NATIONAL REPORT OF FINDINGS 2016

ISSUE BRIEF No. 8

PROFESSIONALISM

ACGME

Issue Briefs

The CLER Program presents this series of Issue Briefs to supplement the *CLER National Report of Findings 2016*.

Each issue in the series features one of the focus areas of the CLER Program—supplementing the key challenges and opportunities highlighted in the National Report and enhancing the discussion as to their relevance and potential impact on GME and patient care.

In both the National Report and the Issue Briefs, the findings are based on data collected during the CLER site visits, including responses to closed-ended questions collected via an audience response system, open-ended structured interviews with the clinical site's executive leaders and leaders in patient safety and health care quality, and information gathered from the many individuals interviewed during walking rounds of the site's clinical units.

Background

The ACGME established the CLER Program to provide formative feedback that presents graduate medical education (GME) leaders and the executive leadership of the clinical learning environments (CLEs) for GME with information on six areas of focus: **patient safety, health care quality, care transitions, supervision, duty hours/fatigue management and mitigation, and professionalism.**[1,2,3]

The *CLER National Report of Findings 2016*[4] presents information from the first set of CLER site visits to participating sites of 297 ACGME-accredited Sponsoring Institutions of residency and fellowship programs. These visits, conducted from September 2012 through March 2015, focused primarily on teaching hospitals, medical centers, and ambulatory sites that host three or more core residency programs.

In the group sessions conducted during these visits, the CLER teams collectively interviewed more than 1,000 members of executive leadership (including CEOs), 8,755 residents and fellows, 7,740 core faculty members, and 5,599 program directors of ACGME-accredited programs in the group sessions. Additionally, the CLER teams interviewed the CLEs' leadership in patient safety and health care quality and thousands of residents and fellows, faculty members, nurses, pharmacists, social workers, and other care providers while on walking rounds of the clinical areas.

OVERARCHING THEMES OF THE NATIONAL REPORT OF FINDINGS

The initial visits of the CLER Program revealed a number of findings that appeared to be common across many of the CLEs and six focus areas.

- Clinical learning environments vary in their approach to and capacity for addressing patient safety and health care quality, and the degree to which they engage residents and fellows in these areas.

- Clinical learning environments vary in their approach to implementing GME. In many clinical learning environments, GME is largely developed and implemented independently of the organization's other areas of strategic planning and focus.

- Clinical learning environments vary in the extent to which they invest in continually educating, training, and integrating faculty members and program directors in the areas of health care quality, patient safety, and other systems-based initiatives.

- Clinical learning environments vary in the degree to which they coordinate and implement educational resources across the health care professions.

In addition to serving as a basis for the overarching themes, the initial CLER visits sought to establish baseline structural and operational characteristics of the clinical sites, as well as their training practices in the six focus areas for residents and fellows. In future cycles, the CLER Program will also seek to understand how the sites identify and prioritize areas for improvement and assess progress over time.

Professionalism

A STORY FROM THE FIELD

In a group discussion during one of the CLER visits, a resident mentioned that his attending physician asked him to code as many diagnoses and co-morbidities as possible for each patient in order to maximize the billing claims. The resident went on to note that, on occasion, the attending physician would ask him to add a diagnosis that the resident felt was not indicated. The resident said that his attending physician was not pleased when he questioned him about this documentation practice. He noted that the attending physician went on to state that the hospital's billing department viewed this as appropriate, that this practice was common, and told him not to be concerned. The resident said that when he mentioned this to his senior resident, he was told not to do any coding that made him uncomfortable.

The story above highlights several issues regarding professional behavior and expectations for residents and fellows, GME leaders, and the CLE in which they are working and learning. This resident was placed in the uncomfortable situation of being asked to document in a manner that fulfilled his attending physician's desire to maximize patient billing, while believing that some of the documentation was not a true representation of the care provided.

In this story, the resident was placed in a position in which he believed he knew the right thing to do for the care of the patient, but systemic barriers inhibited pursuit of a satisfactory resolution of his concern. This situation is consistent with the concept of moral distress.[5] The resident may have felt that voicing concerns about the perceived inappropriateness of coding could result in retaliation having far-reaching effects. Residents' inability to raise concerns may lead to undesirable behaviors that may continue to manifest throughout their careers.[6]

This story also raises issues of over-coding or up-coding, which could indicate inappropriate billing practices. The attending physician noted he was following what he believed was appropriate practice. In addition, when the resident raised concerns to his senior resident, the senior resident's response appeared to be supportive but did not address the underlying apparent concern of billing impropriety. This response did not fully address the underlying concern, and may indicate that the CLE manifested an environment where the senior resident was intimidated, unprepared, or unable to directly deal with the issue. Alternatively, the CLE's expectations with regard to coding and billing practices may have been unclear. The story illustrates that ambiguity about the expected manner with which to deal with situations such as this scenario can lead to perceived or actual issues of professionalism in the CLE.

The concept of professionalism encompasses a number of attributes. The *CLER National Report of Findings 2016* presents data focused on issues of honesty, integrity, and mistreatment. The sections that follow highlight several examples of the detailed information found in the National Report and expand upon the areas identified as challenges and opportunities.

Selected Findings

Figures 1-3 present data based on group interviews with residents and fellows, and conversations with physicians, nurses, and other health care providers on walking rounds of numerous clinical areas.

Across CLEs, nearly all residents and fellows reported that their clinical site provides a supportive, non-punitive environment for bringing forward concerns regarding honesty in reporting—a median of 95.2 percent (Figure 1).[a]

Figure 2 presents the distribution of CLEs by the percent of residents and fellows within their CLE who reported having felt pressured to compromise their honesty or integrity to satisfy an authority figure during their GME experience at the clinical site—a median of 14.3 percent.[a]

In nearly half of CLEs, some individuals reported observing or experiencing incidents of disruptive or disrespectful behavior across multiple clinical units (Figure 3); some of the behaviors were described as chronic, persistent, and pervasive.

Together, these findings indicate that while a majority of the residents and fellows across CLEs perceive an environment of professionalism, mistreatment of residents and fellows, nurses, and other clinical providers continues to exist across some CLEs. GME and CLEs are encouraged to continually explore opportunities for improvement and promote a system of integrity that contributes to high quality patient care.

[a] Distribution includes 90% or more of the 297 CLEs

Figure 1

Percentage of residents and fellows who reported that their clinical site provides a supportive, non-punitive environment for coming forward with concerns regarding honesty in reporting (e.g., patient data, duty hours): Distribution across CLEs
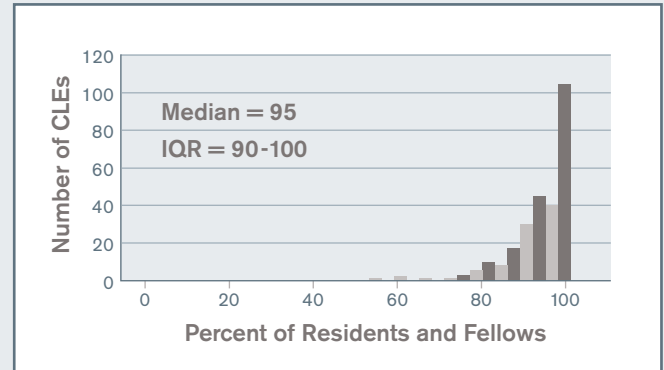

Figure 2

Percentage of residents and fellows who reported having felt pressured to compromise their honesty or integrity to satisfy an authority figure during their training at the clinical site: Distribution across CLEs
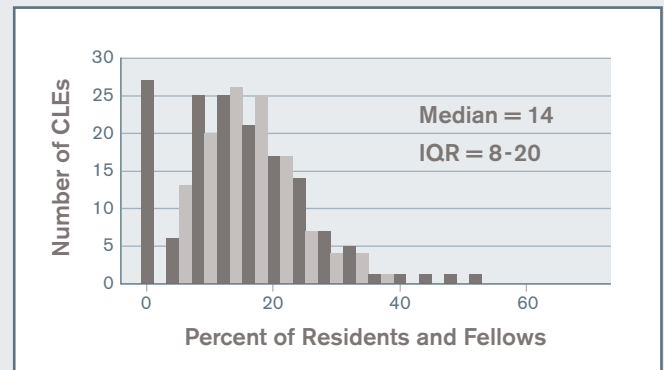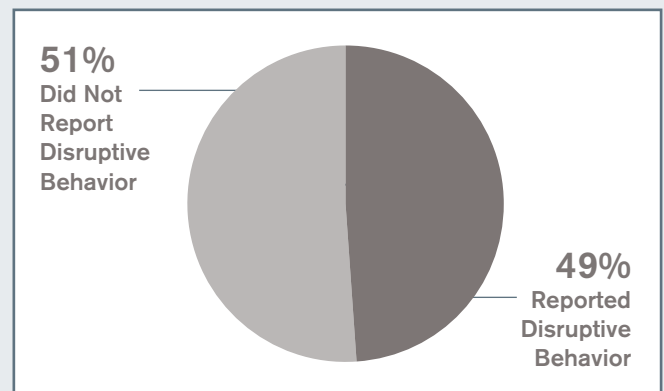

Figure 3

Percentage of CLEs where disruptive or disrespectful behavior was reported across more than one clinical unit

51% Did Not Report Disruptive Behavior

49% Reported Disruptive Behavior

Challenges and Opportunities

For the National Report, the members of the CLER Evaluation Committee reviewed aggregated data and selected three to four key findings to highlight and discuss. The following section expands upon the information presented in the National Report to include additional selected findings and a more in-depth discussion regarding the potential impact on patient care and resident and fellow education.

Across nearly all CLEs, residents, fellows, and faculty members reported that they had received education about professionalism. For residents and fellows, this education most frequently occurred at orientation and through subsequent annual online modules.

Generally across CLEs, residents and fellows reported that overall they work in a respectful environment.

Across CLEs, nurses indicated that, in general, they are able to establish respectful relationships with the residents and fellows.

Across some CLEs, residents, fellows, and clinical staff members described witnessing or experiencing incidents of disruptive or disrespectful behavior on the part of attending physicians, residents, nurses, or other clinical staff members. These ranged from descriptions of isolated incidents to allegations of disruptive behavior that were chronic, persistent, and pervasive throughout the organization.

- Frequently, senior leaders were unaware of the extent of disruptive, disrespectful behavior described by the residents, fellows, and nurses.

- In clinical sites that have non-teaching physician staff members, in many of the CLEs, residents and fellows reported a higher level of disrespectful behavior from non-teaching as compared to teaching physician staff members.

Occasionally across CLEs, residents, fellows, and nurses indicated that the patient safety event reporting system was also used as a vehicle to report issues of disruptive or disrespectful behavior. Occasionally these systems were used to anonymously report issues relating to the attitude of residents, fellows, nurses, or faculty members that were perceived to be minor and not necessarily related to patient safety events. Executive leadership varied in awareness of the use of the CLE's patient safety event reporting system for these purposes.

Across CLEs, there was variability and often uncertainty as to the expectations, thresholds, and specific processes for nurses to escalate issues of perceived unprofessional behavior.

Across many CLEs, issues related to disrespectful behavior of faculty members were reported to be principally addressed informally within the department, and variably addressed at the level of GME or executive leadership of the CLE. Issues related to disrespectful behavior of residents and fellows were reported to be principally managed within the program and appeared to vary as to how often this knowledge was transmitted to GME or the executive leadership of the CLE.

Generally across CLEs, there appeared to be lack of coordination among GME, the CLE, and the medical school (when applicable) in addressing issues related to disruptive or disrespectful faculty members. Often, these issues appeared to be addressed through parallel activities with varying degrees of shared processes.

Some residents and fellows reported they have had to compromise their integrity to satisfy an authority figure. In many CLEs, leadership appeared to be unaware of this perception.

In most CLEs, residents, fellows, faculty members, and program directors appeared to lack a shared understanding of the process residents and fellows would follow to resolve perceived mistreatment if seeking assistance outside of the mechanisms offered by GME.

Across many CLEs, residents, fellows, faculty members, and program directors reported some degree of uncertainty about the source of the materials that they used to prepare for in-service or board examinations – specifically whether questions used in this preparation were available in the public domain.

Across some CLEs, residents and fellows reported documenting history and physical information in a patient's health record that they did not personally elicit (such as copying and pasting in the electronic health record (EHR)). Residents and fellows varied in their reports of whether they properly attached attribution to these copy and paste sections.

Discussion

The CLER site visits were designed to look at several selected topics in the realm of professionalism — including issues of honesty, integrity, and mistreatment. The National Report focuses primarily on how issues of professionalism are exhibited within the GME community, primarily among residents, fellows, and faculty members. The National Report also provides some insight to how professionalism is demonstrated among other clinical staff members within the CLE.

Generally, the findings suggest that CLEs are committed to providing a clinical and educational environment where professionalism is manifest. In considering the findings and the discussion below, it is important to note that across CLEs, residents, fellows, faculty members, and other health care providers in general described the overall culture of their learning and working environment as respectful and professional. It is in this context that the challenges and opportunities for improvement are brought to light.

While all CLEs have mechanisms to address disruptive and disrespectful behaviors, the findings suggest that existing mechanisms are not always effective. Even if a CLE has an aggressive system to deal with unprofessional behavior, that system is undermined if standards are applied inconsistently. Disrespectful behavior has wide-ranging implications across the CLE, particularly with regard to how it affects patient safety and staff morale. Dealing with unprofessional behavior in a decentralized, informal manner may prevent the CLE's executive leadership from being aware of this important patient safety vulnerability. Reporting unprofessional behavior through an explicit, standardized mechanism that is communicated to CLE executive leadership is a more effective means of ensuring consistency in addressing problems as well as improving patient safety throughout the organization. Disrespectful behavior will likely continue to persist and be tolerated until the CLE, GME, and patient safety leaders work together to make its elimination a high priority.

No CLE wants its personnel to compromise their integrity. The finding that some residents and fellows feel compromised in this regard suggests the need for further exploration. Absent robust attention to these issues, resident, fellow, physician faculty members, and other staff members may conclude that the system lacks integrity or makes exceptions capriciously.

For a CLE to create and sustain an optimal environment with regard to professionalism, it must first establish and maintain a just and fair culture that permeates the organization from the executive leaders to the front-line care providers. Essential to this culture is a recognition that all individuals are susceptible to human error. A broad commitment to a systems-based approach focused on prevention is more effective than an approach based on punitive or individually directed actions. Punitive or individually directed actions do little to improve future performance across the CLE. At the same time, clinicians in a just culture need to understand that they are accountable for deliberate unsafe actions and disrespectful behavior towards colleagues and patients.[7]

Unprofessional behavior manifests in various ways across CLEs. It ranges from subtle to overt behaviors and may be normalized in the culture — sometimes referred to as normalization of deviance. Some of these unprofessional behaviors may manifest themselves broadly across a CLE. Alternatively, some unprofessional behaviors may manifest in specific clinical service areas or be limited to specific groups

of the clinical care team. Also in the specific case of GME, unprofessional behaviors may become manifest when professional expectations have to be managed across more than one organizational entity. The most common example is a health care delivery organization and a medical school.

Recurrent unprofessional behavior adversely affects patients, staff members, and institutional culture, as well as resident and fellow learning. Disrespectful behaviors have been directly associated with worse patient outcomes and increased cost of care. Team members exposed to such behaviors suffer low morale and have higher turnover rates. Unaddressed unprofessional behavior leads to an intimidating atmosphere that results in suboptimal communication throughout the CLE, reinforces and emboldens others to behave poorly, and creates an environment that is the antithesis of the safety culture.

The optimal management of professionalism needs to be based on a model of continuous quality improvement. CLEs need to develop consistent standards and implement improvement activities to effect consistent use of these standards at all times. To that end, the CLE needs to continually examine what is being viewed as the norms of professional behavior. Most of those norms will reflect excellence in professional behavior. However, some of the norms may be the result of normalization of undesirable behaviors. In addition, CLEs need to continually monitor how well they are achieving their standards and to apply consistent responses to breaches of professionalism across the organization. Ultimately, the goal of a CLE is to create a shared commitment to and practice of well-defined and widely understood standards of professionalism.

The findings in the National Report also suggest that didactic and computer-based education are not sufficient to guide residents and fellows in important aspects of professionalism. CLEs are encouraged to improve resident and fellow learning about professionalism through planned experiential activities. Such training could include role modeling and procedures to address a diverse set of topics, such as safety culture, teamwork, patient interaction, cultural sensitivity, and diversity. Similarly, CLEs are encouraged to provide faculty development that involves experiential activities that promote role modeling of professional behavior with the goal of eliminating mistreatment of residents, fellows, and other clinical providers.

With regard to issues of mistreatment, there may be situations in which residents or fellows are uncomfortable pursuing resolution within the GME administrative structure. In these situations, the resident or fellow and the CLE are at high risk for an unfavorable outcome. While all CLEs have established confidential, non-punitive reporting mechanisms for handling unprofessional behavior, this does not ensure residents and fellows are familiar and comfortable with the reporting mechanisms outside of GME.

With regard to issues of honesty and integrity, the CLER Program's findings as to how residents and fellows may use questions that are not in the public domain to prepare for in-service and board examinations was met with a considerable amount of challenge from the GME community. Across CLEs, many of the GME leaders appeared to be unwilling to consider the possibility that there may be cheating in the form of inappropriate use of board exam questions occurring in their institution, even though this was recognized to be a national problem as recently as 2012.[8] GME programs could easily address this issue by clearly and unambiguously declaring the permitted source of all questions provided to residents and fellows for the purpose of preparing for in-service or board examinations.

The issue of copying and pasting within the EHR is particularly challenging, and can adversely impact patient safety.[9] Many CLEs have EHRs that carry forward clinical information and their policies and procedures relating to documentation are evolving rapidly. Currently, EHRs vary in the mechanisms available to mitigate the issue of copying and pasting. While in training, residents and fellows may view documentation more as a required inconvenience than an essential component of health care communication. Residents and fellows do not bill and therefore may not share their attending physician's views of charting as a means to justify the billing and reducing liability risk.[10] Experiential education could be used to demonstrate the hazards associated with copy and paste. An example of experiential education would be a simulation of a legal cross-examination or Centers for Medicare and Medicaid Services claims review, which could demonstrate the importance of accurate documentation.

Residents, fellows, and faculty members often do not feel a personal responsibility to attempt to resolve professionalism concerns that they know of but are not involved in directly. Unless each member of the care team embraces this responsibility, undesirable situations related to professionalism are tacitly reinforced and these concerning behaviors become part of the culture. This responsibility is particularly important for faculty members and CLE leaders as role models for professional behavior.

Conclusion and Next Steps

The first cycle of CLER visits explored selected topics of professionalism, including issues of honesty, integrity, and mistreatment. CLE and GME leaders, residents and fellows, and other clinical providers reported their environment to be one that is generally respectful of one's colleagues. At the same time, a number of areas related to professionalism emerged as opportunities for improvement. Perhaps most notable was the critical issue of mistreatment. Verbal or non-verbal mistreatment, when tolerated even at very low rates of occurrence, can create a culture that does not support honest and open communication. This is true across all levels of interaction within GME. It also applies to interactions across health professions (e.g., physicians and nurses). One critical component to prevent, manage, and mitigate these issues is to establish a close working relationship that defines appropriate behavior clearly, as well as define prohibited practices. Creating a culture of professionalism within the clinical learning environment is a shared responsibility between GME and CLE leadership.

Professionalism is not solely an individual responsibility; it is shaped by the environment. Unprofessional behaviors may be an unconscious reaction to task misalignment, inconsistent expectations for accountability, or clinical productivity pressures. CLEs have a responsibility to create environments where professionalism can flourish.

Across CLEs, other aspects of professionalism, whether related to communication, documentation, or attribution, could all benefit from continual, coordinated engagement of GME and executive leadership. While general education about professionalism is ubiquitous, to date, most of the efforts appear to be passive and episodic – and appear to be largely reactive. CLE and GME leaders need to actively collaborate to put in place systems that promote active experiential learning, proactive monitoring, and consistent approaches to addressing and eliminating unprofessional behaviors. The goal is to achieve and maintain a culture that supports safe, high quality patient care and sets an expectation for continuous professional development to ensure effective communication and cooperation among all health care providers.

Acknowledgments

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