Pursuing Professionalism:

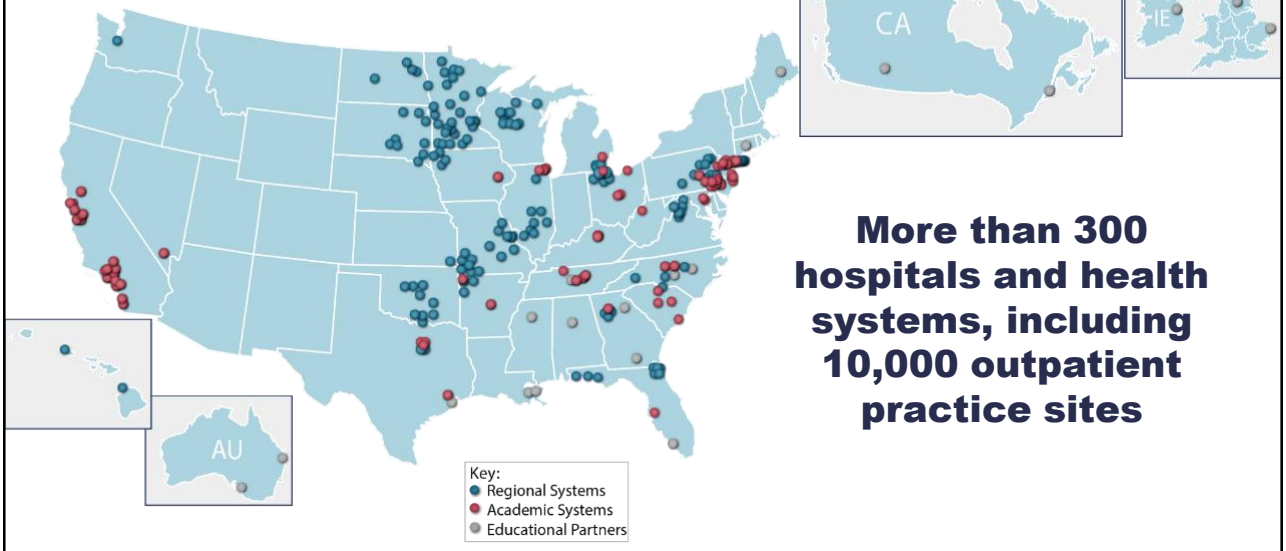
Requires Intentionally Designed Systems and Accountable Professionals

Allison Suttle, MD, MBA, FACOG
Executive Faculty, Vanderbilt Health CPPA
Assistant Professor of Clinical Obstetrics & Gynecology

VANDERBILT HEALTH | Center for Patient and Professional Advocacy

1

CPPA Partner Sites



More than 300 hospitals and health systems, including 10,000 outpatient practice sites

 2

2

High Reliability

Reliability: **failure-free** operation over time

Health care should be safe, effective, efficient, timely, and patient-centered.

However, an institution cannot achieve high reliability and safety on will alone, it requires a plan.

- Vision / Goals / Core Values
- Leadership / Authority
- A **Safety** Culture Includes:
  - **Psychological Safety**
  - **Trust**

Nolan, et al., Institute of Medicine, 2001 | Nolan, et al., Institute for Healthcare Improvement, 2004
Hickson, et al., Joint Commission Resources, 2012

3

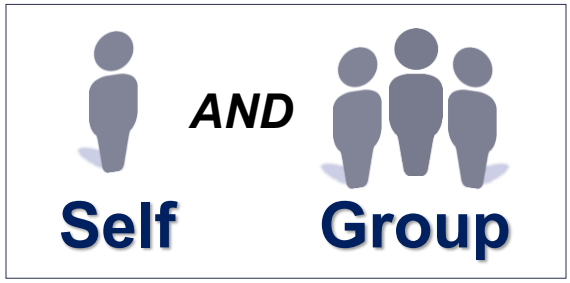
Professionalism and Self-Regulation

Carlasare and Hickson, AMA J Ethics, 2021 | Hickson, et al., Joint Commission Resources, 2012

4

Professionalism and Self-Regulation

Professionals commit to…



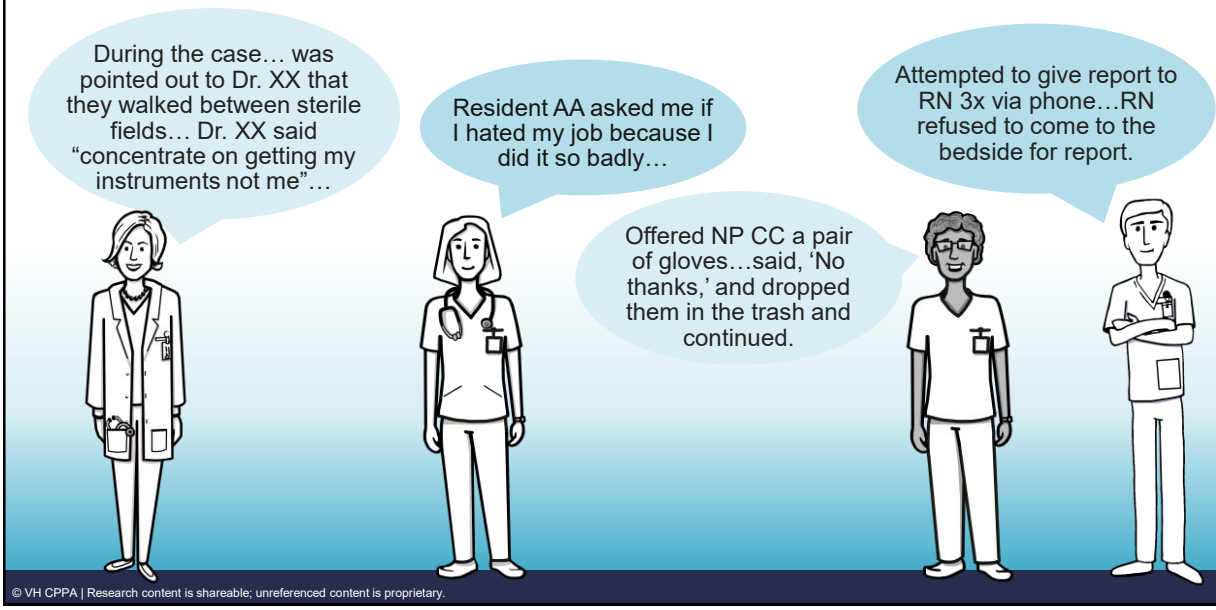
regulation of behavior and performance

Hickson et al., From Front Office to Front Line, 2012

 5

5

Sometimes we are not the best version of ourselves…



 6

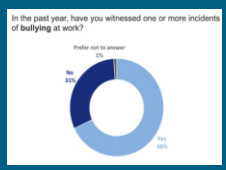
6

Unprofessionalism Bullying and Incivility

AONL Longitudinal Nursing Leadership Insight Study

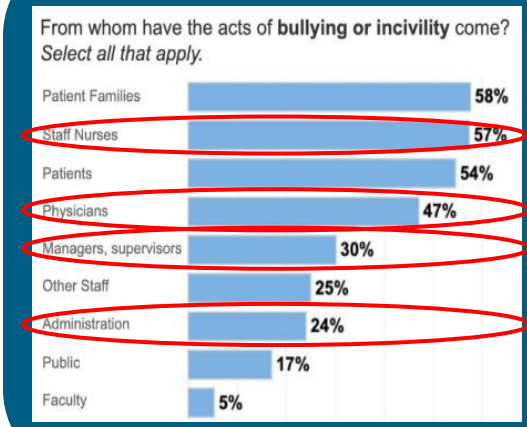
Witnessed or Experienced

Incivility – 77%



Bullying – 63%

Who From



American Organization for Nursing Leadership Foundation's 2024 Longitudinal Nursing Leadership Insight Study

7

Behaviors That Undermine a Culture of Safety

Disregarding care pathways and established practices *(including conflicts of interest and compliance)*

Threaten safety *(aggressive or violent physical actions)*

Create intimidating, hostile, offensive *(unsafe)* **work environment**

e.g.

- *Team* **jousting**
- **Dismissing** *work-flows*
- **Rude and disrespectful** *communication*
- **Delayed responses** *to pages*
- **Ignoring** *timeouts and handwashing*

ANY behaviors that interfere with the team's ability to achieve intended outcomes

It's About **Safety** and quality

Excerpts from Vanderbilt University and Medical Center Policy #HR-027, 2021

8

Why is it Important to Address Disrespect?

Disrespectful team members create a ripple effect that impacts culture, performance, and retention

INCREASED

- Withdrawal
- Anxiety
- Jousting

DECREASED

- Creativity
- Learning
- Motivation

Patients under the care of disrespectful physicians are

20-30% more likely to have a surgical site infection…

20-40% more likely to develop sepsis…

24-30% more likely to die if trauma care is required

Physicians who model disrespect account for

50-70% of your organization's malpractice claims experience and cost

Hickson, et al., JAMA, 2002 | Moore, et al., Vanderbilt Law Review, 2006 | Felps, et al., Research & Organizational Behavior, 2006 | Hickson, et al., So Med J, 2007 | Cooper, et al., JAMA Surgery 2017 & 2019
Cooper, et al., Annals of Surgery, 2022 | Doub, et al., Journal of Bone & Joint Surgery, 2024

 9

9

How Wellness Affects Professionalism

Burnout

Occupational distress and sleep-related impairment[1]

Coworker reported:

"I went and found the charge nurse to let her know that Dr. X was having a meltdown at the nurse's station in front of patients and staff."

[1] Welle, et.al., Mayo Clinic Proceedings, April 2020

Relationships

Adverse impact of work on personal relationships[2]

Physician reported:

"In the past year, my job has made it harder for me to develop new meaningful personal relationships."

[2] Trockel, et al., Mayo Clinic Proceedings, 2022

Cognitive impairment

Interaction descriptions include Neuro-cognitive Disease diagnostic domain words[3]

Nurse reported:

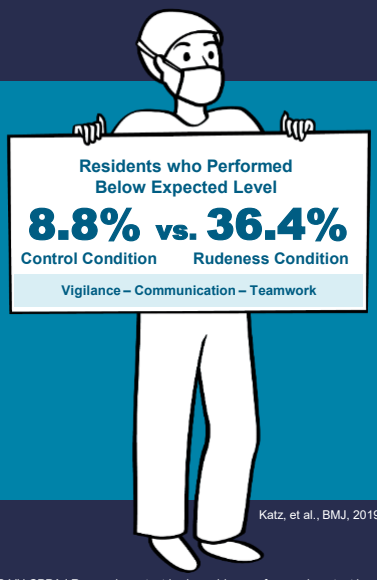
"We discussed the plan of care. Dr. Y was confused, had to be directed twice to the patient's room." (EXECUTIVE FUNCTION)

[3] Cooper, et al., American Journal of Geriatric Psychiatry, 2018

 10

10

Impact of Rudeness on Performance



Individuals exposed to rudeness during an emergency were 4 times more likely to underperform.

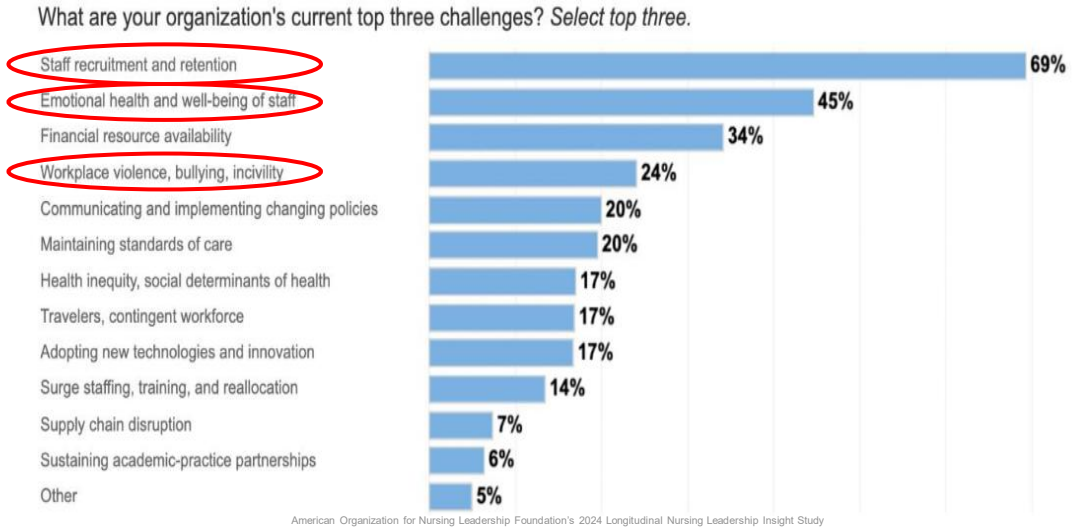
Katz, et al., BMJ, 2019 | Weinger, et al., Anesthesiology, 2017

Teams exposed to disrespect don't share information and don't seek help, and as a result the team underperforms.

Riskin, et al., Pediatrics, 2015

11

Nurse Leaders are uniquely positioned but equally challenged when trying to address these behaviors…



American Organization for Nursing Leadership Foundation's 2024 Longitudinal Nursing Leadership Insight Study

12

VitalSmarts, AORN, & AACN present:

The Silent Treatment

Why Safety Tools and Checklists Aren't Enough to Save Lives

David Maxfield, Joseph Grenny, Ramón Lavandero, and Linda Groah

But wait, how do you get team members to report?

It requires trust…

…Of those who have witnessed:

- Disrespect
- Incompetence
- Dangerous Shortcuts

Less than **35%** spoke to the person or shared their concerns...

Maxfield, et al., VitalSmarts, AORN & AACN, 2010

13

13

A Barrier to Address...

When asked:

"Choose the most important reason [you] did not report…"

It's All About Trust

Cole, et al., J Nurs Manag, 2019

14

14

Reporting Unprofessional Conduct in Healthcare

Reporters considered…
- Concern for coworkers **(52%)**
- Patient safety **(38%)**
- Possible retaliation **(32%)**

This wasn't the first time…
- "I spoke to them, did it anyway…" **(56%)**
- "Didn't report the first 20 times…" **(26%)**

For those who reported…
- Confident it would be addressed **(82%)**
- Confident something would change **(96%)**

But how many remain silent?

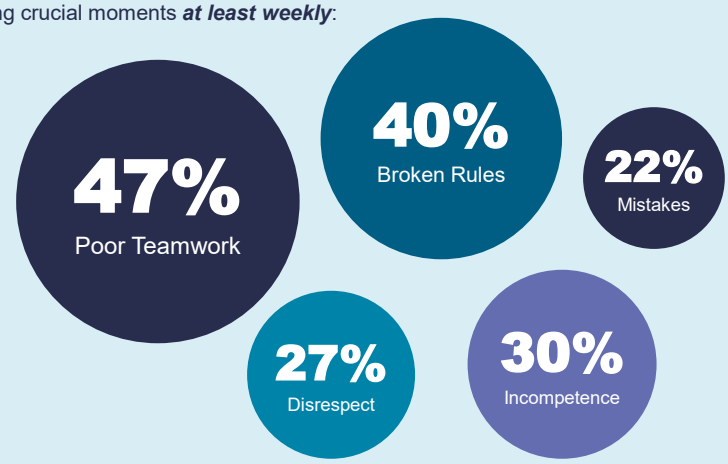
Webb et al., BMJ Open Quality, 2026

15

15

Witnessing Crucial Moments

Study of 3,500 individuals, consisting of registered nurses, administration/frontline leaders, and physicians. Below is the percentage of those individuals who witnessed the following crucial moments ***at least weekly***:



Grenny, et al., AJCC, 2026

16

16

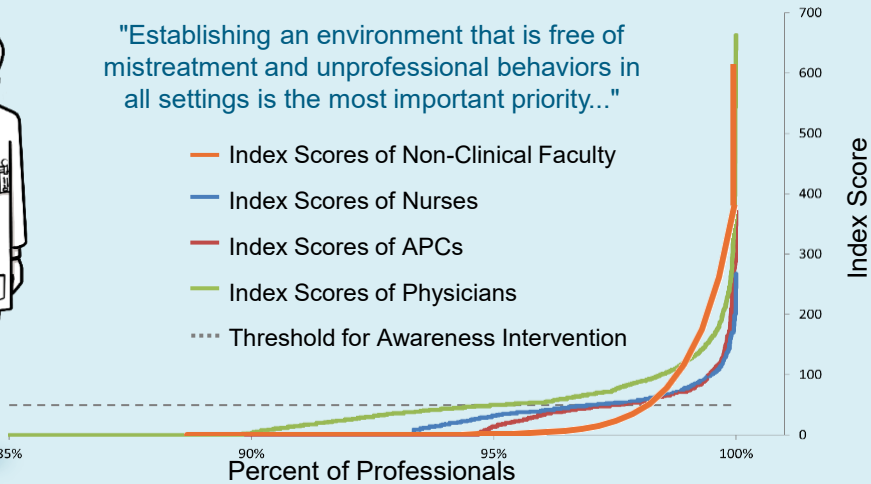
Deciding Whether to Address

Studer, et al., June 2009 | Hickson, et al. Ntnl. Pt. Safety Fnd. Stand Up for Pt. Safety Resource Guide, 2008 | Pichert, et al., Handbook of Human Factors and Ergonomics in Healthcare and Pt. Safety, 2007

17

Report Distribution is Similar for All Professionals
(National Coworker Observation Database)

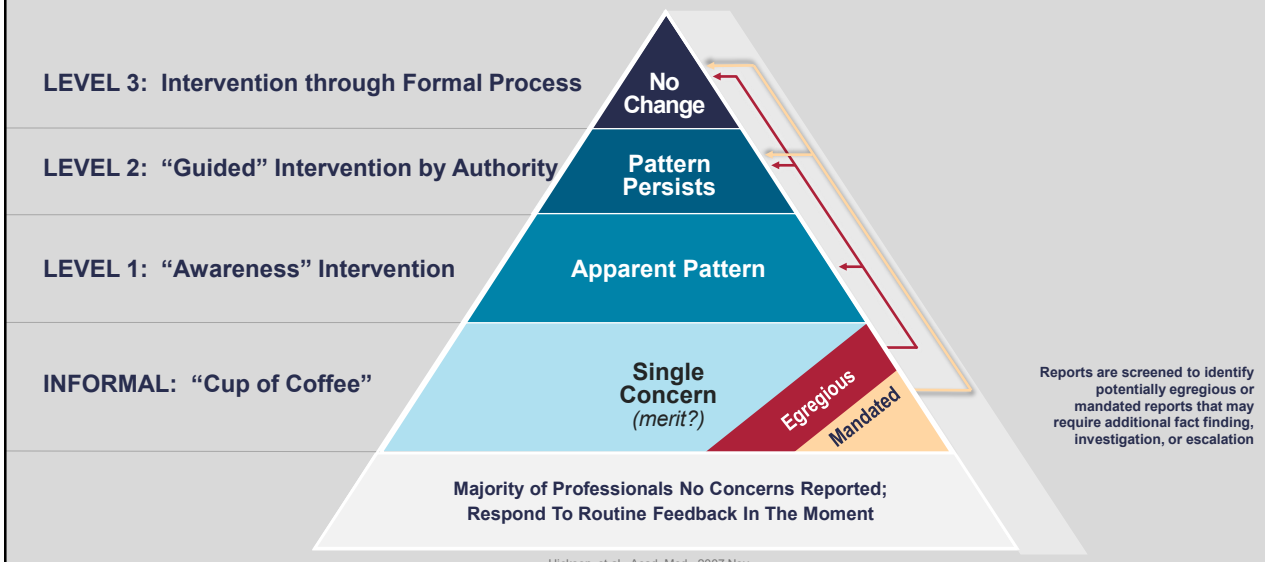
"Establishing an environment that is free of mistreatment and unprofessional behaviors in all settings is the most important priority..."



Webb, et al., The Joint Commission Journal on Quality and Patient Safety, 2016 | Martinez, et al., Journal of Patient Safety, 2018
Cooper, et al., JAMA Surgery, 2019 | Baldwin, et al., The Joint Commission Journal on Quality and Patient Safety, 2022 | Leitman, et al., Jama Network Open, 2022

18

CPPA's Approach: Promoting Professionalism Pyramid

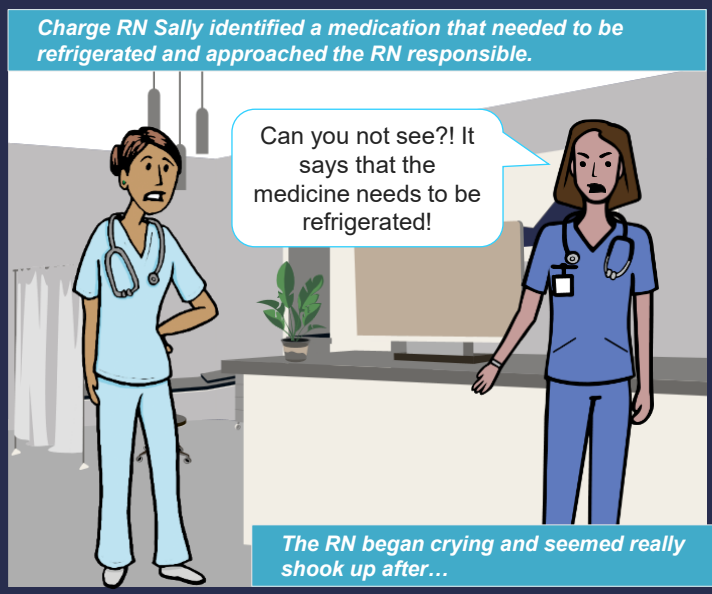


Hickson, et al., Acad. Med., 2007 Nov

19

19

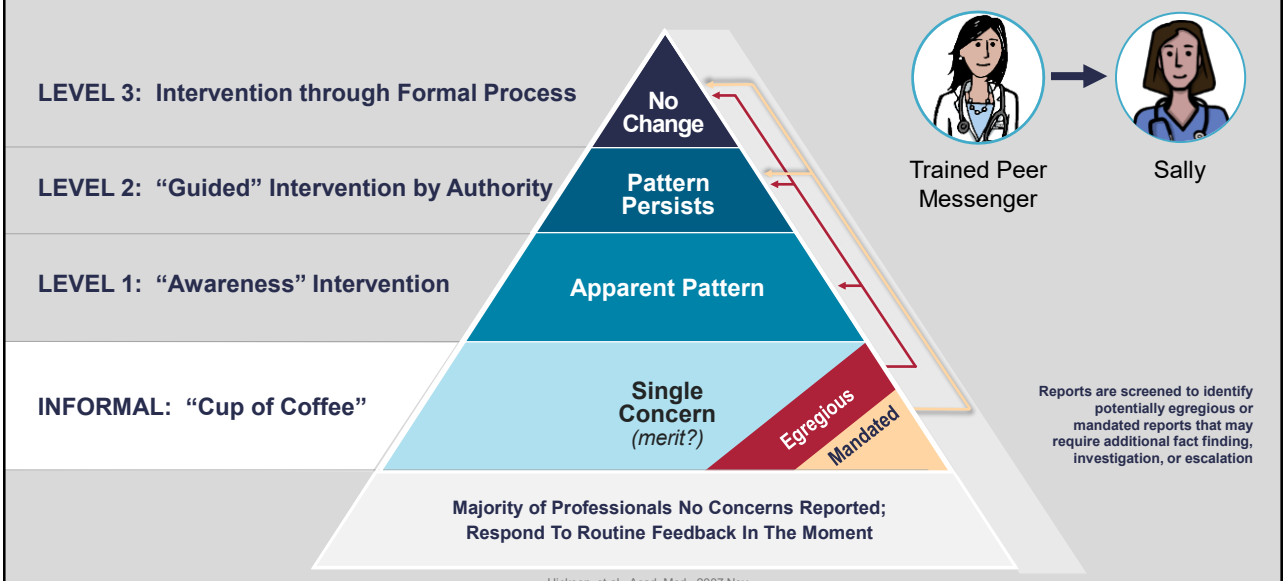
Sally: *A colleague observes…*



20

20

CPPA's Approach: Promoting Professionalism Pyramid



Hickson, et al., Acad. Med., 2007 Nov

21

21

Elements of *"Informal"* Conversations

Elements of a Cup of Coffee

- I am here as ____ (peer, professionalism committee, etc.)
- You are an important team member…
- I observed/received a report…wanted you to know
- We are committed to sharing…
- We don't investigate… two sides to every story
- Inconsistent with our core values…
- …could this have gone differently

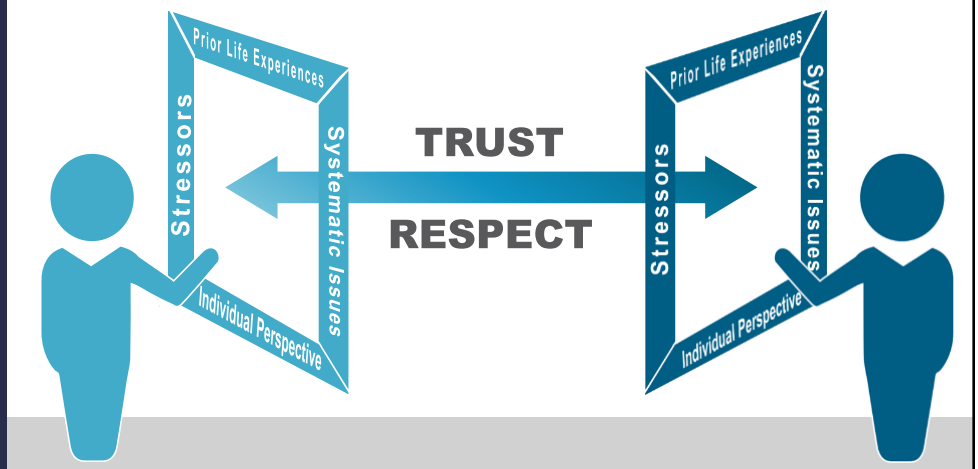
Hickson, et al., Acad. Med., 2007 Nov | Dubree, et al., American Nurse Today, 2017 May

22

22

"Two Sides of the Story"

How do we consider professional accountability in this context?



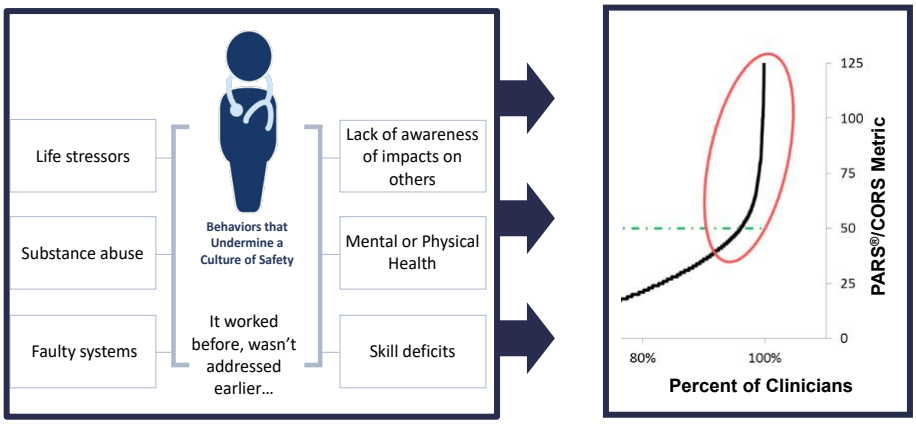
Filut, JNMA, 2020 | Shen, J Rac Ethn Disp, 2018
Weech-Maldonado, et. al., MedCare50, 2012
Mead & Roland, BMJ, 2009

23

23

The High-Risk Clinician

High Risk Clinicians can be affected by a number of influences…



Samenow, et al., Physician Executive, 2008 | Cooper, et al., American Journal of Geriatric Psychiatry, 2018 | Stimson, et al., J Urol., 2010
Moore, et al., Vanderbilt Law Review, 2006 | Cooper, et al., JAMA Surgery, 2017

24

24

Sally's Reports Continue

Nurse Reports: "I asked Sally for help because I had two discharges to finish and an admission coming up simultaneously. She said, 'We're all buried today. Figure it out.'"

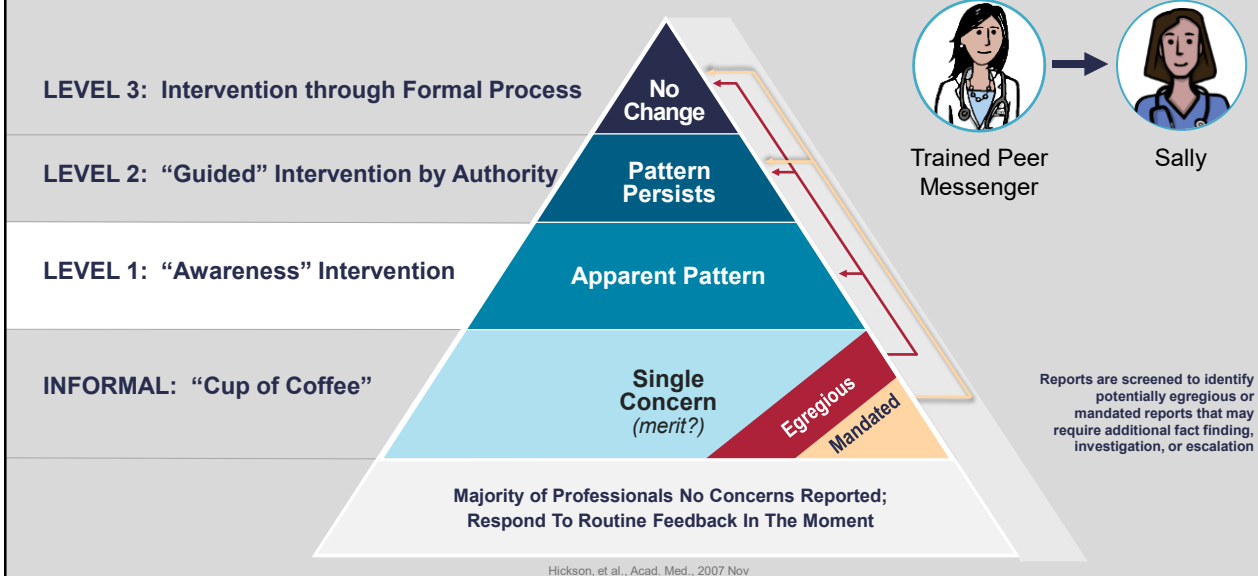
Transporter Reports: "When I brought the patient, Sally raised her voice and said, 'Why did you send them up before the room was cleaned? You know we can't take patients into a dirty room!' I tried to explain that as a transporter I was simply doing what I was asked."

Resident Reports: "I asked Sally to assist with a bedside procedure, but she completely ignored the request. She didn't acknowledge me at all, she walked away without saying anything."

25

25

CPPA's Approach: Promoting Professionalism Pyramid



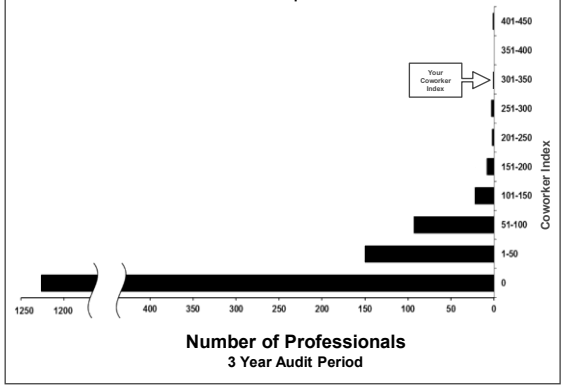
Hickson, et al., Acad. Med., 2007 Nov

26

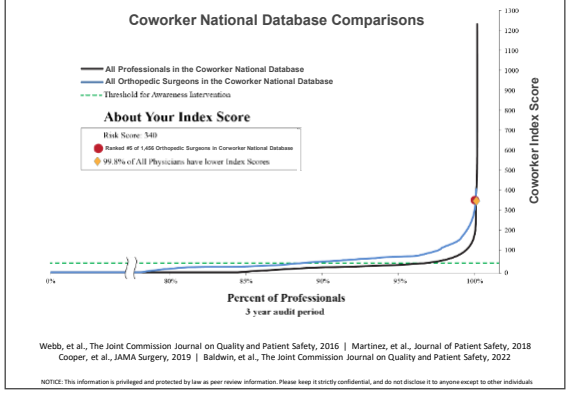
26

Coworker Awareness Intervention Tools

Local Comparison

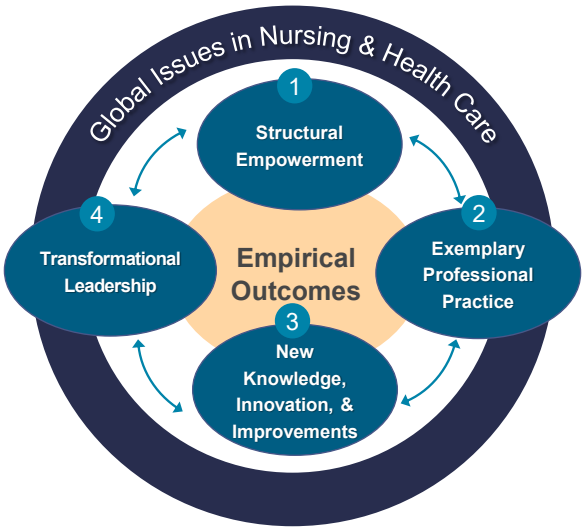


National Comparison



Webb, et al., The Joint Commission Journal on Quality and Patient Safety, 2016 | Martinez, et al., Journal of Patient Safety, 2018
Cooper, et al., JAMA Surgery, 2019 | Baldwin, et al., The Joint Commission Journal on Quality and Patient Safety, 2022

Aligning Values: Magnet and a Professional Accountability Model are both about empowering nurses



The magnet framework and foundation

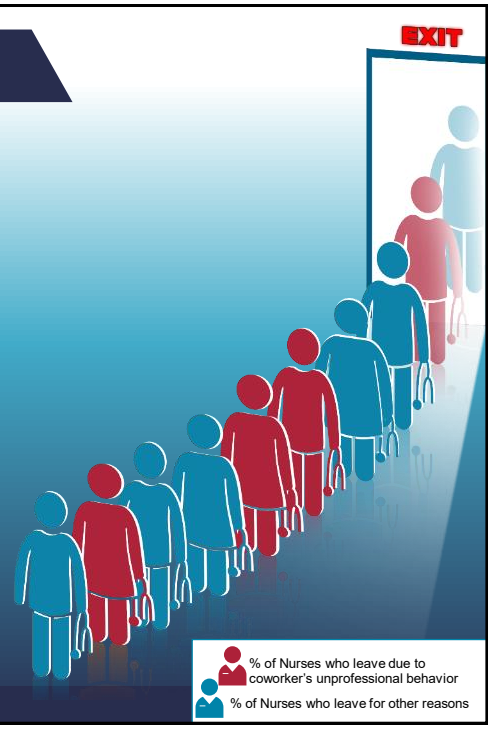
1. Shared decision-making
2. Autonomy, personal development, self-evaluation and awareness
3. Improved outcomes
4. Empowerment of staff… peers

Baldwin, et al., The Joint Commission Journal on Quality and Patient Safety, 2022 | ANCC American Nurses Credentialing Center, 2019 | Porter-O'Grady, et al., Nurs Manage, 2019 | Bashaw, et al., Nurs Manage, 2012

Annual Costs of Nursing Turnover

Medical Center	Total RNs	Total leaving annually (17.6%)[1]	Estimated Cost @ $60,090/ Nurse[1]	20% of turnover associated with Unprofessional Behavior[2]
VUMC	6,800	1,197	$71.9M	$14.4M
HOSPITAL B	8,900	1,566	$94.1M	$18.8M
HOSPITAL C	3,000	528	$31.7M	$6.3M
HOSPITAL D	4,200	739	$44.4M	$8.9M

Baldwin, et al., The Joint Commission Journal on Quality and Patient Safety, 2022 | NSI, 2026[1]
Shah, et al., JAMA Netw Open, 2021[2] | Sauer & McCoy., Nurs Econ, 2018[2]



29

What If a Change of Culture Could...

Support Nurse Retention?

What other benefits might you see?

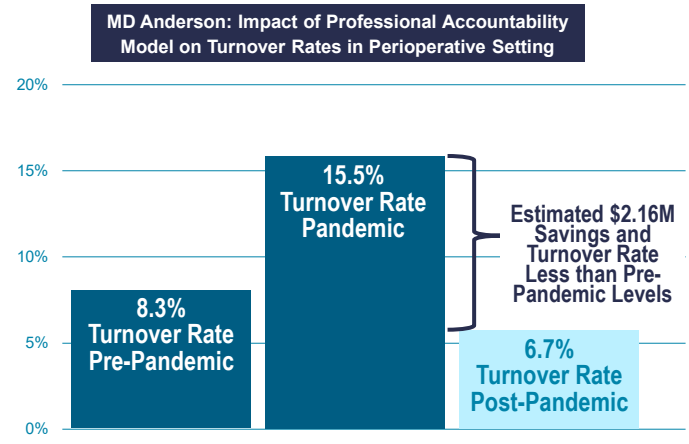
- Quality Outcomes
- Safety Culture
- Staff engagement and satisfaction
- Travel nursing costs
- Continuity of care
- High Reliability

Baldwin, et al., The Joint Commission Journal on Quality and Patient Safety, 2022
Arnetz, et al., Journal of Nursing Care Quality, 2019 | Braithwaite, et al., BMJ, 2017
Nelson-Brantley, et al., The Journal of Nursing Administration, 2018

 30

30

Value of Culture & Team Engagement: MD Anderson Reduction in Staff Turnover

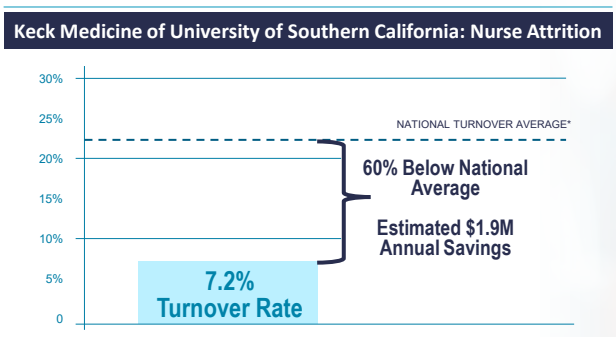


> *We recommend hospital organizations consider implementing appropriate organizational approaches to ensure lapses in professionalism are addressed early in order to enhance workplace culture, employee well-being and patient safety.*

Wright, et al., Joint Commission Journal on Quality and Patient Safety, 2024 | Hickson, Joint Commission Journal on Quality and Patient Safety, 2024

31

Culture & Team Engagement



Ashley, Becker's Hospital Review, Jan 2024 | Gooch & Kayser, Becker's Hospital Review, Dec 2023 | *NSI, 2023

32

VUMC Professional Accountability Model

WHAT OUR MODEL HAS TARGETED	DOES IT WORK?	THE RESULTS
Improve and sustain hand hygiene practice	✓	From 50% to > 95% compliance [1]
Reduce malpractice claims expenses	✓	By >70% [3, 4]
Improve unprofessional behavior towards patients and coworkers	✓	Approximately 85% of professionals improved [2, 4]
Improve and sustain vaccination compliance	✓	From 80% to 97% [5]
Adhere to surgical bundles to reduce infections	✓	Improvement [5]

1 Talbot, et al., Infect Control Hosp Epidemiol, 2013
2 Schaffner, et al., JAMA, 1983 | Ray, et al., JAMA, 1985 & 1986
3 Catron, et al., Am J Med Qual, 2016 | Webb, et al., Joint Commission, 2016
4 Hickson, et al., JAMA, 2002 | Hickson, South Med J, 2007 | Pichert, AHRQ, 2008 | Hickson, Jones & Bartlett Publishers, 2012 | Pichert, Jt Comm Jnl, 2013 | Webb, et al., Joint Commission, 2016
5 Talbot, et al., Infect Control Hosp Epidemiol, 2021

33

VANDERBILT HEALTH | Center for Patient and Professional Advocacy

Thank You

Follow us on LinkedIn

34