Fostering Psychological Safety: A key driver of patient safety, the learning environment, and our wellbeing

Jo Shapiro, MD, FACS

Associate Professor, Otolaryngology Head and Neck Surgery

Harvard Medical School

Massachusetts General Hospital

Department of Anesthesia, Pain Medicine and Critical Care

Principal Faculty, Center for Medical Simulation

Boston, MA

Thank You

Dean Lee Hamm
Mary Killackey
Jenny Gibson
Bethany Branson
The Tulane SOM Professionalism Program
All of You

I have nothing to disclose

Team Sport

CMS: **Jenny Rudolph, Janice Palaganas, Laura Rock, Rebecca Minehart Dan Raemer, Jeff Cooper**

Allan Frankel

Tony Suchman
Diane Rawlins

Jerry Hickson

Photo by Mitchell Luo on Unsplash

Pamela Galowitz

Think of a time …

The dark side

Photo by NASA on Unsplash

Dr. Demeaning

An attending physician has repeated demeaning behaviors towards residents and other HCT members– in tone, body language, and content.

- *Expresses **impatience** with questions*
- ***Denigrates** their competence*
- ***Sarcastic** statements about motivations*
- ***Blames** them if something goes wrong*

*HCT members are **afraid** of them*

Psychological Safety: Making the Case

- Culture of psychological safety drives safe care delivery, clinician well-being and learning environment
- Culture is dynamic and changeable
- Unprofessional behaviors erode trust and creates fear
- Both individuals and organizations can build psychological safety

Mass General Brigham

What is Culture?

What is Culture?

“The organization's culture consists of patterns of relating that persist and change through ongoing interaction.”

- Tony Suchman, MD
J Gen Intern Med. Jan 2006

Team Psychological Safety

shared belief in interpersonal safety within the team

"…sense of confidence that the team will not embarrass, reject, or punish someone for speaking up."

"…stems from mutual respect and trust among team members."

A. Edmondson Psychological Safety and Learning Behavior in Work Teams 350/Administrative Science Quarterly, 44 (1999): 354

Just Culture: Learning and growth mindset

- All feel safe talking about error
- Do not punish for human error (or for choices made in the face of legitimate competing priorities)
- Find and fix vulnerabilities in our systems and behaviors

Photo by Tingey Injury Law Firm on Unsplash

Leonard MW, Frankel A. Patient Education and Counseling 80 (2010) 288–292

Mass General Brigham

Dr. Demeaning

An attending physician has repeated demeaning behaviors towards residents and other HCT members– in tone, body language, and content.

- *Expresses **impatience** with questions*
- ***Denigrates** their competence*
- ***Sarcastic** statements about motivations*
- ***Blames** them if something goes wrong*

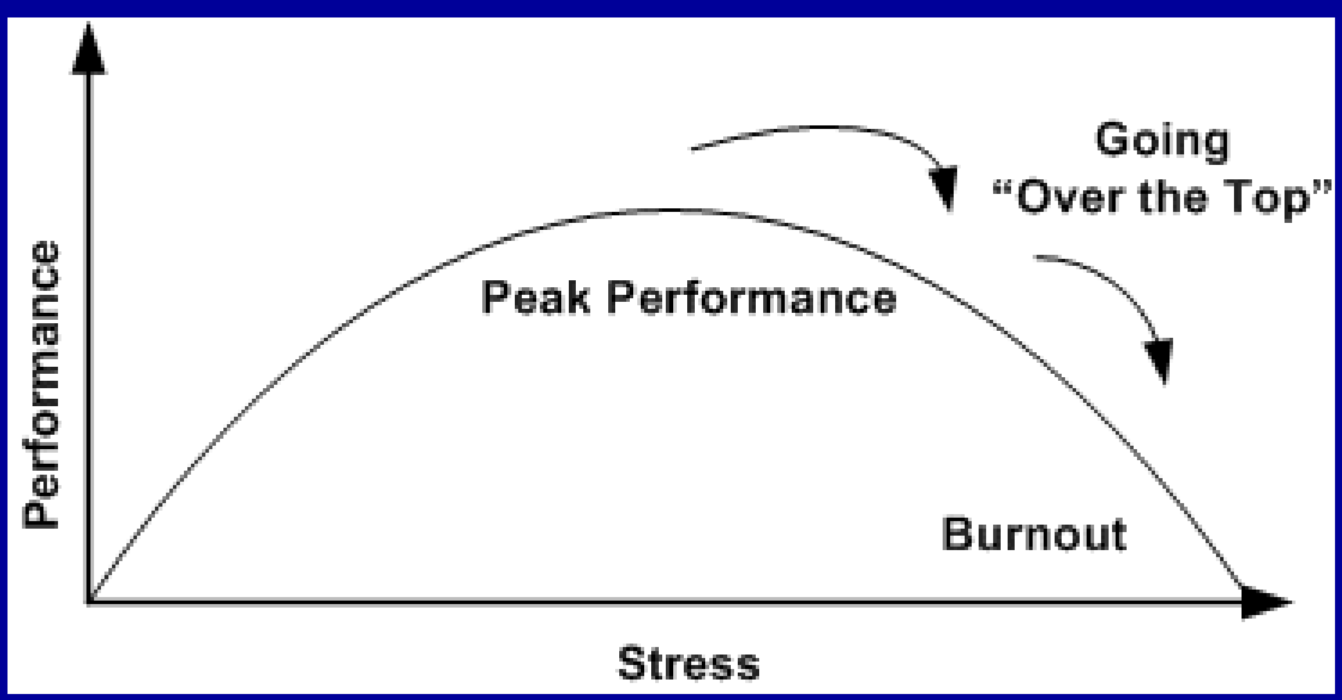
*HCT members are **afraid** of them*

Why have we tolerated all of this for so long?

Why have we tolerated this for so long?

- $
- Fear
- Justifications
- Tradition
- Missed connection to patient safety
- Lack of knowledge re effect on others
- Cultural relativism
- Myth of pedagogic rationale

Stress and performance



Yerkes Dodson Curve

Ideal learning state

Dexterous skill acquisition facilitated by the absence of strong arousals

Pavlidis I, Zavlin D, Khatri AR, et al.
Absence of Stressful Conditions Accelerates Dexterous Skill Acquisition in Surgery.
Scientific Reports;9:1747 (2019).

Emotional impact of errors on clinicians

- *Sadness*
- *Shame*
  - *Self-doubt*
- Fear
- Anger
- Isolation

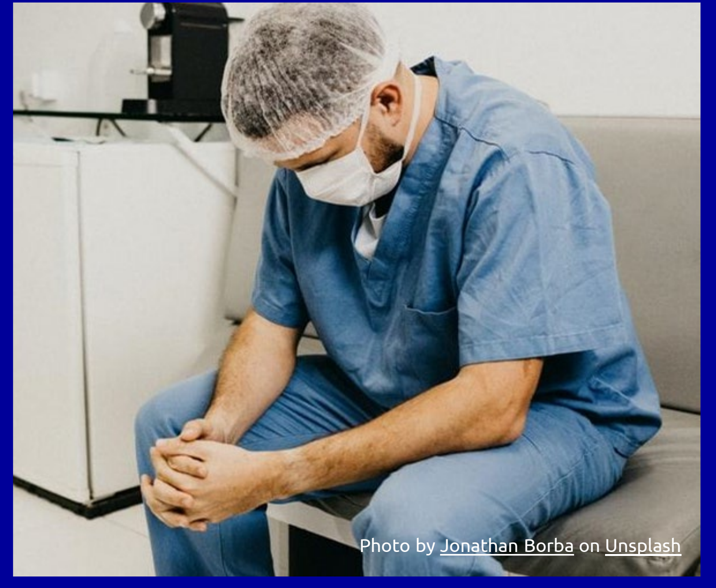


Photo by Jonathan Borba on Unsplash

Fantasy

No more shame and blame

We now have a Just Culture:
Personal accountability *and* systems accountability

Internal and external regulatory judgment and punishment

Photo by Adi Goldstein on Unsplash

- Event analysis: M&M, RCA
- Peer review
- Department of Public Health
- Inspectorate
- Royal College of Physicians and Surgeons
- Court of law
- Media

Unpacking culture

Professionalism
Conflict Management
Learning Environment
Psychological Safety
Teamwork
Event Analysis
Well-being
Peer Support

Trustworthy relationships

Types of Untrustworthy Behaviors

- Demeaning/Angry
- Blaming
- Harassment/ Discrimination
- Uncollegial
- Microaggressions

Unprofessionalism and Patient Care

3-5% of MDs

Demonstrate behavior that **interferes with patient care**

(Ann Intern Med. 2006;144(2):107-115)

National survey of 3,900 MDs, RNs, staff in hospitals

51%

Disruptive behavior
correlates with
patient safety compromise

71%

Disruptive behavior
correlates with
quality compromise

(Jt Comm J Qual Patient Saf. 2008;34(8):464-471)

Teamwork:
The dark side …

300 surgical cases: pts whose surgical teams exhibited less teamwork behaviors were at higher risk for death and complications

(Am J Surg. 2009 May;197(5):678-85)

Joint Commission Sentinel Event Alert

End intimidating and disruptive behavior among physicians, nurses, pharmacists, therapists, support staff and administrators

"behaviors that undermine a culture of safety"

“Behaviors that undermine a culture of safety”

- Verbal or physical threats
- Intimidation
- Reluctance/refusal to answer questions, refusal to answer pages or calls
- Impatience with questions
- Condescending language or intonation

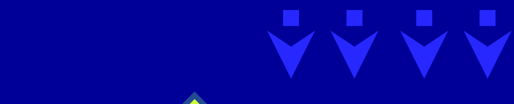
Teamwork:
The bright side …

Reported levels of positive communication and collaboration with attending and resident MDs correlated with lower risk-adjusted morbidity

(J Am Coll Surg. 2007 Dec;205(6):778-84)

Respectful work environments can promote health and wellness

n=2,813 physicians



Each 1-point ↑ in supervisor leadership score (respect, dignity, interested in my opinion)

9% ↑ likelihood of satisfaction

3.3% ↓ likelihood of burnout

Shanafelt TD, et al. Mayo Clin Proc 2015;90(4)

High clinician trust correlates with:

Higher satisfaction

Lower Stress

Decreased odds of intending to leave

Linzer et al. Characteristics of Health Care Organizations Associated with Clinician Trust. JAMA Network Open.2019

Hierarchy of *Responsibility*

Mass General Brigham

☑ Hierarchy of *Responsibility*

☒ No Hierarchy of *Respect*

Burning platform:
Society, TJC, ABMS, ACGME, LCME

- Patient safety/experience
- Learning environment
- Litigation risk
- Retention
- Morale and productivity
- **Wellbeing – all of us**

Photo by Rowan Freeman on Unsplash

***Not* doing this is costly on many levels**

Building a program

"Failure is an opportunity to grow"

GROWTH MINDSET

"I can learn to do anything I want"

"Challenges help me to grow"

"My effort and attitude determine my abilities"

"Feedback is constructive"

"I am inspired by the success of others"

"I like to try new things"

Dr. Carole S. Dweck

Leaders* Need to Model a Growth Mindset

Expressing fallibility

Soliciting and giving feedback

Make speaking up safe

Helping people do the right thing

Holding ourselves and others accountable

Listening and acting on concerns

*(we are all leaders in some capacity)

NEW YORK TIMES BESTSELLER

Douglas Stone & Sheila Heen

of the Harvard Negotiation Project and coauthors of

DIFFICULT CONVERSATIONS

Thanks for the Feedback

THE SCIENCE AND ART OF RECEIVING FEEDBACK WELL*

**even when it is off base, unfair, poorly delivered, and, frankly, you're not in the mood*

Mass General Brigham

Speaking up: Welcome concerns

Addition to OR Checklist

Building a program

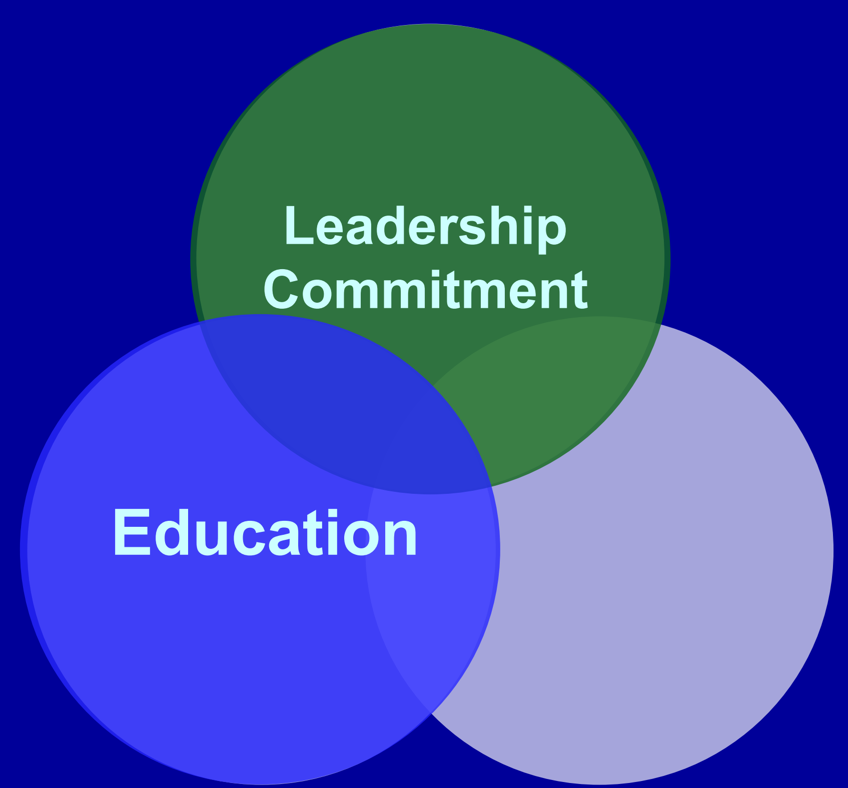
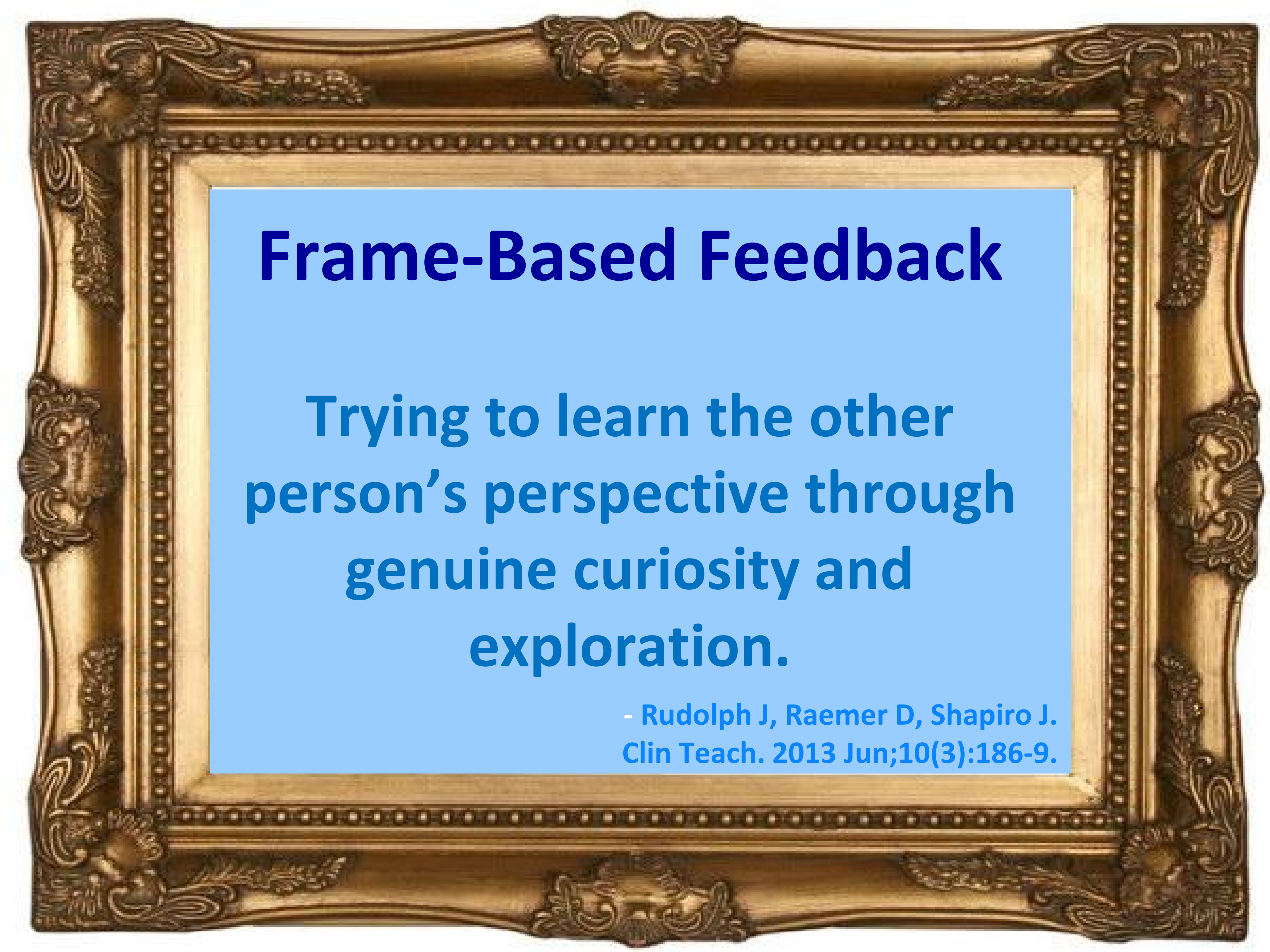


Photo by Li Lin on Unsplash

Photo by Adi Goldstein on Unsplash

Look in the Mirror First

You might be a
Target or Bystander, but also a
potential
Source



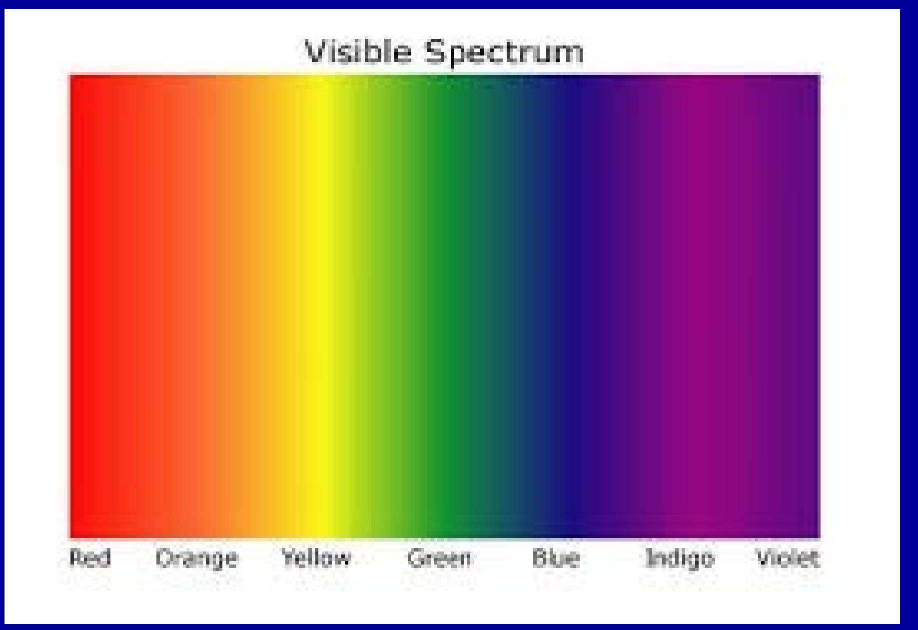
Frame-Based Feedback
Trying to learn the other person's perspective through genuine curiosity and exploration.
- Rudolph J, Raemer D, Shapiro J.
Clin Teach. 2013 Jun;10(3):186-9.

Fisher, H.N., Chatterjee, P., Shapiro, J. et al. "Let's Talk About What Just Happened": a Single-Site Survey Study of a Microaggression Response Workshop for Internal Medicine Residents. J Gen Intern Med 2021 Nov; 36(11): 3592–3594

Building a program

Shapiro J, Whittemore A, Tsen LC. Jt Comm J Qual Patient Saf 2014; 40(4):168-177

Occasional → Pattern → Egregious



Need a safe, relational environment for raising concerns

Enables early feedback and chances for remediation and improvement

Protects reporters

Fair to individuals

Relational…

Online safety reporting systems

"gotcha"

Myers JS, Shapiro J, Rosen IM. Gotcha! Using patient safety event reports to report people rather than problems. *J Grad Med Educ*. 2020;12(5):525-528

Programmatic Outcomes

Jan 2010 - Jun 2013

Outcome	Count	Percent
Some Improvement	52	(35%)
Significant Improvement	34	(23%)
Insignificant Improvement	8	(5%)
Need f/u info	36	(24%)
Work in progress	10	(7%)
Not a professionalism issue	9	(6%)

Shapiro J, Whittemore AW, Tsen LC. Instituting a culture of professionalism: the establishment of a center for professionalism and peer support. Jt Comm J Qual Patient Saf 2014; 40(4):168-177

*So, how do we facilitate coping and **resilience**?*

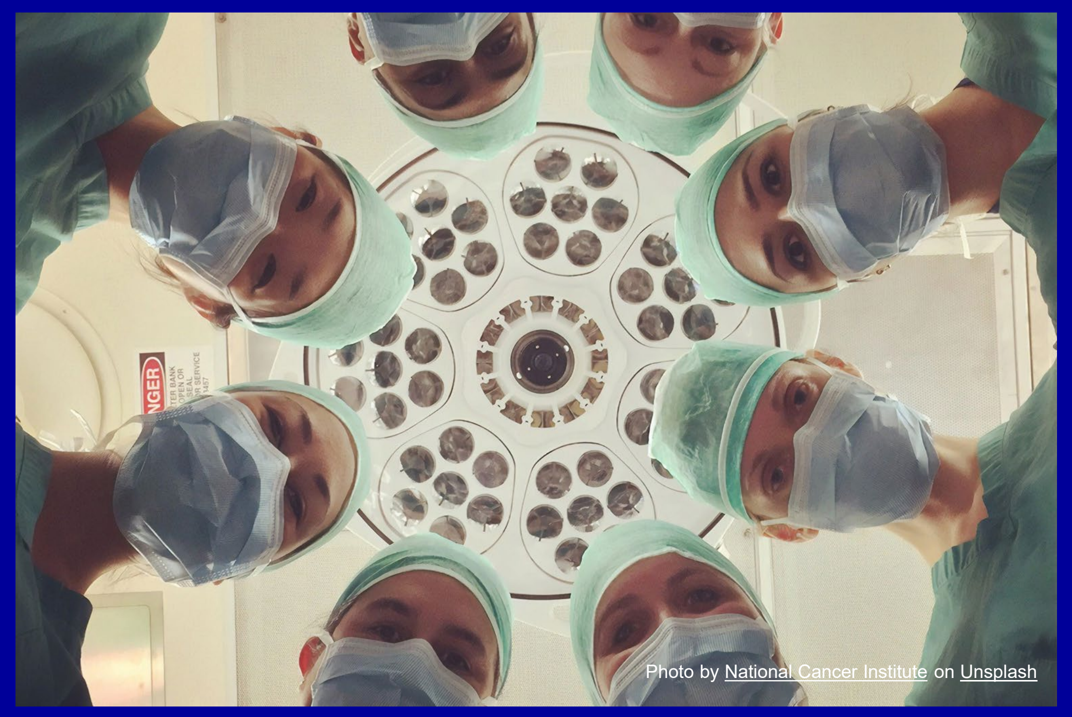


Photo by National Cancer Institute on Unsplash

Hu Y, Fix M, Hevelone N, Lipsitz S, et al. Attitudes and needs of physicians for emotional support:
The case for peer support. *JAMA Surg 2012*

Mass General Brigham

Sources of support

	Physician Colleagues	Mental Health Professionals	EAP
Value	88	48	29

Hu Y, et al. *JAMA Surg 2012*

Factors associated with resilience after adverse events

Talking about it with colleagues

Disclosure and apology

Forgiveness

Dealing with imperfection

Learning from the error/ understanding how to prevent recurrences

Sharing that learning with colleagues and trainees

Photo by Francesco Gallarotti on Unsplash

Plews-Ogan M, May N, Owens J, Ardelt M, Shapiro J, Bell SK. Wisdom in medicine: What helps physicians after a medical error. Acad Med. 2015 Sep 4.

Peer Support

Shapiro J, McDonald T. Supporting clinicians during Covid-19 and beyond — learning from past failures and envisioning new strategies NEJM/ Oct 2020

Photo by Jo Shapiro, MD (2014)