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Pursuing a Culture of Safety

The Importance of Self-Regulation

Professional self-regulation is effective when dealing with staff with high numbers of patient complaints and coworker observations.

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The Vanderbilt Center for Patient and Professional Advocacy is dedicated to making medicine kinder, safer, and more reliable by supporting their partners' objectives of using professionalism as the foundation of safe, quality healthcare. The Center provides data, tools, and effective processes for promoting professional accountability, including the proprietary systems PARS® (Patient Advocacy Reporting System) and CORS℠ (Co-worker Observation Reporting System). *HealthManagement* spoke to Center Director, Dr. William O. Cooper, to find out more.

Why was the Vanderbilt Center for Patient and Professional Advocacy established?

The Center was established 20 years ago in response to research by colleagues at Vanderbilt, in particular Dr. Gerald B. Hickson, which identified the risk for medical malpractice claims and what led families to sue (Hickson et al. 1992; 1994). This research found that there was a small group of physicians that accounted for a disproportionate share of malpractice risk. Those same physicians could be identified through unsolicited patient complaints, when patients aren't pleased with their care and reach out to the office or to the hospital to share their concerns. Dr. Hickson and his colleagues found that the same 3% of physicians who accounted for 50% of the malpractice risk also accounted for 35-40% of unsolicited patient complaints (Hickson et al. 2002). Dr. Hickson and his colleagues developed an intervention model where peer messengers share data with the individuals to give them the chance to self correct. As we found success in this work at Vanderbilt, other groups across the United States approached us to see whether the same models would apply there. The Center now provides surveillance for over 33,000 physicians at 140+ hospitals across the United States with PARS® (Patient Advocacy Reporting System) and CORS℠ (Co-Worker Observation Reporting System). We also provide leadership development, education and resources to organisations to address behaviours that undermine their culture of safety.

The Center has developed the Patient Advocacy Reporting System (PARS®). What data is collected on patient complaints?

Our system is known as PARS® (Patient Advocacy Reporting System). Patients are uniquely positioned to make observations about their care. When they observe things that either fail to meet or exceed their expectations, they will often speak up. In many cases that gives

healthcare organisations a chance to engage in service recovery or efforts to make right whatever the patient perceived was wrong. That might be addressing their specific concerns, but often in their observations are system issues. Individuals may be identified, who have a disproportionate share of complaints. We know that not only do these complaints lead to medical malpractice risk, but they also decrease the likelihood that patients are going to adhere to care recommendations. Patients may also speak poorly about the healthcare system to their friends and family or through social media. Research has shown in healthcare that every one voiced patient complaint represents 40-70 unvoiced complaints, which serve as a strong indicator for malpractice risk (Annandale and Hunt 1998).

> “WHEN MADE AWARE, 80% OF PHYSICIANS WILL SELF-REGULATE”

Many organisations that have robust service recovery programmes collect these data already. We have found that they can be extremely useful to identify and successfully intervene with physicians and advanced practice nursing professionals at particularly high risk of receiving patient complaints. Additionally, the data have proven to have a substantially improved impact when this information is delivered in person and by a peer (Schaffner et al. 1983).

Is the proportion (3%) of physicians at risk of patient complaints and malpractice suits consistent over time?

In the original work that looked at those 3% of the physicians who are responsible for a disproportionate share of patient complaints, the physicians were included in a randomised controlled trial (Hickson et al. 2002). One group received the intervention and the other group didn’t, and we still track their responses. What we learned from this study was that by sharing data with the involved physician you could not only decrease their patient complaints, you could also improve the malpractice experience. For 78% of the time, across the studied 3,000 physicians, when we identify those physicians and intervene their patient complaints decrease. Many of our sites have also done an analysis that suggests that those physicians who receive interventions can drop their medical malpractice risk by 75-85% in some cases, which results in significant savings for the healthcare systems.

One question that might follow is whether you can just address those individuals once and that will solve the problem. However, these types of risk are dynamic and change throughout a person’s career. When physicians are establishing their career, this is often a high-risk period for both patient complaints and malpractice. Physicians may also develop mental illness, substance abuse or significant life stressors that lead them to respond in ways to patients and colleagues that are less than respectful, or they may be unable to face challenges and respond in a timely manner. There is a need for ongoing surveillance to identify and intervene with those physicians. If they don’t respond due to a significant underlying problem, in our model, guided by the Vanderbilt professionalism pyramid, there are opportunities to connect individuals who are persistent outliers to resources to assess and potentially help restore them to full practice.

The Co-worker Observation Reporting System CORS℠ keeps feedback within the clinicians rather than involve human resources. Why is this? What advantages does this have over formal investigations of patient complaints and observations and coworker reporting?

The work we do is guided by the Vanderbilt professionalism pyramid (**ww2.mc.vanderbilt.edu/cppa/45627**), which is a tiered intervention model. The model is based on the notion that single interactions, such as coworker reports about failure to return a phone call or speaking rudely to a nursing professional should just be shared, because it gives the opportunity for the individual to reflect. If that interaction is mandated to be reported, or egregious, of course you engage human resources or the appropriate authority to investigate. Meaning, if someone violates a regulation or policy, such as sexual harassment, physically touching another person, coming to work impaired by drugs or alcohol, those cases are moved to formal investigatory processes. What we found, however, is that when there is a case of disrespectful behaviour, if you were to investigate it takes a long time, and what you find at the end of the day is often a “She/he said” situation. You never really know the truth, and all we want, whether it happened or not, is for that professional to know that the behaviour was observed and that someone thought it wasn’t consistent with the organisation’s values and goals for treating everyone respectfully. If someone fails to respond, and develops what appears to be a pattern under the pyramid model, a peer would bring that pattern to their attention and say: “Dr X, for some reason your practice appears to be associated with more of these coworkers’ concerns than your colleagues. All I want to let you know is that

within our healthcare system, you are in the top 1% and we just want to make you aware of that." If they fail to respond then they move to more formal processes where we begin to equip them with resources as well as corrective action plans where leaders work with the individual to get them to respond. Failing that they then move to the formal disciplinary processes. This process aligns with human resources work and it is consistent with clinical practice. The concept of self-regulation and group regulation is very important; when made aware, 80% of clinicians will self-regulate.

When you introduced CORS℠ at Vanderbilt did you find that people were reluctant to report?
Quite the contrary. When we introduced this system we found that once people began to trust that we were going to respond and would surround them with an environment of physiological safety, meaning that someone wasn't going to retaliate against them for reporting, we found a large uptick in people's willingness to report and share observations. This has been sustained over the last four years.

On professionalism, with Dr. Gerald B. Hickson you have written: "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.... while it requires courage to examine one's own performance, it requires even more courage to assess and intervene on the behaviour and/or performance of others" (Hickson and Cooper 2015). Please comment.
I am a practising paediatrician and I have been a peer messenger in the Vanderbilt medical system for the last 10 years. In clinical care, when new antibiotic prescribing guidelines come out and I am treating a child who has pneumonia, I have the opportunity to reflect on my practice and see whether my practice is consistent with my peers according to those guidelines. The same opportunity applies when we give physicians information to suggest that, relative to their peers, they are outliers in terms of complaints and that they have risk of malpractice suits. By giving them their own data and comparison data we give them the chance to have that "A-ha!" moment, to have self regulation. As professionals the medical societies within which we work give us the right and the privilege to group regulate, monitor and help each other in what it means to be a professional. This courage and this ability to encourage self reflection is just as if I were to have a conversation with a colleague about their antibiotic prescribing. As a peer messenger I can sit and bring to their attention that there may have be something about their interactions that leads patients to complain more commonly about them than about their peers. We know that this increases the risk for malpractice and other challenges, and all we are asking them to do is to reflect on how it is that for some reason their practice appears to be associated with more of these patient complaints then their colleagues. We find that in 80% of cases the opportunity to reflect on that is very helpful, because many folks will tell us: "No one has ever told us this, I have been like this for years and no one has ever brought it to my attention." ■

William O. Cooper, MD, MPH is a practising physician, researcher, teacher, and administrator. He has led School of Medicine programmes, including the Center for Patient and Professional Advocacy, the Master of Public Health Program and the Pediatrics Office for Faculty Development. He is an internationally recognised expert in medication safety in children and has published over 100 scholarly articles to date with research published in journals including *New England Journal of Medicine* and *JAMA*. In his role as Director of Vanderbilt's Center for Patient and Professional Advocacy, Dr. Cooper oversees the operations of the center's PARS® program, education and training, and research programmes. He has lectured on professionalism and is recognised for his innovative approach to teaching. Dr. Cooper has won numerous awards and was selected for Vanderbilt's Academy for Excellence in Teaching in 2010.

REFERENCES AND FURTHER READING

Annandale E, Hunt K (1998) Accounts of disagreements with doctors. Soc Sci Med, 46(1): 119-29.

Hickson GB, Clayton EW, Githens PB et al. (1992) Factors that prompted families to file medical malpractice claims following perinatal injuries. JAMA, 267(10): 1359-63.

Hickson GB, Clayton EW, Entman SS et al. (1994) Obstetricians' prior malpractice experience and patients' satisfaction with care. JAMA, 272(20): 1583-7.

Hickson GB, Cooper WO (2015) Pursuing professionalism (but not without an infrastructure). In: Byyny RL, Papadakis MA, Paauw DS, eds. Medical professionalism: best practices. Menlo Park, CA: Alpha Omega Alpha Honor Medical Society, pp. 81-98.

Hickson GB, Federspiel CF, Pichert JW et al. (2002) Patient complaints and malpractice risk. JAMA, 287(22): 2951-7.

Schaffner W, Ray WA, Federspiel CF, Miller WO (1983) Improving antibiotic prescribing in office practice. A controlled trial of three educational methods. JAM, 250: 1728–32.

Webb LE, Dmochowski RR, Moore IN et al. (2016) Using coworker observations to promote accountability for disrespectful and unsafe behaviors by physicians and advanced practice professionals. Jt Comm J Qual Patient Saf, 42(4): 149-64.