Establishing Transdisciplinary Professionalism for Health Global Forum on Innovation in Health Professional Education

INNOVATIONS IN TEACHING ABOUT TRANSDISCIPLINARY PROFESSIONALISM AND PROFESSIONAL NORMS

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TRANSDISCIPLINARY PROFESSIONALISM

an approach to creating and carrying out a shared social contract that ensures multiple health disciplines, working in concert, are worthy of the trust of patients and the public.
TRANSDISCIPLINARY TEAM PROFESSIONALISM COMPETENCIES

*Shared Understanding*
- Shared vision
- Shared mental models

*New Forms of Leadership*
- Decision-making
- Conflict resolution

-- Olupeliyawa, Hughes, & Balasooriya, 2009
TRANSDISCIPLINARY TEAM PROFESSIONALISM COMPETENCIES (cont.)

*Team Support
  -Mutual trust
  -Collaboration

*Communication
  -Respect
  -Feedback
  -Accountability

-- Olupeliyawa, Hughes, & Balasooriya, 2009
TRANS DISCIPLINARY PROFESSIONALISM: Topics for my Talk

*How do we transfer collaborative skills, values, and behaviors?

*What are the barriers to doing so?

*What teaching methods are we using now to dissolve those barriers?
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ADMISSIONS AND HIRING

We select for AUTONOMY
Professionals

*Highly competent individuals
*Guided by personal & professional norms
*Prefer to control their own work
*Distrust bureaucracy & administration

--Steve Bogdewic PhD
Exec Assoc Dean, Indiana School of Medicine
Selecting for People who align with the Values of Transdisciplinary Professionalism

*mission-centric
*team-ready
*emotionally intelligent
Strong Professional Identities
AND
Strong Collaborative Skills
Physicians

- Cold, insensitive
- Rigid, Controlling
- Egotistical, arrogant
- Obsessive compulsive
- Pressed for time
- Technician, counterdependent
- Somatically-fixated
Psychologists

- Too cerebral, impractical
- Touchy-feely, wishy-washy
- Impotent, neurotic
- Weird, & flaky
- Not real docs!
- Right-brained & left-winged
- Psychosocially-fixated
PROFESSIONAL TRIBALISM

* Elevate it
* Examine it
* Challenge it
Interprofessionalism: Teamwork

The behaviors, conditions, and attitudes needed in order to function are the same across organizations:

*task interdependence*

Salas, 2013
Interprofessionalism: Elements of Successful Team Training

Information
Demonstration
Practice
Feedback

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Salas, 2013
TEAM COLLABORATIVES
at the
University of Rochester Department of Family Medicine

*Once/mo all 6 teams meet in a “Team Collaborative” to report on their PDSA projects and share best practices. Staff and trainees make the presentations.
Tuesday last week, there was the most incredible rainstorm. It seemed like it would never stop. I remember it was Tuesday because my car was in the shop and I needed to catch the bus; I started on the 11 and picked up the number 1 before I finally got the 14 to get to the mall. I needed to do some last minute back to school shopping.

*It was raining, it was raining. I had to catch the bus.*
Telephone Prompt 2

Last week on Tuesday, the day of the big rain, you told me that you were going to take care of that issue that I talked to you about. I told you it was really important to me. You said it would be no problem, and you could finish it before you left for the day. But you didn't. I'm confused about what happened and frustrated it's not done yet.

You said you would take care of it, but you didn't.
COMMUNICATION PEARLS
from “Telephone” Exercise

1. Keep it short
2. Actively check for understanding
3. EHR really is better for many communications
4. Be kind when giving feedback
Great Teams: Five Prerequisites

* Trust
* Managing Conflict
* Commitment
* Accountability
* Attention to Results

--Patrick Lencioni, 2002
Vulnerability
- Open to one another around failures, weaknesses, fears
- This is not let-it-all-hang-out, touchy-feely theory
- Clear out political and hidden motivations

The myth or the façade of invulnerability, especially with a leader, is utterly destructive.
Trust Building Exercise

Tell us

where you grew up,
your birth order,
your cultural background, and
an important or challenging thing you had to deal with in your childhood
Conflict

- Productive, even passionate debate around ideas of importance to the team.
- Getting it all out on the table.
- Controlled discomfort.
- Requires patient, active listening.
- Not arguments based on politics, pride or competition.
- Not trying to win.
How did your family air differences?

- Write your preferences about acceptable and unacceptable behaviors around discussion and debate.
  - Language
  - Tone of voice
  - Emotional Content
  - Participation
- Develop a common understanding of acceptable and unacceptable behavior.
Collaborative Practice =

*the power of the physician and bhp to diagnose and suggest treatment

*the power of the patient to make sense of the illness experience, decide, and embark on treatment

*the power of the family or social group to provide a healing environment
The Sociology of Superordinates

*Those higher feel burdened and responsible rather than powerful or blessed

*Those lower feel invisible, unappreciated, disrespected, and resentful

*Why Men Resist, WJ Goode, 1980*
CREATING A SAFE AND EFFECTIVE COCKPIT CULTURE

* flatten the hierarchy
* use first names
* reward the co-pilot for disagreeing or speaking up
“Planes are safer when the least experienced pilot is flying, because it means the second pilot isn’t going to be afraid to speak up.”

Malcolm Gladwell, *Outliers*
HIDDEN CURRICULUM =

What is modeled rather than what is taught

The need to create a culture that welcomes feedback
The University of Rochester Patient- and Family-Centered Care Physician Coaching Program
University of Rochester Medical Center
ICARE Values

* Integrity
* Compassion
* Accountability
* Respect
* Excellence
Physician ICARE Behaviors:

ICU

\[ I = \text{Introduce yourself and your role} \]

\[ C = \text{ask the patient/family Concerns} \]

\[ U = \text{check for Understanding} \]
URMC- PFCC Clinical Observation Form

I: Introduce yourself
C: Ask about patient’s concerns
U: Discuss plan and check for understanding

1. Initiate the Session
   Develop initial rapport
   - Greet Patient
   - Greet any Family Member
   - If new, introduce self and role
   - Call every person by name
   - Smile
   - Make eye contact
   - Demonstrate interest in the patient as a person
   - Sits down, if chair available

2. Gather Information
   Discover the patient’s and family’s perspectives, what they think and know
   - Use open ended questions appropriately
   - Solicit patient concern & view of problem
   - Solicit any family member’s view of problem
   - Set agenda early
   - Accept the patient and family’s views non-judgmentally
   - Speak about other team members/professionals respectfully

3. Build the Relationship
   Respond empathetically to empathetic cues
   - Give affirmations
   - Give acknowledgements
   - Show courtesy and respect
   - Communicate warmth and compassion

4. Explain and Plan
   Discuss diagnosis and options re treatment plan
   - Relate explanation to patient and family’s perspectives and expectations
   - Involve patients and families as part of the team; Ask for patient and family input
   Check for understanding
   - Ask, “do you understand?”
   - Teach back

5. Close the Session
   Discuss next steps
   - Ask if there is anything else you can do?
   - Say when you will see them again

Physician:
Dept/Division:
Patients:
Family/Other:
Visit type:
Date:
Feedback on the PFCC Coaching Program:

- Very helpful: 60%
- Helpful: 40%
...I believe this type of experience is valuable since habits (good or bad) creep into communication...Very professional and insightful. I would like to do this again...
COMMENTS FROM PHYSICIAN PARTICIPANTS IN THE PFCC COACHING PILOT

Very helpful indeed, even though it was truthful!
Advantages of coaching

1) innovative
2) interdisciplinary,
3) openness to feedback,
4) diminishment of professional hubris, and
5) respect for the value that other disciplines bring.

William Watson PhD, 2013
The Ideas behind Coaching

- we all have blind spots,
- we don't know everything,
- we are constantly missing things,
- we can improve our practice in critical ways, and, most importantly,
- we can learn from others who are not of the same discipline.

William Watson PhD, 2013
Coaching is subversive to the dominant culture of the disciplinary silo.

William Watson PhD, 2013
Physicians Criticizing Physicians to Patients

McDaniel, Morse, Reis et al, *J of Gen Int Med*, In Press
Experiencing Transdisciplinary Professionalism

Ian Deutschki, MD and Lauren DeCaparole, PhD
University of Rochester
Department of Family Medicine
Rochester NY
SHARED MENTAL MODEL
The Biopsychosocial Approach
REFLECTIVE COLLABORATIVE PRACTICE AND APPLICATION TO OTHER PATIENTS
THANK YOU!