Chapter 7

Pursuing Professionalism
(But not without an infrastructure)

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You are a senior leader in an academic medical center. A junior surgical resident you have worked with has scheduled time to discuss some concerns:

Dr. Resident states: "I feel miserable and guilty about my failure." Dr. Resident was asked to insert a central line on a patient. "We were a little slow getting everything assembled when Dr. Attending rushed in and asked, 'You're not finished yet? Which part of my instructions did you not understand?' I tried to explain. . . . Dr. Attending just proceeded to take over and insert the line. The problem is his prep was quick and he did not fully drape the patient. I just stood there. Now the patient is on pressors in the ICU and her blood culture is growing staph. I feel responsible. I just stood there. . . ."

As a medical leader within the health system, and as an individual with responsibilities for mentoring students and residents, how might you respond?

• Attempt to reassure Dr. Resident that a certain proportion of patients get central line associated bloodstream infections and that the failure to carefully prep is probably unrelated.

• Remind the resident of your physician wellness program, noting that all professionals have patients with bad outcomes. Suggest that it is important to understand these personal challenges early in a career and learn how to cope.

• Explain to the resident that sometimes when professionals are busy and stressed they can behave as described but that, "I know Dr. Attending and he is a really committed clinician. He was probably just having one of those days."

• Encourage the resident to share the concern with risk management and/or quality. "We have an event reporting system and you can always report and even do so anonymously."

• Contact Dr. Attending directly and share your concern about his unprofessional behavior.

These options represent just a few of many available. The decision about which action(s) to take in responding is complex and potentially influenced by the answers to several questions. Is the story true? Should you investigate to see if others observed the same event? But if the event is true as presented and you talk to Dr. Attending, how will he respond? He

might thank you (but you doubt that will happen); he might even ask you who reported him and then seek to retaliate (i.e., verbally challenging Dr. Resident or negatively evaluating Dr. Resident's performance). Who else beyond Dr. Resident was impacted? What other health care professionals observed Dr. Attending's behavior? If leaders do not respond to verbal assaults or failures to follow evidence-based practices, how will it affect your culture of safety? Furthermore, isn't it the duty of every professional to do whatever is possible to prevent harm? On the other hand, if leaders spend all of their time policing individuals who on occasion fail to wash their hands or follow best practices in central line insertion, will there be enough time in the day to accomplish other important activities? Who wants to be a behavior monitor anyway?

How often do members of medical teams observe slips and lapses in professional performance and conduct? How do we help leaders understand how best to weigh the pros and cons of acting when they either observe or become aware of an event that seems inconsistent with the highest standards of the profession?

We assert that whereas much is written about professionalism and its noble tenets, far too little attention has been focused on understanding a critical component of professionalism—the commitment to group and self-regulation. We further assert that while it requires courage to examine one's own performance, it requires even more courage to assess and intervene on the behavior and/or performance of others. Furthermore, courage by itself is not sufficient, and leaders will fail to achieve the success they intend unless they are supported by the people, processes, and technology that provide an infrastructure designed to address single lapses in professionalism and facilitate early identification and intervention for those who appear to be associated with patterns of unprofessional behavior and/or performance.

What is professionalism and professional self-regulation?

As you reflect on how to respond to Dr. Resident, you pause and reflect on your personal goals for the practice of medicine and your view of what it means to be a professional, as well as your group's mission and goals for care delivery. Specifically, how does being a professional inform or influence your decisions and interactions with patients, families, learners, and colleagues?

Professionalism represents a commitment to cognitive and technical competence and to certain behavioral attributes that promote optimal team performance.[1] These behavioral attributes include a commitment to clear and effective communication, being available, modeling respect for

others, and committing to reflect on how one's own behavior impacts the performance of others.

For example, professionals need to effectively communicate with peers and other colleagues about plans, instructions, and expectations to promote best outcomes. Availability may take the form of physical presence or response to communication, including answering pages for consults from colleagues or from nurses who are concerned about a change in a patient's status. Failing to respond threatens team function and on occasion directly affects patient outcomes. How often do nursing professionals hesitate to call and report a new finding because a clinician has a reputation for not responding or responding in a disrespectful way? We believe that real professionals model respect for others and value the dignity of all team members, including the patient and family. Finally, one of the most important distinguishing requirements of a professional is the commitment to be reflective. When a professional experiences an unintended outcome of care or is presented with a story or data suggesting his deviation from desired performance, he commits to reflect as appropriate and adjust his behaviors and performance accordingly.

Professional accountability and reliability

As you review your conversation with Dr. Resident, you conclude that public humiliation of a learner does not model respect and is not an effective means for communicating. That lapse should be addressed.

Failures to self- or group-regulate have a negative impact on all members of the health care team. Unprofessional behaviors, whether aggressive, passive-aggressive, or passive, threaten reliability and safety. Studies of teams in business settings suggest that negative behaviors modeled by one team member lead others to adopt negative mood and/or anger in interactions with others.[2,3] Unaddressed disruptive behaviors lessen trust among team members and can contribute to worse task performance as individuals are forced to monitor the disruptive professional's behavior and are not focused on their primary tasks. Distraction and lack of focus during medical practice contribute to slips and lapses.[4,5] Finally, as disruptive behaviors persist, team members may withdraw or leave the organization entirely.[6,7] Consider Dr. Attending's behavior with the central line insertion. Did his slip in professionalism "cause" the infection? It is never really possible to know, but his performance had an impact on Dr. Resident and perhaps on other team members in a variety of ways, including some team members who possibly may decide that it is acceptable to deviate from evidence-based practice.

Over the past decade, medical educators have focused attention on teaching many of the tenets of being professional.[8–10] We assert however

that the collective dialogue has failed to include sufficient attention to the concept of self- and group-regulation and how to create effective plans to address clinicians who model unprofessional performance. It may be easier to sit in a lecture hall or classroom and discuss a vision of the noble professional than to consider practical issues such as how to address Dr. Attending's behavior. A leader might think, "Besides, if we keep focusing on this 'regulation' stuff, I might actually have to go and talk to Dr. Attending. He may not be so happy to hear from me, not refer patients to me, seek to retaliate, or choose to leave." Perhaps this is why professionals often talk about each other, but not to each other.[11]

A second incident

You (Dr. Leader) decide to speak with Dr. Attending, but before you can do so, a second event comes to your attention.

> A nurse reported in your organization's electronic event system: "Dr. Attending was examining a patient with an abscess. When he entered the room he did not foam in [wash his hands]. I offered a pair of gloves. He took the gloves from my hand, smiled, and dropped them in the trash, and said, 'No, thank you.' He then went back to examining the patient."

Professionals need an infrastructure

Established policy in Dr. Leader's hospital is for professionalism concerns to be entered into an electronic event reporting system. Such stories are reviewed by authorized personnel from the Department of Quality and Safety and then forwarded to a designated medical peer for face-to-face delivery. Creating a process to accomplish reliable delivery promoting accountability required years of work, dialogue, and consensus building. The plan was developed with a set of core principles in mind, including **justice**, **data certainty**, and a commitment to provide individual clinicians the **opportunity through feedback to develop personal insight**.[12] The overarching goal was **restoration**, giving the clinician who has strayed an opportunity to regain the honor of being a professional. **Justice** means that all professionals are subject to the same rules with respect to performance, data sharing, and accountability. Justice requires that there are no individuals with "special" value who for whatever reason are exempt because they have unique clinical skills or generate high levels of clinical revenue.[12]

Data certainty does not reflect the need for a p value <0.05, but refers to the notion that in the context of the individual's group or health system, as reports begin to accumulate, sharing seems reasonable and is done in a way that encourages personal insight.

Insight includes "both intellectual and emotional awareness of the nature, origin, and mechanisms of one's attitudes, feelings, and behavior,"[13] and is an essential prerequisite for individuals to take meaningful action toward change with a goal for a restoration of professional behavior and performance.

In reflecting about these guiding principles, we suggest that there are eight elements of an infrastructure required to support professionals to effectively and reliably handle the important challenge of self- and group-regulation.[1,14] They include:

1. Leadership commitment
2. Vision, mission, core values, and supportive policies
3. Surveillance/measurement tools to capture observations/data
4. Process for reviewing observations/data
5. Model to guide graduated interventions
6. Multi-level professional/leader training about professionalism and ways to equip clinicians to share data, promoting accountability
7. Resources to address the reasons that professionals fail to achieve intended outcomes, including ineffective or failing systems and human behavior
8. Resources to help other team members, patients, and families who may have suffered psychological or physical harm related to the behavior and performance of clinicians.

Of these eight elements, **leadership commitment** is key. By that we mean the willingness to:[1]

• Hold all team members accountable for modeling right behaviors and performance, whether related to washing hands, completing documentation, or treating other members of the medical team with respect.

• Enforce standards of practice and code of conduct consistently and equitably among all regardless of seniority or "special" value to the organization. (Special value may be defined based on an individual's unique skills and ability, record in amassing a large number of research grants or clinical revenue, playing a critical role in a unique clinical service, or personal or social relationships.) Real leaders will not "blink."

• Honor and recognize professionalism in action. Positive reinforcement of clinicians who exceed expectations helps to publically demonstrate the organization's commitment.

• Employ appropriate tools (i.e., reporting systems) designed to facilitate both early identification and reporting of slips and lapses in behavior and performance, and to give feedback in ways designed to promote insight and self-regulation.

• Provide resources to build and maintain the infrastructure to support professional self-regulation efforts. Sustaining a reliable approach to

professional regulation is not possible if it is supported only by individuals' spare time.

Take a moment to reflect on the extent to which the system in which you work models leadership commitment to address "early and often" the behavior inconsistent with the concept of what it means to be a professional. In addition, think about your personal commitment to address behavior and performance issues among your colleagues. If you happened to walk into a unit and encountered Dr. Attending yelling at Dr. Resident, would you be willing and able to act? Promoting professionalism requires action.

Leaders also understand the need to create and disseminate **vision and mission statements** with associated **performance goals**. Creating a vision and mission is powerful. Consider the impact of the 100,000 Lives Campaign, as professionals across the United States committed to implement six evidence-based interventions to improve patient safety. It has been estimated that over 122,000 lives were saved as a result.[15] A medical group should also document its credo, a set of core values that define who its members are. For example, the Vanderbilt University Medical Center credo states: "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."[16] The elements of the credo are used to support performance evaluation, reinforcing a commitment to principles of professionalism. They also may be used to support dialogue between professional peers when an event occurs that appears to be inconsistent with the group's core values. Finally, new team members should be introduced to the group's vision, mission, goals, credo, and policies as a part of their onboarding. Such an approach facilitates early communication in those uncommon but unfortunately not rare circumstances when a new clinical colleague behaves in a way inconsistent with her letters of recommendation.

Group, health system, or hospital policies governing professional behavior and performance should be written in a way that align them with the credo and with a clearly articulated focus on safety. Medical groups should delineate codes of conduct that include definitions of acceptable and inappropriate behaviors. Policies should be developed that address a lack of tolerance for egregious behaviors or certain behaviors for which the law mandates a formal process for review,[17] including alleged violations of sexual boundaries, inappropriate physical touching, assertions of discrimination, or abuse. Finally, policies must outline clear protection for those who report "events," as the real or perceived threat of retaliation represents formidable barriers to safe reporting. Leaders of health care organizations must constantly be on guard for evidence of subtle and not

so subtle ways that individuals seek to take retribution. Any confirmed "assault," verbal or otherwise, on a safety event reporter mandates an escalated response, including possible disciplinary actions.[1]

Necessary policies are effectively nullified when behaviors and performance inconsistent with the tenets of the profession and that undermine a culture of safety go unreported and unaddressed. Therefore an effective infrastructure includes **surveillance and measurement tools** with **defined processes for data review** and a tiered model for **feedback and accountability**. The development of surveillance and measurement tools and approaches for the review and sharing of data should include review by a broad range of professional leaders who must explicitly declare their support *before* specific individuals (i.e., performance outliers) are identified. Too often, new initiatives are launched and professionals with opportunities for performance improvement are identified, but leaders "blink" by publicly challenging the metrics after they are established or by rationalizing how in "this case" there exist special circumstances justifying the apparent poor performance. All of us are sometimes tempted to rationalize, but professional leaders establish and pursue the established plan regardless of who is identified—as long as the goal of the process is to bring insight and restoration. It is imperative that leadership become engaged early in the process and endorse each step of the data collection, assessment, delivery, and potential consequences for failure to respond.

All members of the team need to understand the critical aspects of a safety culture and accountability. Leaders should receive additional **training** on appropriate use of data and surveillance tools and how to promote accountability. For example, it is useful for a leader to develop skills in sharing observations of behavior that appear to undermine a culture of safety, both for individual reports and when there appears to be a pattern. Leaders should also be trained to identify various types of pushback and how to appropriately respond.

In addition, **resources for individuals** who fail to respond to interventions might include physical and/or mental health evaluations and help in addressing needs that might be identified. **Resources for staff** who may be impacted by negative behaviors should be made available, including critical incident debriefing or other resources through an employee assistance program.

Two important sources of data about professional performance deserve detailed description—the reported direct observations of patients and of medical team members, including other physicians, nurses, and allied health personnel. Patients routinely observe the behaviors and performance of health care team members; they and their families may experience such things as:

• Rude, disrespectful behavior—a patient who reported her physician said, "You don't need to ask questions. Just lay down here."

• Failure to communicate clearly—"Dr. X ended the visit abruptly and I had no idea what was supposed to happen next."

• Lack of access—"We had the test over a month ago and no one called us. Now we are told that there is a problem with the biopsy."

If organizations are committed, they convey to patients that their observations are valued and that the organization "wants to hear from them." Such an approach facilitates service recovery, the effort to systematically respond to any patient or family to address what they perceive is wrong.[18] Even though most individuals who observe unprofessional behavior will not speak up (perhaps only one out of forty to seventy dissatisfied patients),[19] a subset will, and analysis of their stories provides important data to support identification of professionals who model patterns of unprofessional conduct.[19–23]

Similarly, staff, including nurses, fellow physicians, and learners, observe their colleagues, and a subset will share their stories if they feel safe and trust the medical group to use their observations for improvement.[24] A nurse who reports through an event reporting system that a physician failed to respond to several pages and then suggested that the issue "was not her problem—call the cardiologist," seems to be identifying a problem with availability or taking responsibility. Another nurse who reports that a physician interrupted her phone call describing a change in patient status, asking her, "Are you stupid or are you illiterate? I wrote an order on this patient forty-five minutes ago," may be identifying an individual who has a problem with respect for others.

A graded response to stories, reports, and data

To support the pursuit of professional regulation, Dr. Leader's system adopted a professional accountability pyramid to direct the process and method of sharing.[1] The pyramid is built on the fact that the vast majority of professionals are seldom involved in any questions of behavior or performance. On the other hand, single events occasionally occur, like the resident's report about Dr. Attending's failure to follow best practices in line insertion. Staff observations are reviewed shortly after receipt by a member of the safety team. The purpose of the initial review is to identify any evidence of an event that requires a mandated evaluation (the black triangle in the lower right of the pyramid), including assertions of sexual boundary violations, physical assault, or assertions of discrimination or abuse.[1] Dr. Leader's system also has embraced mandated reviews with appropriate escalation and consequences for "egregious events" (the gray triangle in the lower right of the pyramid), such as seeking to retaliate

Adapted from reference 1.
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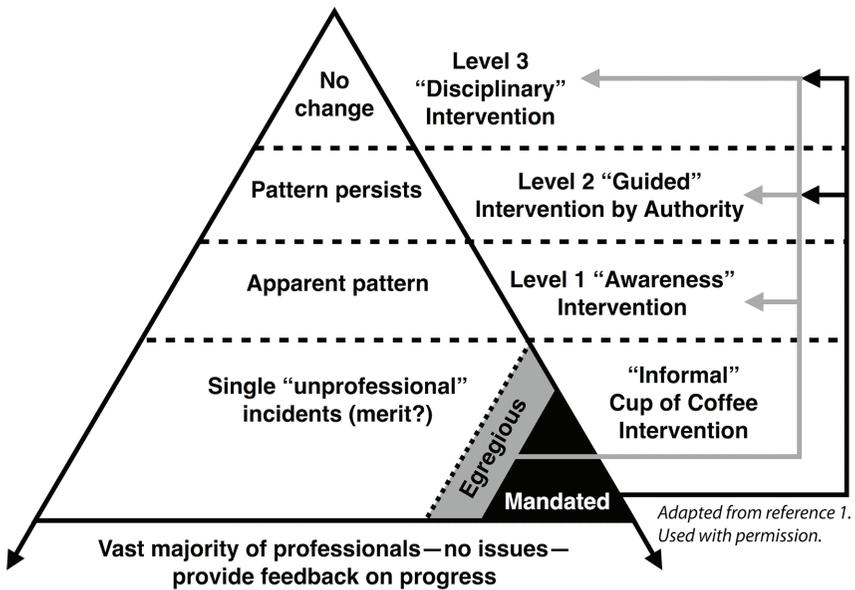
against someone who in good faith reports a safety concern. However, most reports (by patients or staff) do not call for mandated evaluation and should be shared with the named professional in an informal, non-judgmental, and respectful fashion (i.e., over a cup of coffee). For this reason, Dr. Leader's group has designated physician peer messengers by department, who are trained to deliver the individual reports.

When Dr. Attending and the "gloves in the trash" incident was reported, it was shared with the peer messenger. Dr. Peer called Dr. Attending and asked if they could get together briefly in Dr. Attending's office that day or the next. Once greetings concluded, Dr. Peer reminded Dr. Attending that staff members are encouraged to submit concerns about observed behaviors and performance that appear inconsistent with the group's credo. All such reports are reviewed and distributed for delivery. The process was established to support a culture of safety and it is assumed by the group that professionals want to know. At that point the essence of the story was shared and Dr. Peer respectfully paused, offering Dr. Attending an opportunity to respond. Dr. Attending paused briefly and then asserted, "I washed my hands before I entered the room. I always foam in and I don't know anything about throwing any gloves into a trash can." Dr. Peer responded, "I know you are committed to our focus on hand hygiene. As far as the part about gloves, it just didn't seem like you [no point in disputing], but I have to wonder about the details of the report. I just ask you to reflect back on the visit in question and I trust you to do whatever you think is right [no mandated policy or required action]. Dr.

Attending, you are a valued member of the team and that is why I am here to share with you and others whenever such reports are received."

The goal of a cup of coffee is to deliver a message about a single event and provide an opportunity for individual self-regulation and personal insight. Peer messengers are taught that cup of coffee conversations are not control contests or a chance to "fix" their colleagues. Such conversations are short (three to five minutes) and generally not documented, though the event precipitating the need for the conversation remains within the surveillance system for future reference as needed.

Of note, Dr. Leader's organization supports the timely delivery of professionalism reports without investigation if they do not represent egregious or mandated reporting events. Many if not most organizations and medical groups encourage the investigation of stories. In our view, this represents a process that increases conflict, seldom reveals the "truth," delays feedback, and is subject to the judgment of a few leaders who may either choose to the "look the other way" or in rare instances use the events to embarrass or humiliate. Because Dr. Leader's group has an effective surveillance system, he or she can afford to be patient. If the event is indeed isolated, there will not be additional reports entered into the surveillance system. However, if the event reflects just one occurrence of a pattern, there will most certainly be additional reports and opportunities for feedback to the named clinician.

The pyramid is constructed anticipating that some professionals will not respond to the cup of coffee, and those individuals will continue to accumulate complaints. Linking the pyramid to longitudinal data collection for both patient and staff complaints allows the group or system to establish thresholds to direct escalation as needed.[1]

Addressing potential patterns

It turns out that Dr. Attending has been mentioned in three previous staff reports. The dropped gloves incident is a fourth report. What does it mean to have three, four, or five reports in any defined time frame? A leader will not know without a surveillance system, data review, and an associated process to promote professional accountability.

Whenever clinicians are associated with a greater number of complaints than a threshold determined by the organization's leadership, the Chief Safety Officer prepares materials for review by the appropriate authority figure or authorized committee. Dr. Chair knows that eighty-five percent of group members have no complaints, ten percent have only one occasional complaint, and three percent (including Dr. Attending) have four or more complaints during a three-year audit period. In fact,

Dr. Attending is in the small group that accounts for over forty percent of all documented professionalism concern reports. As the leader, Dr. Chair decides to proceed with the awareness intervention as directed by the professionalism pyramid.

The goal of an awareness intervention, whether delivered by an authority figure or peer as a member of a professionalism committee, is to share with Dr. Attending that there appears to be a pattern of behavior or performance inconsistent with the organization's safety culture and to encourage self-reflection. The visit also provides notice that if the unprofessional behavior continues, the leader *may* have to escalate the intervention and become directive. The visit is preceded with a letter stamped confidential from Dr. Chair directed to Dr. Attending. The letter affirms the importance that the medical group places on professionalism and achieving the highest levels of patient safety and satisfaction. It reminds Dr. Attending of the system-wide agreement to share staff reports and reminds Dr. Attending that he has received several individual reports over the past several months, as well as the fact that complaints have continued to accumulate. He is reminded that the purpose of sharing is not to debate the merits of any specific report, but to encourage Dr. Attending to consider why in the aggregate his practice seems to be associated with more complaints than others. The letter serves as a request by Dr. Chair to set up a visit in *Dr. Attending's office* where the stories will be shared, as well as other data to encourage reflection.

At the time of the visit, Dr. Chair thanks Dr. Attending for making time and then proceeds to share the data suggesting that for some reason Dr. Attending's practice is associated with more staff complaints than others. To support the assertion, Dr. Attending is provided the individual complaint narratives, a table illustrating complaint type themes (e.g., communication, medical care, responsibility, professional integrity), a figure illustrating the distribution of all complaints about the physicians in the system with Dr. Attending labeled, and a copy of the group's professionalism policy. Dr. Chair provides several opportunities for Dr. Attending to respond and ask questions. As the visit concludes, Dr. Chair affirms that Dr. Attending is an important member of the team, but reminds Dr. Attending that the accumulation of staff reports does not seem consistent with the group's collective commitment to professionalism. He is asked to reflect on why it might be that his practice is associated with so many complaints. Dr. Attending is reminded that he will continue to receive follow-up about his complaint status on a regular basis and that most professionals who receive such peer-based feedback respond.[1,19] The leader is hopeful that Dr. Attending will respond as well. However "if complaints continue there *may* have to be an escalation in the level of intervention."

Training to conduct "awareness" interventions is case-based and leaders/peer messengers are taught how to address common pushbacks. In addition, training is designed to help leaders/peer messengers recognize and understand boundaries—awareness visits are not designed to be directive, to make a diagnosis, or suggest a treatment plan. A challenge faced by many leaders/messengers arises from a natural inclination to coach. Whereas most leaders are likely to be correct in their recommendations, providing direction at this point is not respectful and does not promote self-reflection and the self-regulation required in a safety culture. Offering advice also sets the leader/messenger up for an all-too-predictable pushback. Whenever a leader/messenger offers a suggestion and there is no subsequent evidence of performance improvement, when follow-up occurs, the recipient very often responds, "I did everything you suggested. This is all about *your* bad advice and one more example of *your* poor leadership."

Unfortunately, over the next few weeks Dr. Attending is named in two additional professionalism concerns.

> "I was shocked that Dr. Attending took a personal cell phone call right in the middle of the procedure. . . . It was scary and upsetting."
>
> The next week a scrub nurse reported that during a stressful point in a surgical procedure, Dr. Attending "grabbed the instrument out of my hand and told me to get the hell out of his operating room."

The group's professionalism policy directs that Dr. Chair and Dr. Leader are notified of the new reports and the need to consider a more directive intervention. In a guided intervention, leaders review the data and develop a plan designed to address whatever they think may be contributing to the problem, whether from a poorly functioning practice or system to physical or mental health challenges that may be affecting Dr. Attending's performance.[12] This level of professional help is possible only if collective leadership ensures adequate resources are available for evaluation and treatment. In our experience most individuals who reach the guided intervention level need to be directed for a mental and physical health screening evaluation. Prior to meeting with Dr. Attending, Dr. Chair develops a written plan that is reviewed and approved by an appropriate leader (dean, chief medical officer, or chief of staff), outlining the group's expectations, Dr. Attending's deficiencies (i.e., continued complaint generation), the mandated intervention (i.e., referral for a screening health evaluation), the potential consequence for failing to comply, the timeline for completion of the evaluation, and ongoing monitoring of performance. The guided intervention visit occurs in Dr. Chair's office.

While many individuals are able to, with appropriate assistance, address their unprofessional behaviors and reenter practice, a few will not. At this point, institutional commitment supported by unified leadership is critical, including policies that define unprofessional behavior, surveillance systems to permit reliable assessment and tracking of performance over time, a process and method for promoting accountability, and resources to provide colleagues an opportunity to improve. We assert such a process with predictable responses is fair, provides reasonable certainty that a peer needs assistance, provides an opportunity for individuals to develop personal insight, and allows change and restoration to the full honor of the profession. If individuals fail to respond, it is not fair to other members of the medical team that they continue to work, putting fellow professionals and patients at psychological or physical risk.[14,25-27]

Does any of this work?

Does any of this work? Is there really any hope of restoring Dr. Attending to the honor of the profession?

Support for a tiered approach to promote professional accountability is provided by a series of studies examining ways to change physician practice performance. Ray et al. demonstrated the effectiveness of academic detailing to improve physician prescribing practices, which resulted in sustained reductions in the contraindicated practice of prescribing chloramphenicol and tetracycline to young children.[28–30] An element of this program's success was data delivery by a professional peer and explanations that the colleague appeared to stand out from others. Building off the success of Ray and others, our research team considered whether the same methods (i.e., peer delivery of comparative data, delineation of expected professional norms supporting group accountability) would help to reduce malpractice risk for the small subset of physicians by discipline (two to eight percent) who are associated with a disproportionate share of malpractice claims and payments.[31,32] A series of studies showed that high claims experience physicians stand out because they consistently model behaviors described by their patients as unprofessional (e.g., being rude, failing to respond to questions, and communicating poorly).[21,22,31,33] High-risk physicians can be identified by coding and aggregating unsolicited patient complaint reports (a critical component of a professional surveillance system), yielding an index that is strongly associated with malpractice claims risk.[31] In a study in a large academic medical center, physicians at high risk (eight percent) were associated with more than forty percent of all group claims and greater than fifty percent of all dollars paid for defense, awards, and settlement costs.[31]

In considering the best approach to promote personal insight and practice change, we borrowed from the Ray model,[30] and created the Promoting Professionalism pyramid. Using an academic detailing model, unsolicited complaint reports were shared in person by trained peer messengers with clinicians identified as being at high risk. High-risk professionals were asked to reflect on why their practice was associated with so much dissatisfaction (compared with their peers) and therefore malpractice risk. Peer messengers encouraged professionals to consider changes in their practices that might reduce their risk, but were specifically trained not to coach the professionals. Since the first interventions, approximately 1,000 high-claims-risk physicians have been made aware that they appear to stand out. The vast majority of those who receive interventions respond with an eighty percent reduction in complaint risk score; a small number require the more directed or guided interventions.[34]

The same process and method for sharing data was successfully used in a health system-wide effort to improve hand hygiene rates.[35] Failure to follow hand hygiene best practice threatens safety and should be addressed in a fair and measured way. The infection prevention team created an aspirational goal, obtained leader and team member support, developed and implemented a surveillance tool, and used the process and model defined by the professional pyramid to promote accountability. Data and performance expectations were shared with individuals and unit leadership where improvement opportunities were identified. The coordinated effort resulted in improvements of hand hygiene from about sixty percent to greater than ninety percent throughout the health system, and an observed reduction in device-associated hospital-acquired infections.[35] Improving care requires a level of commitment to the principle of professional self-regulation supported by a robust infrastructure, which aligns with both the highest aspiration of the professional and society's goals for health care delivery.

What are the critical elements for success?

Creating an infrastructure as outlined in the following table is a requirement for any size clinical group interested in promoting professionalism and pursuing a safety culture. For Dr. Leader, the institution had clearly stated values and a fair, equitable, and balanced process for delivering interventions to Dr. Attending.

Such a system is built on trust. Individuals who report concerns either as patients or colleagues must trust that the institution is committed to reviewing and acting on information that suggests a "disturbance." They must also trust that if they speak up, even if they are mistaken in their observations, they will be safe from retribution. Efforts to retaliate against

reporters must be dealt with swiftly, even if only suspected. Colleagues who appear to be accumulating too many stories must trust that data will be shared in a non-judgmental way, giving them an opportunity to respond. Leaders must trust that other leaders in the organization will not "blink" under any circumstances, when, for example, an individual who has received any level of intervention attempts to circumvent the chain of command and appeal to a more senior leader. Leaders must fairly and consistently hold all accountable. No one can have "special" status.

Infrastructure Elements for Promoting Process Reliability and Professional Accountability	
1. Leadership commitment	5. Model to guide graduated interventions
2. Mission, goals, core values, and supportive policies	6. Multi-level professional/leader training (on infrastructure and communication skills)
3. Surveillance tools to capture observations and reports	7. Resources to help address the causes of unnecessary variation in performance (both system and individual)
4. Processes for reviewing observations and reports	8. Resources to help those affected (psychological or physical harm)

Professional to professional

During the guided intervention, Dr. Attending was presented with a letter directing him to report for a screening evaluation through the institution's professional wellness program. The evaluation identified a number of stressors in Dr. Attending's life that he acknowledged were having an impact on his practice. Review of the surveillance data confirmed that the timing of Dr. Attending's complaints appeared to correspond with his life stressors. Supported by these observations, Dr. Attending's personal insight, the availability of professional mental health services, and a surveillance system to monitor Dr. Attending's ongoing performance, Dr. Chair decides that there is reason for optimism. If complaints continue to accumulate, however, Dr. Attending will face disciplinary action as directed in the medical group's bylaws. The hope is that a professional will respond and again become a role model.

Conclusion

Training in what it means to be a professional is a fundamental part of medical education for learners at all levels. The effectiveness of professionalism training is enhanced when conducted in a culture filled with positive role models. Such a culture is not possible without personal

courage by leaders and professionals who understand the importance of self- and group-regulation. Efforts at self- and group-regulation can only be sustained if there is an established infrastructure to support identification and intervention when individuals fail to live up to the expected norms of the profession, including modeling respect for others and a commitment to follow evidence-based practices. Training in what it means to be professional must focus not solely on the noble tenets of professionalism, but also on how to build, utilize, and sustain a supporting infrastructure. In our opinion, to teach about the former in the absence of teaching about the latter is unprofessional.

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