From Checklists to Dance Lessons:
How Psychiatry Can Move Healthcare From Reform to Renewal
Duke University
Department of Psychiatry Grand Rounds
March 2, 2016

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• Honoraria for educational speaking engagements
• No past or present industry relationships
Objectives

1. By the end of the session, a participant should be able to:
2. List and explain the goals of the quality improvement movement, which underlies recent efforts to reform the healthcare industry, and its relationship to industrial engineering.
3. Name several recent negative findings about the difficulty of replicating quality improvement initiatives.
4. Describe the ways that contemporary philosophers explain the shortcoming of quality improvement initiatives.
5. Describe and discuss the possibility of achieving the goals of the quality improvement movement with techniques drawn from social practices like psychiatry.
DSM-5 defines “mental disorder”

“A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognitions, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.” – DSM-5, p. 20
An accidental wiring diagram?
Southwest Airlines Flight 392

ON TIME

DEN ➔ RDU
The ED waiting room?
The air traffic control center?
OFFICIAL AIR FORCE
FLIGHT CHECK LIST

BEFORE TAKEOFF

PRIME .................. AS REQ.
THROTTLE ................ 1/8”
PROP AREA ............... CLEAR
IGNITION SWITCH ......... START
OIL PRESSURE ............ CHECK

BRAKES ................... SET
DOORS & WINDOWS ...... LOCKED
CONTROLS ................. FREE
FLIGHT INST ............. SET
FUEL SELECTOR .......... BOTH

Credit: aircraft-spruce.com
Surgical Safety Checklist

Before induction of anaesthesia
(with at least nurse and anaesthetist)

- Has the patient confirmed his/her identity, site, procedure, and consent?
  - Yes
- Is the site marked?
  - Yes
  - Not applicable
- Is the anaesthesia machine and medication check complete?
  - Yes
- Is the pulse oximeter on the patient and functioning?
  - Yes
- Does the patient have a:
  - Known allergy?
    - No
    - Yes
  - Difficult airway or aspiration risk?
    - No
    - Yes, and equipment/assistance available
  - Risk of >500ml blood loss (7ml/kg in children)?
    - No
    - Yes, and two IVs/central access and fluids planned

Before skin incision
(with nurse, anaesthetist and surgeon)

- Confirm all team members have introduced themselves by name and role.
- Confirm the patient’s name, procedure, and where the incision will be made.
- Has antibiotic prophylaxis been given within the last 60 minutes?
  - Yes
  - Not applicable

Anticipated Critical Events

To Surgeon:
- What are the critical or non-routine steps?
- How long will the case take?
- What is the anticipated blood loss?

To Anaesthetist:
- Are there any patient-specific concerns?

To Nursing Team:
- Has sterility (including indicator results) been confirmed?
- Are there equipment issues or any concerns?

Is essential imaging displayed?
- Yes
- Not applicable

Before patient leaves operating room
(with nurse, anaesthetist and surgeon)

Nurse Verbally Confirms:
- The name of the procedure
- Completion of instrument, sponge and needle counts
- Specimen labelling (read specimen labels aloud, including patient name)
- Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.
Error in Medicine

Lucian L. Leape, MD

FOR YEARS, medical and nursing students have been taught Florence Nightingale’s dictum—first, do no harm. Yet evidence from a number of sources, reported over several decades, indicates that a substantial number of patients suffer treatment-caused injuries while in the hospital. In 1964 Schimmel reported that 29% of patients admitted to a university hospital medical service suffered iatrogenic injury and that 29% of those injuries were serious or fatal. Steel et al found that 36% of patients admitted to a university medical service in a teaching hospital suffered an iatrogenic event, of which 29% were serious or life threatening. More than half of the injuries were related to use of medication. In 1991 Bedell et al reported the results of an analysis of cardiac arrests at a teaching hospital. They found that 64% were preventable. Again, inappropriate use of drugs was the leading cause of the cardiac arrests. Also in 1991, the Harvard Medical Practice Study reported the results of a population-based study of iatrogenic injury in patients hospitalized in New York State in 1984. Nearly 4% of patients suffered an injury that prolonged their hospital stay or resulted in measurable disability. For New York State, this equaled 98,669 patients in 1984. Nearly 14% of these injuries were fatal. If these rates are typical of the United States, then 180,000 people die each year partly as a result of iatrogenic injury, the equivalent of three jumbo-jet crashes every 3 days.

When the causes are investigated, it is found that most iatrogenic injuries are due to errors and are, therefore, potentially preventable. For example, in the Harvard Medical Practice Study, 69% of injuries were due to errors (the balance was unavoidable). Error may be defined as an unintended act (either of omission or commission) or one that does not achieve its intended outcome. Indeed, injuries are but the “tip of the iceberg” of the problem of errors, since most errors do not result in patient injury. For example, medication errors occur in 2% to 14% of patients admitted to hospitals, but most do not result in injury.

Aside from studies of medication errors, the literature on medical error is sparse, in part because most studies of iatrogenesis have focused on injuries (eg, the Harvard Medical Practice Study). When errors have been specifically looked for, however, the rates reported have been distressingly high. Autopsy studies have shown high rates (65% to 49%) of missed diagnoses causing death. One study of errors in a medical intensive care unit revealed an average of 1.7 errors per day per patient, of which 25% had the potential for serious or fatal injury. Operational errors (such as failure to treat promptly) or to get a follow-up culture) were found in 75% of patients in a study of children with positive urine cultures.

Ref: Leape JAMA 1994

WHY IS THE ERROR RATE IN THE PRACTICE OF MEDICINE SO HIGH?

Physicians, nurses, and pharmacists are trained to be careful and to function at a high level of proficiency. Indeed, they probably are among the most careful professionals in our society. It is curious, therefore, that high error rates have not stimulated more concern and efforts at error prevention. One reason may be a lack of awareness of the severity of the problem. Hospital-acquired injuries are not reported in the newspapers like jumbo-jet crashes, for the simple reason that they occur one at a time in 5000 different locations across the country. Although error rates are substantial, serious injuries due to errors are not part of the everyday experience of physicians or nurses, but are perceived as isolated and unusual events—“outliers.” Second, most errors do no harm. Either they are intercepted or the patient’s defenses prevent injury. (Few children die from a single misdiagnosed or mistreated urinary infection, for example.)

But the most important reason physicians and nurses have not developed more effective methods of error prevention is that they have a governmentally-accepted failure in difficulty in dealing with human error when it does occur. Physicians are required to practice medicine in medical school and residency to strive for error-free practice. There is a powerful emphasis on perfection, both in diagnosis and treatment. In everyday hospital practice, the message is equally clear: mistakes are unacceptable. Physicians are expected to function without error, an expectation that physicians translate into the need to be infallible. One result is that physicians, not unlike test pilots, come to view an error as a failure of character—you weren’t careful enough, you didn’t try hard enough. This kind of thinking lies behind a common reaction by physicians: “How can there be an error without negligence?”

For editorial comment see p 1867.
From IOM reports to Federal Law

D. Berwick + L. Leape
1999

D. Berwick + L. Leape
2001

Pres. Obama
2010
D. Berwick running CMS
CMS alone has 13 QI programs

### CMS has a variety of quality reporting and performance programs

<table>
<thead>
<tr>
<th>Hospital Quality</th>
<th>Physician Quality Reporting</th>
<th>PAC and Other Setting Quality Reporting</th>
<th>Payment Model Reporting</th>
<th>“Population” Quality Reporting</th>
</tr>
</thead>
</table>
| • Medicare and Medicaid EHR Incentive Program  
  • PPS-Exempt Cancer Hospitals  
  • Inpatient Psychiatric Facilities  
  • Inpatient Quality Reporting  
  • HAC payment reduction program  
  • Readmission reduction program  
  • Outpatient Quality Reporting  
  • Ambulatory Surgical Centers  
| • Medicare and Medicaid EHR Incentive Program  
  • PQRS  
  • eRx quality reporting  
| • Inpatient Rehabilitation Facility  
  • Nursing Home Compare Measures  
  • LTCH Quality Reporting  
  • Hospice Quality Reporting  
  • Home Health Quality Reporting  
| • Medicare Shared Savings Program  
  • Hospital Value-based Purchasing  
  • Physician Feedback/Value-based Modifier*  
  • ESRD QIP  
| • Medicaid Adult Quality Reporting*  
  • CHIPRA Quality Reporting*  
  • Health Insurance Exchange Quality Reporting*  
  • Medicare Part C*  
  • Medicare Part D*  

* Denotes that the program did not meet the statutory inclusion criteria for pre-rulemaking, but was included to foster alignment of program measures.
These groups all require QI
Introduction of Surgical Safety Checklists in Ontario, Canada

David R. Urbach, M.D., Anand Govindarajan, M.D., Refik Saskin, M.Sc., Andrew S. Wilton, M.Sc., and Nancy N. Baxter, M.D., Ph.D.

“Implementation of surgical safety checklists in Ontario, Canada, was not associated with significant reductions in operative mortality or complications.”

Ref: Urbach NEJM 2014
"We calculated a mean rate of death from medical error of 251,454 a year .... We believe this understates the true incidence of death due to medical error ..."
Preventable Deaths 1994-2016

1994 estimate
180,000/year

2016 estimate
251,000/year
(or more?)
“Hospitals have devoted considerable time, energy, and resources to solving safety and quality problems. Some progress has occurred. But the improvements have been slow and have not spread throughout the delivery system. ... Altogether, they do not constitute an adequate response to the manifestly large and growing roster of quality problems confronting health care” (p. 1762)

Ref: Chassin Health Affairs 2013
Obeying A Rule Is A Practice

- Wittgenstein: “Obeying a rule is a practice”
- Charles Taylor:
  - rules require background understanding, aka social practices
  - contemporary rules neglect these practices, because they do not account for the other and the body

Credit: www.military-history.org
Common Rhythms

Credit: www.celebbuzz.com
“A very important feature of human action is rhythm, cadence. Every apt, coordinated gesture has a certain flow. When you lose this, as occasionally happens, you fall into confusion, your actions become inept and uncoordinated.”

Like the physician-illustrator Fritz Kahn, we often compare the medical body to industrial sites: the body is a factory which produces health.
CO-PILOT CHECKLIST

1. DON’T TOUCH ANYTHING
2. KEEP YOUR MOUTH SHUT

Credit: sportys.com
Therapeutic Alliances

Credit: Lars and the Real Girl
## The Competing Logics

<table>
<thead>
<tr>
<th>Logic of Choice</th>
<th>Logic of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ill people as Consumers or Citizens</td>
<td>Ill people as Patients</td>
</tr>
<tr>
<td>We are made by our choices</td>
<td>We are made by adaptations</td>
</tr>
<tr>
<td>Mastery of the body</td>
<td>Living with the body</td>
</tr>
<tr>
<td>Outcomes achieved</td>
<td>Process of care</td>
</tr>
<tr>
<td>Practitioners need to follow scripts</td>
<td>Practitioners need patience</td>
</tr>
<tr>
<td>Patients receive the care they chose</td>
<td>Patients tenaciously adapt</td>
</tr>
<tr>
<td>Consequentialist ethics (outcomes)</td>
<td>Virtue ethics (process)</td>
</tr>
<tr>
<td>Transaction</td>
<td>Relationship</td>
</tr>
<tr>
<td>Policy from above</td>
<td>Tinkering from below</td>
</tr>
<tr>
<td><em>Healthcare Reform</em></td>
<td>Renewal of Medicine</td>
</tr>
</tbody>
</table>

© 2012 Denver Health
More like this kind of flying...

Credit: www.sanantonioquinceanera.com
Major Depressive Disorder

Diagnostic Criteria

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.
The Phenomenology of Major Depression and the Representativeness and Nature of DSM Criteria

Kenneth S. Kendler, M.D.

How should DSM criteria relate to the disorders they are designed to assess? To address this question empirically, the author examines how well DSM-5 symptomatic criteria for major depression capture the descriptions of clinical depression in the post-Kraepelin Western psychiatric tradition as described in textbooks published between 1900 and 1960. Eighteen symptoms and signs of depression were described, 10 of which are covered by the DSM criteria for major depression or melancholia. For two symptoms (mood and cognitive content), DSM criteria are considerably narrower than those described in the textbooks. Five symptoms and signs (changes in volition/motivation, slowing of speech, anxiety, other physical symptoms, and depersonalization/derealization) are not present in the DSM criteria. Compared with the DSM criteria, these authors gave greater emphasis to cognitive, physical, and psychomotor changes, and less to neurovegetative symptoms. These results suggest that important features of major depression are not captured by DSM criteria. This is unproblematic as long as DSM criteria are understood to index rather than constitute psychiatric disorders. However, since DSM-III, our field has moved toward a reification of DSM that implicitly assumes that psychiatric disorders are actually just the DSM criteria. That is, we have taken an index of something for the thing itself. For example, good diagnostic criteria should be succinct and require minimal inference, but some critical clinical phenomena are subtle, difficult to assess, and experienced in widely varying ways. This conceptual error has contributed to the impoverishment of psychopathology and has affected our research, clinical work, and teaching in some undesirable ways.

### What DSM-5 Misses in MDD

<table>
<thead>
<tr>
<th>Symptom Area</th>
<th>Degree of Coverage by DSM Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood</td>
<td>Partly covered, criterion A1</td>
</tr>
<tr>
<td>Interest</td>
<td>Well covered, criterion A2</td>
</tr>
<tr>
<td>Cognitive content</td>
<td>Partly covered, criterion A7</td>
</tr>
<tr>
<td>Cognitive function</td>
<td>Well covered, criterion A8</td>
</tr>
<tr>
<td>Volition/motivation</td>
<td>Not covered</td>
</tr>
<tr>
<td>Decision making</td>
<td>Well covered, criterion A8</td>
</tr>
<tr>
<td>Anhedonia</td>
<td>Well covered, criterion A2</td>
</tr>
<tr>
<td>Psychomotor changes</td>
<td>Well covered, criterion A5</td>
</tr>
<tr>
<td>Energy</td>
<td>Well covered, criterion A6</td>
</tr>
<tr>
<td>Speech</td>
<td>Not covered</td>
</tr>
<tr>
<td>Sleep</td>
<td>Well covered, criterion A4</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Not covered</td>
</tr>
<tr>
<td>Appetite</td>
<td>Well covered, criterion A3</td>
</tr>
<tr>
<td>Weight</td>
<td>Well covered, criterion A3</td>
</tr>
<tr>
<td>Other physical symptoms</td>
<td>Not covered</td>
</tr>
<tr>
<td>Suicidal behavior</td>
<td>Well covered, criterion A9</td>
</tr>
<tr>
<td>Circadian effects</td>
<td>Well covered, criterion B2 for melancholia</td>
</tr>
<tr>
<td>Depersonalization/derealization</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
1. In our search for **reliability**, we avoid criteria which require inference and interpretation (e.g. derealization)

2. In our search for **specificity**, we avoid criteria more specific to other disorders (e.g. anxiety)

3. In our search for **concise** criteria sets, we avoid signs which require longer descriptions (e.g. cognition)
A Map ≠ The Territory Itself

Ref: Nussbaum JAMA 2013
Field Trials of Adult Diagnoses

FIGURE 1. Interrater Reliability of Diagnoses From the Initial DSM-5 Field Trials

Ref: Freedman, AJP 2013
Field Trials of Child Diagnoses

Ref: Freedman, *AJP* 2013
When to use the CFI

1. Difficulty in diagnostic assessment owing to significant differences between a clinician and the individual
2. Uncertainty about the fit between culturally distinctive symptoms and diagnostic criteria
3. Difficulty in judging illness severity or impairment
4. Disagreement between the individual and clinician on the course of care
5. Limited engagement in and adherence to treatment by the individual
Cultural Formulation Interview (CFI)

**GUIDE TO INTERVIEWER**

The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual’s social network (i.e., family, friends, or others involved in current problem). This includes the problem’s meaning, potential sources of help, and expectations for services.

**INSTRUCTIONS TO THE INTERVIEWER ARE ITALICIZED.**

**INTRODUCTION FOR THE INDIVIDUAL:**
I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about your experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

**CULTURAL DEFINITION OF THE PROBLEM**

**Cultural Definition of the Problem**
(Explanatory Model, Level of Functioning)

- Elicit the individual’s view of core problems and key concerns.
- Focus on the individual’s own way of understanding the problem.
- Use the term, expression, or brief description elicited in

1. What brings you here today?
   
   *IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:*
   People often understand their problems in their own way, which may be similar to or different from how doctors
## CFI Categories

<table>
<thead>
<tr>
<th>Domain of Assessment</th>
<th>CFI ?s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Definition of the Problem</td>
<td>1-3</td>
</tr>
<tr>
<td>Cultural Perceptions of Cause, Context, and Support</td>
<td>4-10</td>
</tr>
<tr>
<td>Cultural Factors Affecting Self-Coping and Past Help Seeking</td>
<td>11-13</td>
</tr>
<tr>
<td>Cultural Factors Affecting Current Help Seeking</td>
<td>14-16</td>
</tr>
</tbody>
</table>
Cultural definition of the problem: What problems or concerns bring you to the clinic? What troubles you most about your problem? People often understand their problems in their own way, which may be similar to or different from how doctors explain the problem. How would you describe your problem to someone else? Sometimes people use particular words or phrases to talk about their problems. Is there a specific term or expression that describes your problem? If yes: What is it?

Supplementary modules (e.g. child/adolescent, elderly, immigrants and refugees) are available at www.psychiatry.org/dsm5
Good questions do ≥2 things
Persuasion & Healing
A COMPARATIVE STUDY OF PSYCHOTHERAPY
Jerome D. Frank, PH.D., M.D.
Julia B. Frank, M.D.

The PSYCHOTHERAPY of HOPE
The Legacy of PERSUASION AND HEALING
Edited by Renato D. Alarcón, M.D., M.P.H.
& Julia B. Frank, M.D.
## Can depression be meaningful?

<table>
<thead>
<tr>
<th></th>
<th>Anhedonic</th>
<th>Demoralized</th>
<th>Posttraumatic</th>
<th>Grief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood/affect</td>
<td>Depressed, sad, black, sullen</td>
<td>Sad (loss of joy) in current circumstance and for the future (hopelessness)</td>
<td>Anxious Relates to reminders and implications of event</td>
<td>Sorrowful (sad) Sadness or anxiety about lost object</td>
</tr>
<tr>
<td></td>
<td>Loss of mood reactivity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hedonic tone</td>
<td>Pervasive</td>
<td>Ability to feel pleasure in the present partly maintained</td>
<td>Ability to feel pleasure in the present partly maintained</td>
<td>Ability to feel pleasure in the present partly maintained</td>
</tr>
<tr>
<td>Volition</td>
<td>Profound loss of motivation</td>
<td>Motivation compromised by feelings of futility</td>
<td>Inhibited in relation to trauma</td>
<td>Intermittently impaired</td>
</tr>
<tr>
<td>Sense of self</td>
<td>Diminished</td>
<td>Feels incompetent</td>
<td>May be challenged by trauma</td>
<td>Self intact; may feel depleted by loss</td>
</tr>
<tr>
<td>Thoughts</td>
<td>About self, predicament</td>
<td>Hopelessness</td>
<td>Memories of traumatic event</td>
<td>Thoughts of lost object</td>
</tr>
</tbody>
</table>
Intervening in demoralization

Thoughts → Emotions → Interventions

<table>
<thead>
<tr>
<th>Thought / Emotion</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>“This is stressful”</td>
<td>Apprehension, panic, threat</td>
</tr>
<tr>
<td>“I don’t know what to do”</td>
<td>Helplessness, inability to cope</td>
</tr>
<tr>
<td>“I can’t resolve the problem”</td>
<td>Incompetence, diminished esteem</td>
</tr>
<tr>
<td>“I have no help”</td>
<td>Hopelessness</td>
</tr>
<tr>
<td>“This is worse than I expected”</td>
<td>Shame, aloneness, disconnection</td>
</tr>
<tr>
<td>“I no longer have any sense of meaning or purpose”</td>
<td>Despair, meaninglessness</td>
</tr>
</tbody>
</table>

Adapted from Clarke 2012
Pursuing a disease or a person?

Platonic medicine pursues disease as an **ontological entity**.
(What you have.)

Hippocratic medicine pursues **understanding of a person**.
(Who you are.)

Credit: wikimedia
Should we count or see?

- Quantification is “a technology of distance”
- Which devalues trust and relationships
- ...So we encourage physicians to “count something” instead of “seeing someone”
How medicine works

Trauma surgery: heal with steel
Infectious disease: heal with pills
Psychiatry: heal with relationships

Credit: wikipedia, prevention.com, correcttech.com
<table>
<thead>
<tr>
<th>Positive Clinician Traits</th>
<th>Frequency (% named by patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring, empathy, compassion</td>
<td>43</td>
</tr>
<tr>
<td>Attentive or broader awareness</td>
<td>33</td>
</tr>
<tr>
<td>Accessibility</td>
<td>28</td>
</tr>
<tr>
<td>Advocacy</td>
<td>25</td>
</tr>
<tr>
<td>Honesty</td>
<td>25</td>
</tr>
<tr>
<td>Trustworthy, good judgment</td>
<td>25</td>
</tr>
<tr>
<td>Calms, puts patients at ease</td>
<td>24</td>
</tr>
<tr>
<td>Respectful</td>
<td>20</td>
</tr>
<tr>
<td>Openness</td>
<td>20</td>
</tr>
<tr>
<td>Warmth</td>
<td>18</td>
</tr>
<tr>
<td>Confidence</td>
<td>17</td>
</tr>
<tr>
<td>Humorous</td>
<td>16</td>
</tr>
<tr>
<td>Shared authority</td>
<td>13</td>
</tr>
<tr>
<td>Humility</td>
<td>12</td>
</tr>
<tr>
<td>Spiritual, religious</td>
<td>8</td>
</tr>
<tr>
<td>Cheerful or positive demeanor</td>
<td>7</td>
</tr>
<tr>
<td>Technical competence</td>
<td>6</td>
</tr>
</tbody>
</table>

Ref: Churchill et al. 2013: 34
Changing my Clinical Practice

By:
• Focusing on culture
• Hiring to the mission
• Empowering all staff
• Discussing the why of QI metrics
• Building in flexible time for clinicians

We:
• Reduced turnover
• Decreased burnout
• Improved patient satisfaction scores
• Met QI metrics
• Increased revenue
Secret Sauce

Ingredients:
• Culture > management scheme
• Process > outcomes
• Forming relationships > following algorithms

OF HIGH PERFORMANCE
Hippocratic Oath concludes...

“May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.”

Credit: www.philatelia.net
"There is only one thing I can do: listen to people, see how they stick themselves into the world, hand them along a ways in their dark journey and be handed along, and for good and selfish reasons."

Q: Can We See Patients Again?

www.abrahamnussbaum.com

Credit: Fritz Kahn
References


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