ensuring optimal patient outcomes should focus on addressing surgeons whose behavior toward other medical professionals may increase patients' risk for adverse outcomes.

JAMA Surg. doi:10.1001/jamasurg.2019.1738
Published online June 19, 2019.

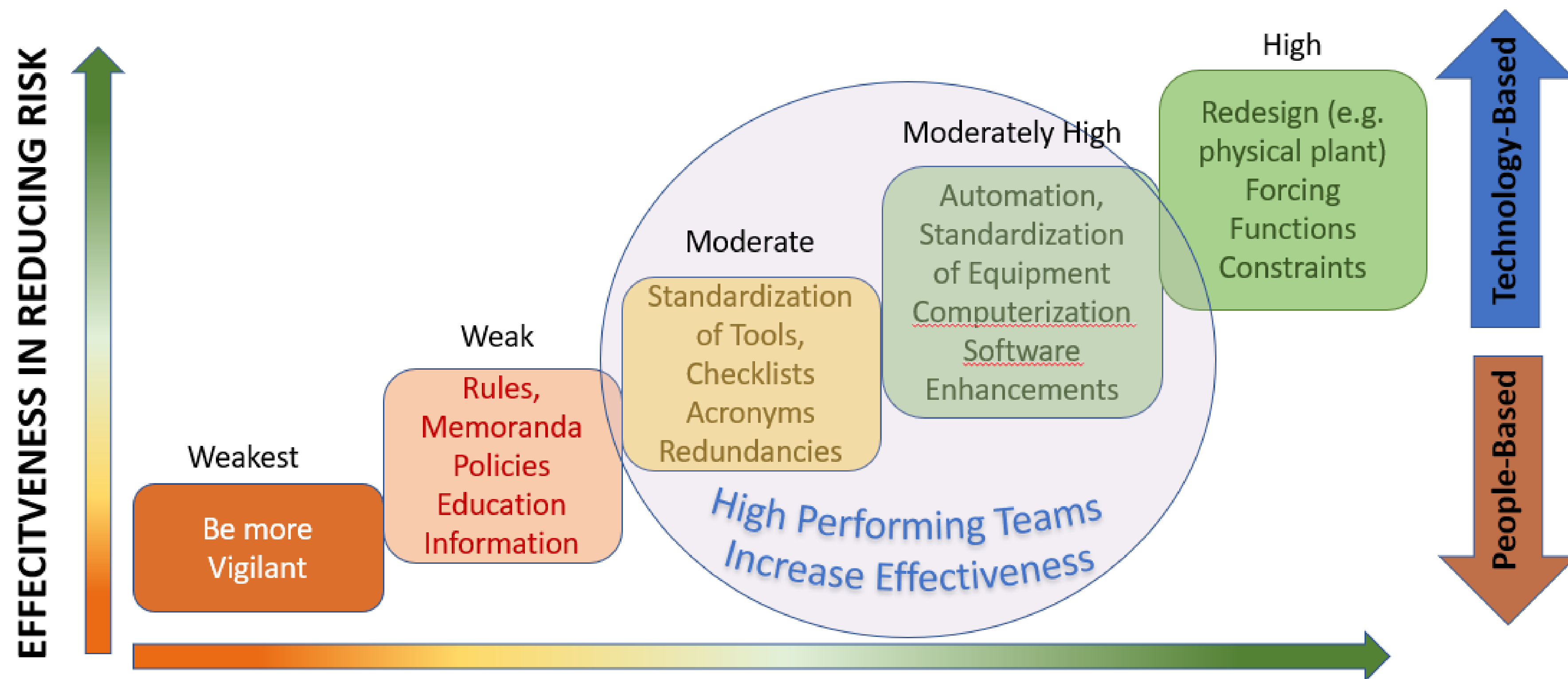
Figure 2. Estimated Complication Rate According to the Operating Surgeon's Reports by Coworkers About Unprofessional Behaviors in the 36 Months Preceding the Operation



Compared with patients whose surgeons had zero reports:

- Patients whose surgeon had 1 to 3 reports were at **18.1%** higher estimated risk of complication
- Those whose surgeon had 4 or more reports were at **31.7%** higher estimated mean risk of complication

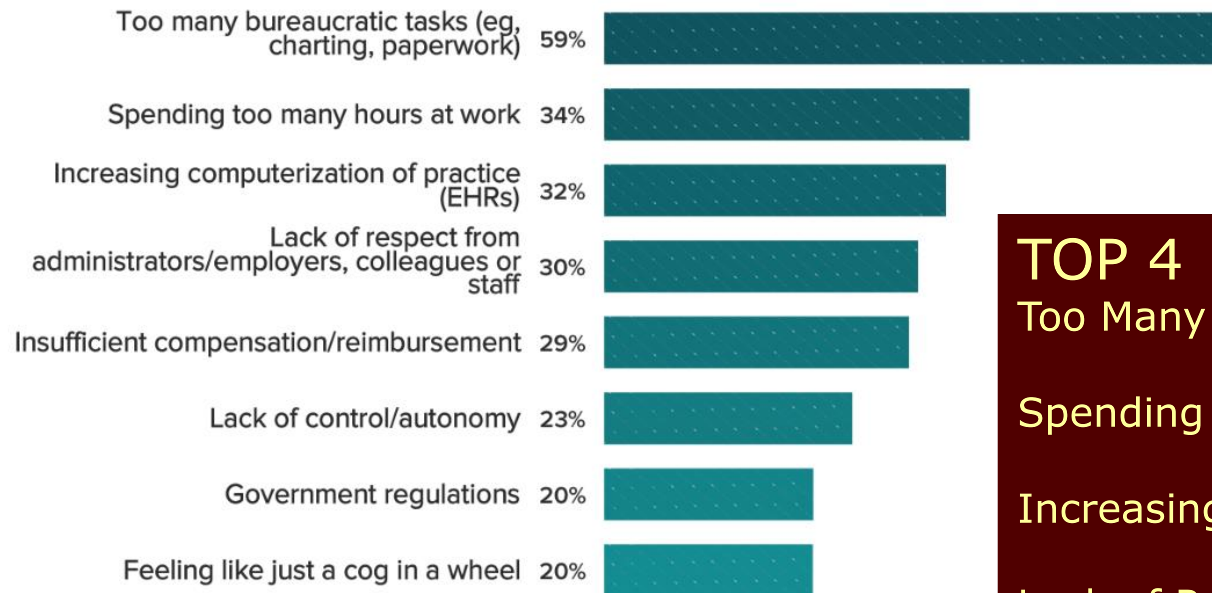
Cooper, WO et. al JAMA Surgery Published Online June 16, 2019



Hierarchy Effectiveness of Risk Reduction
EFFECTIVENESS IN REDUCING RISK
Weakest
Be more Vigilant
Weak
Rules, Memoranda Policies Education Information
Moderate
Standardization of Tools, Checklists Acronyms Redundancies
Moderately High
Automation, Standardization of Equipment Computerization Software Enhancements
High
Redesign (e.g. physical plant) Forcing Functions Constraints
High Performing Teams Increase Effectiveness
Technology-Based
People-Based
COST AND EFFORT
Della Lin, M.D.
Adapted from John Gosbee, MD; Dept of Veteran Affairs and Institute for Safe Medication Practices

Emotional Courage

"Accumulation of Hundreds of Thousands of Tiny Disappointments" … Richard Gunderman, M.D. Ph.D.



TOP 4

Too Many bureaucratic tasks

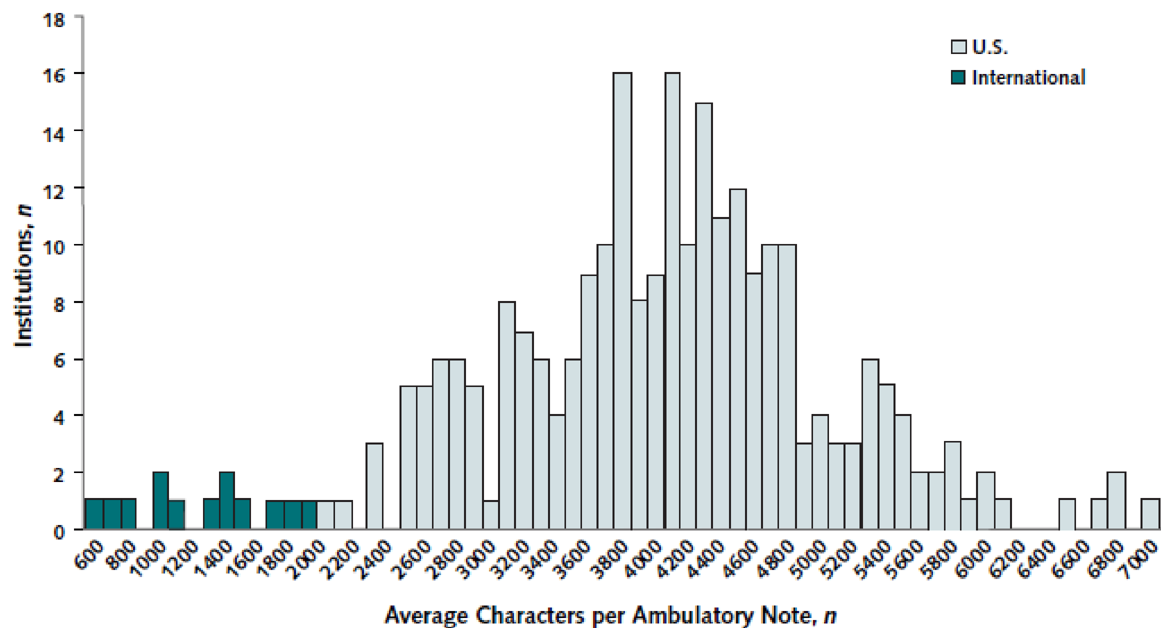
Spending too many hours at work

Increasing computerization

Lack of Respect

Medscape Lifestyle Report January 16, 2019

Clinical notes in the United States are nearly **4 times longer** than in other countries



Column height represents number of organizations. Dark columns represent 13 organizations outside the United States (140 000 notes from Canada, the United Kingdom, Australia, the Netherlands, Denmark, the United Arab Emirates, and Singapore). Light columns represent 254 organizations in the United States (10 million notes).

Downing, NL et. al. Ann Intern Med. 2018;169:50-51.

Huge Economic Burden even *without* taking quality/safety consequences into account

Annals of Internal Medicine
MEDICINE AND PUBLIC ISSUES

Estimating the Attributable Cost of Physician Burnout in the United States

Shasha Han, MS; Tait D. Shanafelt, MD; Christine A. Sinsky, MD; Karim M. Awad, MD; Liselotte N. Dyrbye, MD, MHPE; Lynne C. Fiscus, MD, MPH; Mickey Trockel, MD; and Joel Goh, PhD

Background: Although physician burnout is associated with negative clinical and organizational outcomes, its economic costs are poorly understood. As a result, leaders in health care cannot properly assess the financial benefits of initiatives to remediate physician burnout.

Objective: To estimate burnout-associated costs related to physician turnover and physicians reducing their clinical hours at national (U.S.) and organizational levels.

Design: Cost-consequence analysis using a mathematical model.

Setting: United States.

Participants: Simulated population of U.S. physicians.

Measurements: Model inputs were estimated by using the results of contemporary published research findings and industry reports.

Results: On a national scale, the conservative base-case model estimates that approximately $4.6 billion in costs related to physician turnover and reduced clinical hours is attributable to burnout each year in the United States. This estimate ranged from $2.6 billion to $6.3 billion in multivariate probabilistic sensitivity analyses. At an organizational level, the annual economic cost associated with burnout related to turnover and reduced clinical hours is approximately $7600 per employed physician each year.

Limitations: Possibility of nonresponse bias and incomplete control of confounders in source data. Some parameters were unavailable from data and had to be extrapolated.

Conclusion: Together with previous evidence that burnout can effectively be reduced with moderate levels of investment, these findings suggest substantial economic value for policy and organizational expenditures for burnout reduction programs for physicians.

Ann Intern Med. doi:10.7326/M18-1422 Annals.org
For author affiliations, see end of text.
This article was published at Annals.org on 28 May 2019.

Occupational burnout is a syndrome characterized by 3 key dimensions: emotional exhaustion, feelings of cynicism and detachment from work, and a sense of low personal accomplishment (1, 2). The prevalence of burnout among physicians is high relative to the general working population: In a 2014 study, approximately 54% of physicians reported at least 1 symptom of burnout, almost twice the rate of the general U.S. working population (3, 4).

Recent studies have begun to provide a more complete picture of the challenges physician burnout presents to the nation's health care delivery system. Systematic reviews have documented associations between physician burnout and negative clinical outcomes as well as unfavorable productivity-related outcomes (5, 6). For example, studies have found that burned-out physicians have higher rates of self-reported medical errors (7–9) and their patients have poorer clinical outcomes (10, 11). Physicians with burnout are more likely to report an intention to reduce their work hours or to leave medical practice altogether (12–14). They also have higher absenteeism rates (13).

See also:
Editorial comment
Web-Only

Recent research has uncovered the organizational roots of burnout (15, 16), and health care executives have begun to recognize the urgency of this problem. A group of 10 CEOs of leading U.S. health care organizations "unanimously concluded that physician burnout is a pressing issue of national importance" (17) and called on other leaders to commit to addressing it.

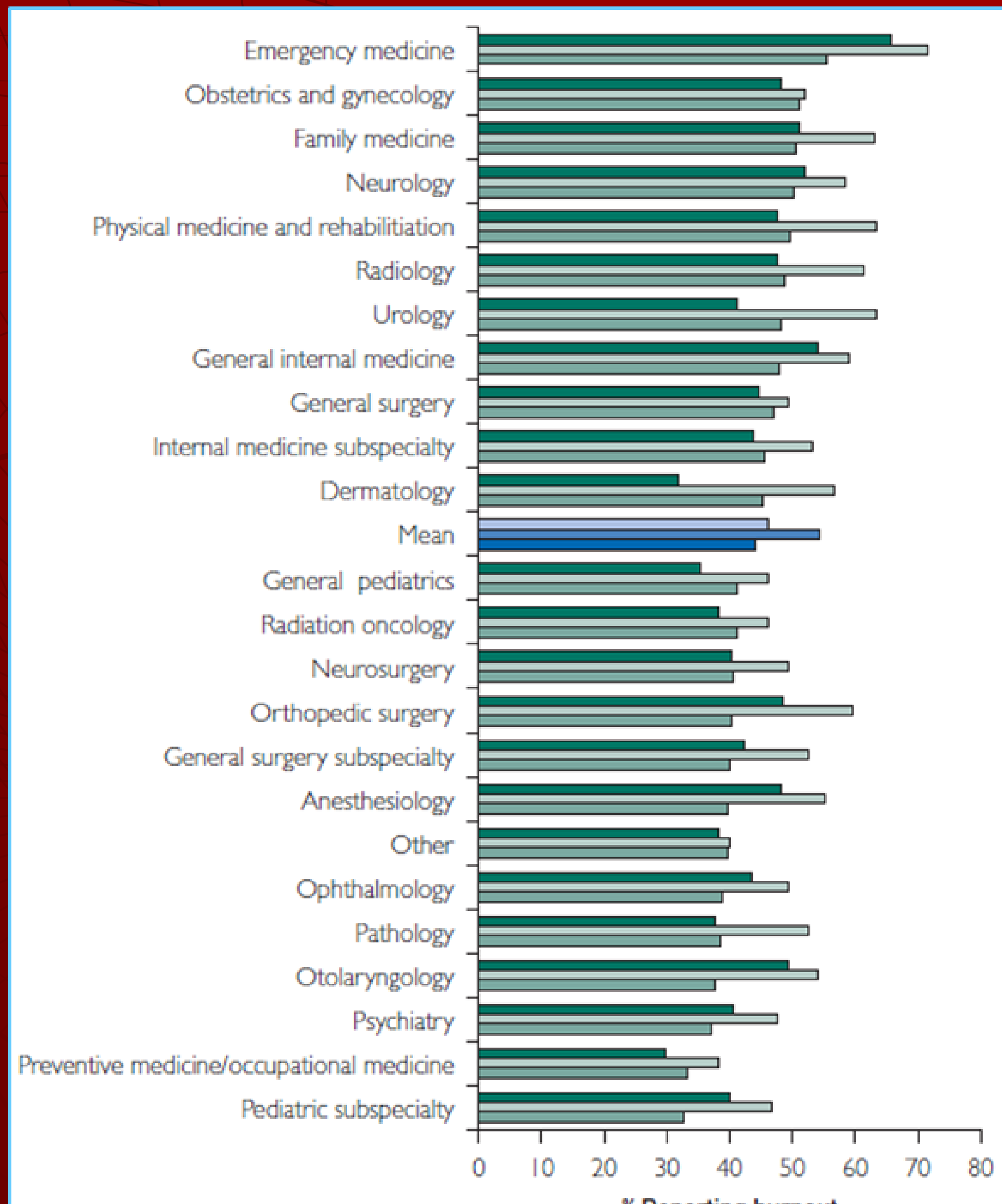
Despite the recent public interest in this subject and literature suggesting that burnout has the potential to be a major problem, only a few studies (18, 19) have attempted to quantify its economic magnitude in the form of easily understandable metrics. As a result, policymakers cannot holistically assess the extent of the burnout problem and develop appropriate policy responses, nor are leaders of health care organizations equipped to make informed decisions when determining whether to invest scarce resources into programs to mitigate burnout.

In this study, we undertook a cost-consequence analysis to investigate the economic burden associated with physician burnout. We used cost as a metric because it is easily understandable by policymakers and organizational leaders and is typically an important data point they can use to make informed decisions, develop organizational strategy, and effect change. We followed a standard approach used by cost-effectiveness studies (20, 21): We constructed a mathematical model linking mea-

- $4.6 billion annual costs attributable to burnout in the United States
- ~ $4100-$10,200/ physician
  - Hypothetical 1000 physician group, the estimate is an organizational level cost of $7.6 million

Han, S. et. al. Ann of Internal Medicine. Published online May 28, 2019

Mean Physician Burnout Score: 43.9%



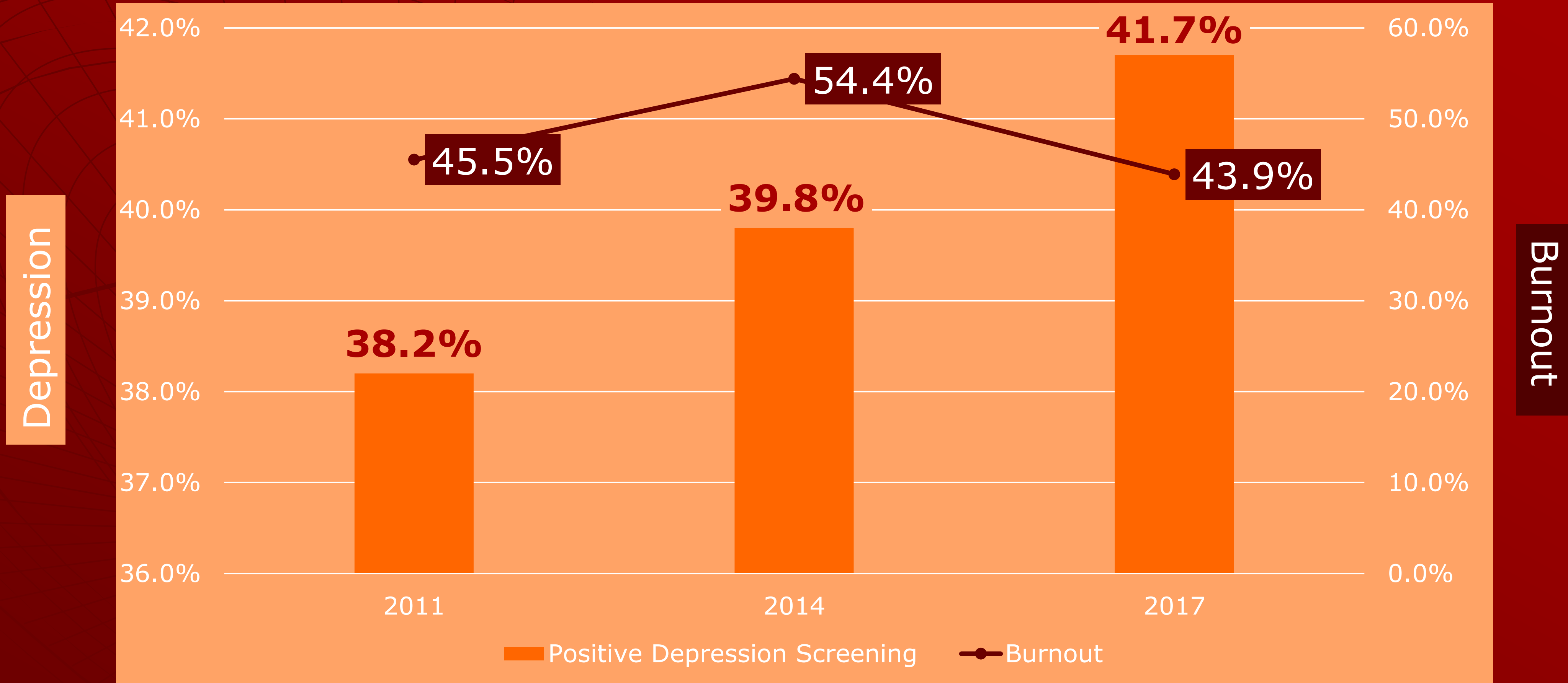
Autonomy

Mastery

Purpose

Shanafelt, TD et. al. Changes in Burnout and Satisfaction With Work-Life Integration in Physicians and the General US Working Population Between 2011 and 2017. Mayo Clinic Proceedings. Online Feb 2019

Screening for depression is increasing although Burnout scores may be trending lower



Peer Support and Professionalism Systems

- "creating a peer support program is one way forward, away from a culture of invulnerability, isolation, and shame and toward a culture that truly values a sense of shared organizational responsibility for clinician well-being and patient safety."

… Jo Shapiro

- Center for Professionalism and Peer Support
  - professionalism
  - teamwork training and conflict management
  - just culture
  - disclosure coaching
  - peer support

"the smallest acts of kindness made the unbearable bearable."

Those who have a WHY to live can bear with almost any HOW…. Viktor Frankl

Moral Courage

Thinking Beyond Clinical Care

African-American
Female
Democrats

White
Female
Republicans

White + Latino
Male
Swing voters

African-American + White
Female
Democrats

White
Male
Republicans

White + Lower-income
Female
Democrats

Rebecca Onie

Something we have in common….

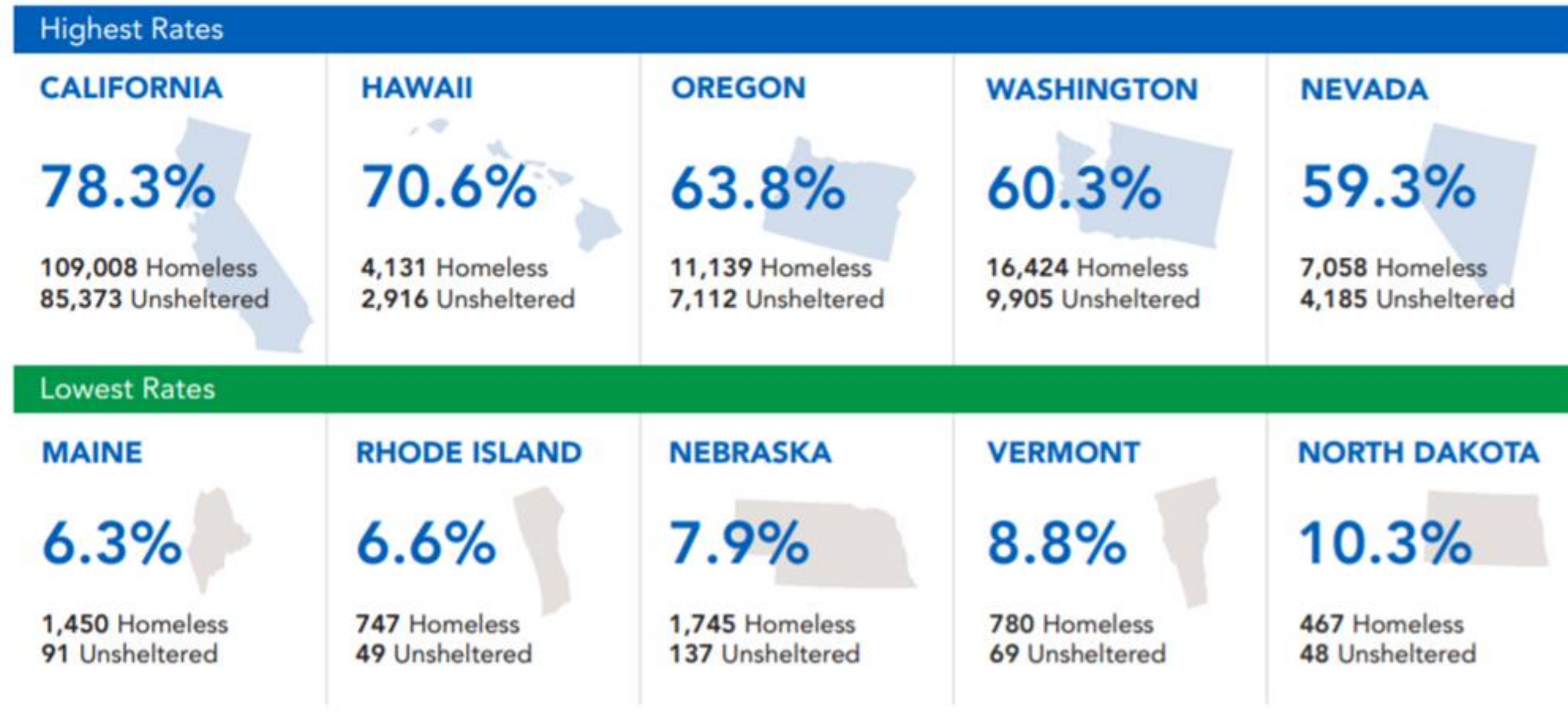


EXHIBIT 2.6: States with the Highest and Lowest Rates of Unsheltered Homeless Individuals, By State, 2018

Highest Rates				
CALIFORNIA	HAWAII	OREGON	WASHINGTON	NEVADA
78.3%	70.6%	63.8%	60.3%	59.3%
109,008 Homeless	4,131 Homeless	11,139 Homeless	16,424 Homeless	7,058 Homeless
85,373 Unsheltered	2,916 Unsheltered	7,112 Unsheltered	9,905 Unsheltered	4,185 Unsheltered
Lowest Rates				
MAINE	RHODE ISLAND	NEBRASKA	VERMONT	NORTH DAKOTA
6.3%	6.6%	7.9%	8.8%	10.3%
1,450 Homeless	747 Homeless	1,745 Homeless	780 Homeless	467 Homeless
91 Unsheltered	49 Unsheltered	137 Unsheltered	69 Unsheltered	48 Unsheltered

HUD Homeless Report to Congress 2018

It’s easy to mind our own business

“People talk to me like I’m stupid because I can’t speak English good.
If they spoke Chinese, they would know how smart I am”

Hawaii Super-Utilizers Initiative

The Hug that helped change medicine

Knowledge Courage

Social Courage

Emotional Courage

Moral Courage

Caring Courageously