

Project Title: Examination of System-Based Contributions to Reports of Unprofessional Behavior in an Academic Medical Center

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Topic Category: Administration

Background and Significance:

Stanford Healthcare (SHC) has used the Stanford Alerts for Events (SAFE) system for reporting both patient safety events and unprofessional behavior. Feedback amongst medical staff, have pointed to the perversion of this system to highlight negative behaviors and its weaponization as a means of punishment rather than for ushering positive change. In response, SHC separated reporting of physician behavior to its own system: Behavioral Incident Observational System (BIOS). Within BIOS, reports are over-represented among physicians working in intervention/procedural-based areas. In their counseling sessions, these “interventionist” often note hospital system-based issues as significant aggravating factors contributing to negative behavior with no perceived mechanism to be addressed.

Purpose/Objective:

The purpose of this project was to improve the handling of unprofessional behavior reports. Specifically, we sought to identify systems-based issues contributing to reports of unprofessional behavior and design a process to address them.

Methods/Approach/Evaluation:

Four methods were employed to investigate and inform next steps for the SHC Committee on Professionalism:

1. Stakeholder meetings were held with Patient Safety Committee, Interventional Platform Chief, and Chief Wellness Officer with the goal to:
 - Determine current state of the BIOS workflow
 - Determine areas of weakness for improvement
2. BIOS report audit was conducted for reports involving hospital interventional/procedure areas.
3. SAFE reporting system and new patient safety dashboard were reviewed for cross-referencing to potential new BIOS categories.
4. Defining the future state to redesign the BIOS workflow to make it more efficient, queryable, and address the areas of weakness identified above.

Outcomes/Results:

We identified several areas for intervention to the current workflow:

- Reorganize the Counseling/Reporting process: create validated data fields for queries, tracking and process improvement
- Create formal process for referral of BIOS reports to the process owner when a system issue is identified (assisted by Quality Committee)
- Provide feedback to the provider for closed-loop communication

The BIOS report audit categorized unprofessional behavior reports from 1/1/2020 to 1/1/2023 (n=373). The final cohort consisted of 63 reports (50 unique faculty), 28 procedural locations (25% operating rooms, 24% peri-operative areas, 19% ambulatory surgery center, 11% cardiac catheterization lab). A total of 24 codes were used of which the most common were: communication (27%), protocol (22%) and

patient safety (19%). The most common system-based codes were: protocol (22%), timing (ie OR turnover 7%), and equipment (4%). Review of the new Patient Safety Dashboard for overlap with revised BIOS report categories is ongoing.

Discussion/Conclusion/Statement of Impact

The next steps will be to perform a review of counseling reports which we feel will provide more direct insight into the system-based issues discussed by the physicians and to meet with the Chief Quality Officer to explore the possibility of integrating system issue triage into the work of the Quality Committee.