“The Tipping Point”: Improving Mutual Respect AND Quality Care

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Session Overview:

- Establish the “respect – quality” connection
- “Attitude is Everything”
- The “Tipping Point” for mutual respect
- Leadership in the First Person
  - Accentuate the Positive, Eliminate the Negative
the definition of insanity

- doing the same thing over and over and expecting different results
- “if you always do what you always did, you’ll always get what you always got”
- “if you always think how you always thought, you’ll always do what you always did”
- “if we don’t want to think or act differently, then we are choosing,
  - ‘the insanity defense’
“Never underestimate that a small group of thoughtful, committed people can change the world... in fact, it’s the only thing that ever has.”

Margaret Mead
“The question is, how small can a small group be to make an impact?”

Dr. Brent James answer: \( \sqrt{n} \)

Where “n” = the number of physicians on your active medical staff
“Most Physicians Are Here... Everywhere”

Physicians range from... they’ll likely feel this way about many administrative initiatives...

- **Leaders** → “I want to help lead this”
- **Partners** → “Physicians should help lead”
- **Participants** → “When’s the next meeting?”
- **Lukewarm** → “What’s this meeting for again?”
- **Neutral** → “Sounds okay, but I’m too busy”
- **Skeptical** → “Show Me!”
- **Resistant** → “Here’s why not”
- **Hostile** → “If they’re for it, I’m against it”
“The question is, how small can a small group be to make an impact?”

Wong’s Answer: +10

The number of leaders/partners over and above
The number of “serial disruptors”
What is job number one in our medical community?

What is the ONE thing that all of us have in common?
Module One:
The “Respect – Quality” Connection
The “Respect – Quality” Connection

- Take a moment to think about one example in your own direct experience either as a patient, a family member or an employee where:
  - Lack of respect led to a bad outcome.
  - Demonstrated respect led to a good outcome
- Share this story with your table. (10 minutes)
- Select your table’s best story. (3 minutes)
- Be prepared to share best story with the larger group.
Report back: “no respect = poor quality”
Report back:
“no respect = poor quality”
Report back:
“no respect = poor quality”
Report back:
“no respect = poor quality”
Report back:
“demonstrated respect = quality”
Report back:
“demonstrated respect = quality”
Report back:
“demonstrated respect = quality”
Report back:
“demonstrated respect = quality”
Module two: “attitude is everything”

“skill is everything else”
How are we teaching and learning?
“Listen to the patient: He is telling you the diagnosis.”

Sir William Osler
(1849-1919)
“The Father of Internal Medicine”
What does suggest about how well we communicate/listen?

- Physicians + poor communication + malpractice: 29,100 hits
- Physicians + poor listening + malpractice: 22,800 hits
- Physicians + not listening + malpractice: 51,600 hits
Communication ≠ Conversation!!

1. “I talk, you listen
   - let me tell you something...
   - ...and please don’t interrupt me.”
2. “You talk, I’ll listen
   - Your opinion matters to me...
   - ...and I want to hear it!”
Consider this “universal situation”

- Dr. White the doctor on-call for the weekend admitted Mr. Greenbottom on Friday evening for Dr. Black
- Dr. Black is Mr. Greenbottom’s regular physician
- Mr. Greenbottom has known problems of heart failure and diabetes (complicated by peripheral vascular disease)
- He is admitted this time with “a cold blue leg”
- Dr. Gray, a vascular surgeon has already been consulted; a procedure was performed
- Dr. Gray has signed out for the weekend to Dr. Silver
- It is 6:45 a.m. on Monday morning
- Mr. Greenbottom develops a temp of 100.4 and hypotension; according to the nurse, “he just doesn’t look good”
Activity #1

- Form listening groups (4 people):
- Role #1: you are role-playing the nurse
- Role #2: you are the doctor who has been called
- 2 ‘non-conversers’ each pick a different person to observe
- Imagine for a minute this is a conversation that “does not go well”
- Role-play the conversation; you have up to 2 minutes
  - “Play it to the hilt”
Discussion

- Was it real?
- How did it feel?
- Was it productive or efficient?
- Did we get respect?
- Did we give respect?
- Did we help Mr. Greenbottom?
- Observers, what did you notice?
Meanwhile on the floor….

- Mr. Greenbottom’s family has arrived and recognizes “he just doesn’t look good.”
- They hear the phone calls on his behalf at the nurses’ station. They are furious at the hospital for its “poor care,” wonder where Mr. Greenbottom’s “regular doctor is.”
- They demand to talk to the “person in charge,” and make passing mention to Nurse Lawrence Nightingale that “we have lawyers.”
- Larry’s floor mate points out that he could call the risk manager, Abby Lincoln, who has a 24/7 cell phone.
- Legal counsel, Benita Franklin is available on a similar basis.
- The CNO, Ms. Ellie Roosevelt typically is in the hospital at about 0730,
- There has been an administrator-on-call, Mr. Juan Adams, on all weekend. He goes off-call at 0700.
- There is also a CMO, Dr. Fillmore.
- Choose your roles and continue the conversation… imagine this call also “does not go well”
Discussion

- Was it real?
- How did it feel?
- Was it productive or efficient?
- Did we get respect?
- Did we give respect?
- Did we help Mr. Greenbottom?
- Observers, what did you notice?
When things go really badly…

- Mr. Greenbottom dies.…
- A lawsuit is filed… XYZ Hospital loses a huge jury award
- The Greenbottom Foundation becomes an aggressive patient-communication advocate.
- The Mutual Respect for Patient Safety Act, cosponsored by Senators Clinton and Frist, (aka: Greenbottom’s Law) is signed by President Bush on 01/19/08…. 
“Greenbottom’s Law”, paragraph 2, section III, items i – m.

i. All outgoing calls to on-call MDs will be logged and recorded for future review by JCAHO and will be HIPAA compliant.

j. Any time a nurse calls a doctor, the doctor must, under penalty of practice data bank notification, respond with 300 seconds

k. Ensuing conversation must begin with a 30-second update by the calling party, followed by a response time of not less than sixty seconds by the callee. Subsequent to said response time, a followup set of questions must be allowed to the initial caller, with a consummation statement involving future action then determined by the callee (and entered into the medical record)

l. It is further mandated that decibel level meters will be installed on all hospital phones; whenever speaking volumes exceed 106 dBA, it will be automatically entered into the National Practitioner Data Bank as a potential violation

m. ETC....
“the hurrier I go, the behinder I get”
Activity #2: “Instant Replay”

- Form listening groups (4 people):
- Role #1: you are role-playing the nurse
- Role #2: you are the doctor who has been called
- 2 ‘non-conversers’ each pick a different person to observe
- Imagine for a minute this is a conversation that “goes extremely well”
- Role-play the conversation; you have up to 2 minutes
  - “Play it to the hilt”
Discussion

- How did it feel this time?
- How much longer did it take?
- What did you do differently?
- Which interaction was more “efficient”?
- Did we give respect?
- Did we get respect?
- Did Mr. Greenbottom get better care?
- Were there “downstream effects”?
What drove the outcome in these two conversations?

- Form listening groups (4 people):
  - Role #1: the nurse
  - Role #2: the doctor
  - 2 ‘non-conversers’ (observers)
  - Imagine for a minute this is a conversation that:
    - "does not go well"

- Same structure
- Same nurse
- Same doctor
- Same observers
- Imagine for a minute this is a conversation that:
  - "goes extremely well"
Other discussion questions

- For the time when “it did not go well”, how did these conversations conflict with our mission statements?
- For the time when “it went well”, how did these conversations align with our mission statements?
Other discussion questions

- What are we likely to say about “the other person on the line” after hanging up the phone?
  - When it “did not go well”
  - When it went “extremely well”

- What impact could that conversation have “on the rest of our day?”
  - When it “did not go well”
  - When it went “extremely well”

- How likely might we be inclined to refer a patient to the physician
  - When it “did not go well”; what if the only other option was “50 miles away?”
  - When it went “extremely well”
Other thoughts/comments?
Let’s hear from the observers.

- What were you thinking?
- What helpful behaviors did you observe?
- What harmful behaviors did you observe?
- Would you share your observations without being asked?
- If you were asked, how would you articulate what you noticed?
The beauty of coaching…

- When invited, observers go from passive opinion holders to conversation allies….they help create the good conversation.
- Coaches see you from a different angle…and allow you more insight.
- They add “blind spot” perspective to your good intent.
- They can contribute skill if they are willing to teach and you are willing to learn.
- They remind you of why you’re here and how it blends with the rest of the team.
Five “take home” lessons

1. Attitude – “yours”
2. Attitude – “theirs”
3. Attitude – “ours”
4. Listening (especially without judgment) >>>>>> speaking
   - “staying in the conversation”
   - “find out more”
   - “find out why”
5. Informal, on-the-spot, coaching
Short Break
Module Three:
The Tipping Point for Mutual Respect:
“How little things can make a big difference”

Adapted from “The Tipping Point”,
by Malcolm Gladwell
...is that magic moment when an idea, trend, or social behavior crosses a threshold, tips, and spreads like wildfire.
New York City, c. 1980

- NYC: 2,000 murders/year
- NYC: 600,000 felonies/year
- NYC Subway System:
  - All 6,000 subway cars covered with graffiti from top to bottom, inside and out
  - 500 “red tape” areas in the system, forcing the subway to slow < 15 mph
  - $150 million in lost revenue due to “fare-beating”
  - 20,000 felonies/year in the subway system alone
Enter David Gunn, c. 1984 new subway director

- Told to focus on “the big issues”
- “graffiti was symbolic of the collapse of the system”
- Set up a “cleaning station” in Harlem on 135th St.
  - Dirty cars immediately removed from service
  - All graffiti was immediately removed before putting the car back into service
  - Only clean cars were put into operation
Followed by William Bratton in 1990
Head of the Transit Authority Police

- Thousands entering the system without paying a token
  - $1.25/token
- Identified high risk stations
- Stationed up to 10 officers in plain clothes at these stations
- Fare-beaters were apprehended, handcuffed and paraded on the platform until they had a “full catch”
- Converted a city bus into a mobile station house
NYC today: impact on graffiti

• Cars are clean, well-maintained and climate controlled
• Subways reach a top speed of 40 mph with few disruptions in service
NYC today: impact on crime

NY Times: Crime Drops for 17th Consecutive Year; 01/04/06
Application of “The Tipping Point” to Healthcare:

What’s our version of graffiti and fare-beating?
Breakout session: discussion, validation and application

- Take a moment as an individual and write down your thoughts on the following:
  - possible current behaviors that might be the Healthcare equivalent of graffiti, fare-jumping or broken windows
  - **Negative, pervasive, tolerated, high impact, reversible and observable behaviors**

- Share this with your table

- Report back:
  - A table consensus of the “top 5” Healthcare equivalents to graffiti (in six words or less for each item)
Report back: Graffiti in Healthcare
Report back: Graffiti in Healthcare
Now, imagine a future where these behaviors were ELIMINATED in Healthcare...

What would that look like, sound like and feel like?
What can we do/say when we see these behaviors in the future?
From a “Culture of NO” to a “Culture of YES”
Module Four: Leadership in the First Person

Accentuate the Positive
Eliminate the Negative
Can you eliminate the negative by only accentuating the positive?
Audience participation…

Do you believe in 3 strikes and you’re out?
How about 4 strikes?
6 strikes?
16 strikes?
The “Rodney King” Commission:
LAPD, 1986-1990; n=8500 Police Officers
# complaints: excessive force or improper tactics

- 6700 officers with 0 complaints (~80%)
- 1800 officers with at least one complaint (~20%)
  - 1400 officers with 1-2 complaints (~16%)
  - 183 officers with ≥ 4 complaints (~2%)
  - 44 officers with ≥ 6 complaints (~0.5%)
  - 16 officers with ≥ 8 complaints (~0.2%)
  - 1 officer with 16 complaints (~0.0001%)

3% of all officers responsible for 37% of complaints
“Aren’t you just trying to unfairly ‘single out’ a few physicians?”

Answer: Singling out unacceptable behavior is different from singling out individuals.
"All that is necessary for the triumph of evil is that good men do nothing."

Edmund Burke
(1729-1797)
The Return of the Jedi:
*Identify, develop and grow your physician leaders*

“Leadership in the First Person”
PMC’s PALs: Physician Advisory Leaders

- Role of the Physician Administrative Liaisons/Leaders (PALs) is to provide sound advice and insight to support the board and administration on matters related to strategic direction and planning

- in addition, to:
  - Represent the LARGER COLLECTIVE INTERESTS of the medical community
  - Foster effective communication with other members of the medical staff
  - Build trust with all parties, including the board, admin, staff and other physicians
  - Promote mutual respect among all parties
  - Serve as an ambassador and positive agent for change at Parrish
Selection Criteria for PALs

1. Member in good standing on the active medical staff
2. Respected by and respectful of all key stakeholders
   - Objectivity: take an evidence-based approach
   - Listen to other points of view
   - Part of the solution
   - Open to new ideas developed collaboratively between physicians, the board and administration
   - Treat others the way THEY want to be treated (the Platinum Rule)
3. Positive & optimistic attitude
4. Take the time to attend, prepare, participate and improve themselves
What none of us were taught in medical school

1. Personal Leadership
2. Personal Communication
3. Team Leadership
   - Single teams
   - Multiple (interdisciplinary) teams
4. Organizational Leadership
5. Strategic Leadership
6. Change Leadership
“Leadership is about what you stand for…

…and what you won’t.”

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