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Professionalism, Leadership, and a Pilfered Apple

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A medical leader may be confronted unexpectedly with a professional and ethical challenge that presents itself in a surprising way. The leader's response may have significance beyond the moment and stated issue of concern. As a leader, are you prepared to respond to a situation like the case below in a way that supports the mission and values of your health system and the needs of fellow team members?

> *Dr. Lee, a chief of staff, is informed that Dr. S, a recently recruited specialist, has asked to meet. Dr. S shares that he has been visited by Dr. P who "told me I had been bad and eaten a #@^% nurse's apple . . . an apple. I was between cases, and I was hungry. It was on a table in the break room, and I ate it. What I can't believe is the nurse entered a #&* % safety report and YOU have some group of minions wondering around sharing them. This is unbelievable."*

Dr. Lee works in a health system committed to quality and safety. The work is supported by professionals who maintain competency in their fields; commit to safe, equitable care; model respect; and practice self- and group regulation.[1–5] In support of team members, Dr. Lee chairs a Professionalism Committee with responsibilities for supporting performance assessment, key elements of professional practice evaluation, and wellness. A component of the work is a commitment to a safe and healthy workplace where team members feel safe to speak up, and reports of disrespectful/unprofessional behavior are reviewed and shared with the individual named. The goal is to provide the colleague an opportunity to pause and consider if there might be an opportunity to respond differently in similar situations in the future.[1–5]

DR. LEE'S RESPONSE

Dr. Lee was involved in Dr. S's recruitment. Her observations suggest that Dr. S is hardworking with strong technical skills and fills an important practice need. However, in the moment, Dr. S appears angry and is waiting for a response.

If you were Dr. Lee, how might you approach the conversation? What might be your priorities and how might they align with your professional and leadership responsibilities?

Dr. Lee shares with Dr. S:

> *Thank you for reaching out. I want to be available when colleagues have questions. Let me assure you of the importance and confidentiality of our professionalism work. I was unaware you had been identified in a report until you walked in and shared with me.*
>
> *As I am sure Dr. P shared, our commitment to safety and the well-being of our team members directs that all professionalism concerns are shared with the individual identified so they are aware.*
>
> *Medicine can be stressful, and all of us on occasion are subject to slips and lapses in our behavior and performance. The good news is that, even so, most professionals are never the subject of a report. For those who are associated with a report, the vast majority do not have subsequent reports when the story is delivered by a peer as we do in our health system.*
>
> *As chief of staff, I am only directly involved when reports accumulate or there is a report that directs a mandated investigation.*
>
> *Thank you for meeting with Dr. P and reflecting on the event; that is what we ask of each other. If you have questions about our program, Dr. P or I will be happy to address.*

Dr. Lee's approach affirms her leadership commitment, the work of Dr. P and the peer messengers, supports other system professionals, the patients they serve, and Dr. S.

As Dr. S departs, Dr. Lee notes his frustration but trusts he will not be associated with subsequent reports.

THE WHY

Disrespectful/unprofessional behaviors—passive, passive-aggressive, or aggressive—experienced by patients, families, and fellow team members threaten performance and safety.[6–11] Individuals experiencing disrespect in any workplace are more likely to report anxiety, be openly critical of others, and withdraw.[12] Medical team members subject to disrespect are less vigilant and less likely to communicate and ask for help.[6,7] Patients who receive care from physicians who model disrespect are more likely to experience surgical site infections, wound disruptions, and medical complications ranging from readmissions to ICUs, cardiac arrest, septic shock, and stroke.[8,9,11,13] Patients and families exposed to disrespect from health team members also experience "nonphysical" harm with emotional, psychological, socio-behavioral, and financial consequences.[14,15] Physicians who model disrespect have excess malpractice claims experience when compared with others practicing in their specialities.[10,16,17] Team members who work with these physicians report diminished job satisfaction and are more likely to leave their jobs.[18,19] Costs associated with failing to address unprofessional behavior are substantial.[8,9,16–18]

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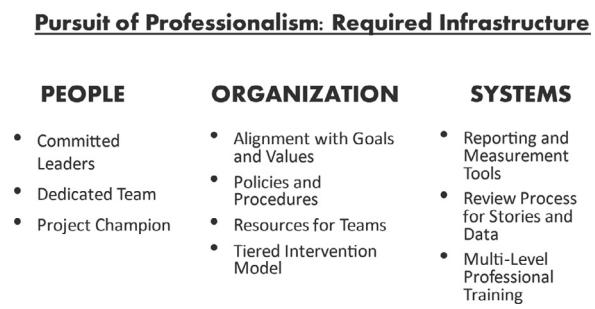

Figure 1: Preventing and addressing disrespectful/unprofessional behavior in medicine requires a plan supported by a well-defined infrastructure.
Source: Adapted from Hickson GB, et al. Balancing systems and individual accountability in a safety culture. In The Joint Commission: From Front Office to Front Line: Essential Issues for Health Care Leaders, 2nd ed. Oak Brook, IL: Joint Commission Resources, 2012, 1–35.

Not Without a Plan Supported by an Infrastructure

Preventing and addressing disrespectful/unprofessional behavior in medicine requires a plan supported by a well-defined infrastructure (Figure 1).[3–5,20,21] The infrastructure includes committed leaders who model professionalism, including a willingness to hold all team members accountable to the same standards of behavior and performance regardless of rank or perceived value. Leaders ensure that the professionalism work is carried out by a dedicated team and that they support a project champion, in this case Dr. Lee, who oversees day-to-day operations and who occasionally faces a challenge from an unhappy Dr. S. Knowing senior leadership fully supports the work makes a difference. Leadership also is actively involved in defining policies and procedures, including how stories and data are shared. For example, prior to launch of their professionalism initiative, leaders considered that stories submitted through the system's electronic event reporting tool reflect reporters' experiences and perceptions and anticipated some stories might seem trivial. Yet, given reporting reluctance, a policy was established that all reports, even those about pilfering food, would be addressed through a defined process that includes sharing with the clinical team member named.[22,23] Even trivial-sounding reports may provide a learning opportunity or represent the first report of what becomes an emerging pattern. Furthermore, failure to address a submitted story may send a message that disrespect is tolerated, at least for some, or might represent a missed opportunity to identify a fellow professional who for whatever reason is struggling. Finally, senior leaders recognized that their ability to sort important from trivial stories is limited, subject to unrecognized biases, inevitable questions about conflict of interest, and assertions that an executive leader is singling out individuals for unfair treatment.[24]

Another important infrastructure element is a tiered intervention model to guide sharing stories and data with professionals (Figure 2).[5] The model is built on recognition that most professionals are never or only rarely associated with a report suggesting unprofessional/disrespectful behavior.[4] In a safety culture many slips and lapses can be addressed in the moment by fellow team members. However, when submitted, all stories are subject to a review process to identify the uncommon events with policy-mandated investigations (for example, concerns about physical violence, sexual boundary violations, discrimination, or drug or alcohol use). If an investigation is not required, the remaining reports, from pilfering food to failing to follow established safety practices, are delivered within 48 hours of submission by a member of the Professionalism Committee, a trained peer (physician, advanced practice professional, or nurse).[3,4,21] Peer training includes exercises on how to share stories and data in a respectful and nonjudgmental manor and how to respond to questions about the process. Training reinforces that peers delivering an informal "Cup of Coffee" or an Awareness Intervention (Figure 2) are messengers only and need to resist natural tendencies to diagnose, coach, and treat their colleagues.[21,25,26] In addition, time is reserved during Professionalism Committee meetings to confidentially share experiences, challenges faced, and overall results of their work.[4]

When possible, sharing occurs in the office of the individual identified. The peer begins the brief meeting by thanking the colleague for contributions to patient care, and our shared commitment to a culture of safety and respect. The peer shares the substance of the story, acknowledges there are often two sides, allows the recipient to respond, and closes by asking the recipient to consider how they might respond differently in the future.[25]

If subsequent reports occur and suggest emergence of a pattern, the pyramid directs escalation to an Awareness visit delivered by the peer (Figure 2). Peers are trained to share about the availability of confidential wellness services if the topic arises or if it seems appropriate. Again, most ($\geq$ 70%) of those with a pattern respond positively to feedback.[3,11,17] For the small numbers of professionals who continue to generate reports, leader-directed corrective action plans (Figure 2) connect the individual to appropriate resources, including coaching, physical and mental health screening, and treatment as indicated, for the health and well-being of the individual and to encourage correction prior to need for a disciplinary intervention (Figure 2).[24,27,28]

DISCUSSION

But it was just an apple? Perhaps for Dr. S, but not for the individual who submitted the report, and perhaps not for others who work with him. And was the report about the apple or taking something that belongs to someone else—an act of pilfering and disrespect?

In spite of the challenges they face, most professionals practice with empathy, compassion, and respect, support-

Figure 2: A tiered intervention model to guide sharing stories and data with professionals is an important infrastructure element.
Source: Adapted from Hickson GB, et al. A complementary approach to promoting professionalism: identifying, measuring, and addressing unprofessional behaviors. Acad. Med. 2007;82:1040–1048. Used with permission of the Vanderbilt Center for Patient and Professional Advocacy, 2022.

ing high-functioning teams.[29] Professionals also reflect on how their behavior and performance affect others' ability to perform their work.[1–5] Members of high-functioning teams share common values and promote cultures in which everyone feels respected and safe to speak up.

Health systems committed to quality and safety actively support their medical team members' pursuit of professionalism in practice. Support includes a systemwide commitment to develop and sustain intentionally designed systems where it is as easy as possible for clinical teams to deliver safe care. Also needed are wellness resources for team members, including counseling, coaching, critical incident support, and resilience skill training to help professionals cope with the stresses they face—for example, in moving and establishing a new practice. In addition, leaders commit to build awareness of the threat that disrespectful behavior has on teams and outcomes of care, establish clear processes by which incidents can be safely reported without fear of retribution, and review and respond to incidents and patterns of unprofessional behavior equitably and effectively.[6–9,13,16,17] The good news is that professionals respond to in-person delivery of performance data, whether about antibiotic prescribing, hand hygiene practice, complying with vaccine requirements, or generating a disproportionate share of patient or coworker complaints.[4,20,21,30–32] When the small number of professionals who develop patterns of disrespectful behavior recognize that their performance varies from their peers, most change.[4,21,31] Individuals who do not respond have increased risk for mental illness, substance abuse, significant life stressors, evidence of early cognitive impairment, and burnout.[27,28]

The case and Dr. Lee's ability to navigate its challenges successfully highlights several unanswered questions. How do we create a culture in health care where individuals can speak directly to individuals who eat their apples without having to use reporting systems? How do we prevent overuse of reporting systems in efforts to target individual clinicians? What are ways for clinicians to advocate for improving faulty systems without fear of being reported? The answers to these questions rest on promoting the fundamental tenets of what it means to be a professional.[1,5] Leaders committed to promoting high reliability and excellent outcomes should strive to support a culture of psychological safety and trust. However, hierarchy in health care and events that represent threats to patient safety necessitate providing a mechanism to share concerns as Dr. Lee's health system has done.

RESOLUTION

Dr. S does not respond and is named in additional reports criticizing a nurse's care in front of a patient, telling a learner to "stop asking stupid questions," and refusing to participate in a time-out, declaring, "come get me when you are done." Dr. S qualifies for and Dr. P delivers an Awareness Intervention (Figure 2).

After the Awareness conversation, surveillance reveals additional reports. A nurse shared, "I raised a question about Dr. S's orders; he waved toward the record and asked, 'can you read?'" Another report was received: "We were in the middle of the time-out," Dr. S just declared, "can we PLEASE get started? I have some real work that needs to get done."

Dr. Lee supports Dr. S's service chief in developing a Guided Intervention by Authority (Figure 2), implementing a Focused Professional Performance Evaluation as described in the medical staff bylaws.[24,33–35] The evaluation includes a physical and mental health assessment, identification of resources to support Dr. S in his interpersonal communication practices and the challenges of establishing a new practice, and monthly meetings with the service chief to monitor performance and identify additional opportunities for improvement that may emerge.

On occasion, Dr. Lee reflects on a conversation about a pilfered apple. She is reminded about her professional leadership responsibilities in supporting healthy teams, the delivery of safe care, and the well-being of team members, including Dr. S. If no one engages Dr. S about what appears to be a trivial story, it may represent a missed opportunity to support a colleague in need. She hopes that Dr. S will benefit from the resources to which he has been directed, but if not, the system is prepared to respond.

Conflicts of Interest. All authors report no conflicts of interest.

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