L eaders of medical institutions are responsible for creating environments in which physicians, scientists, and other health care professionals are able to sustain their deep capacity for high-quality, compassionate care. Creating such environments depends on supporting a culture of trust, which has been identified as the core of successful leadership.1–3

The mission statements of both academic and community-based medical centers and hospitals characteristically reflect high aspirations for excellence in patient care. Yet, despite significant resources directed toward improving the delivery of health care, the rate of preventable and iatrogenic patient injuries has not improved significantly.4,5 Although a number of reasons have been cited for this lack of progress,6,7 there is growing recognition that an environment in which professionalism is not embraced, or where expectations of acceptable behaviors are not clear and enforced, can result in medical errors, adverse events, and unsafe work conditions.7–9

Simultaneously, health care providers are experiencing decreased control over their work environment. Clinicians are expected to increase efficiency by seeing a greater number of patients with fewer resources, be readily available in person or online, and provide timely and error-free care. This environment of decreased control and escalating responsibilities in turn can lead to a self-defeating cycle of clinician stress, depression, and burnout.10 In addition, these factors are likely to contribute to an increase in professionalism lapses. An estimated 3% to 5% of physicians and nurses exhibit “disruptive” (unprofessional) behavior, which negatively affects coworker communication; team dynamics; and, ultimately, patient safety.11

At its best, professionalism fosters what Kirch described as “a culture that is grounded in the values of collaboration, trust and shared accountability. . . . that encourages transparency and inclusivity, rather than exclusivity. . . . [and] that is driven equally by our traditional commitment to excellence, and by service to others.”12

In this article, we describe the development of the Center for Professionalism and Peer Support (CPPS) was created in 2008 at Brigham and Women’s Hospital (BWH), Boston, to educate the hospital community regarding professionalism and manage unprofessional behavior. CPPS includes the professionalism initiative, a disclosure and apology process, peer and defendant support programs, and wellness programs. Leadership support, establishing behavioral expectations and assessments, emphasizing communication engagement and skills training, and creating a process for intake of professionalism concerns were all critical in developing and implementing an effective professionalism program. The process for assessing and responding to concerns includes management of professionalism concerns, an assessment process, and remediation and monitoring.

Results: Since 2005, thousands of physicians, scientists, nurse practitioners, and physician assistants have been trained in educational programs to support the identification, prevention, and management of unprofessional behavior. For January 1, 2010, through June 30, 2013, concerns were raised regarding 201 physicians/scientists and 8 health care teams.

Conclusions: The results suggest that mandatory education sessions on professional development are successful in engaging physicians and scientists in discussing and participating in an enhanced professionalism culture, and that the processes for responding to professionalism concerns have been able to address, and most often alter, repetitive unprofessional behavior in a substantive and beneficial manner.
for Professionalism and Peer Support (CPPS) and the results of our programmatic initiatives at Brigham and Women’s Hospital (BWH), Boston, to educate the hospital community regarding professionalism, as well as our process for managing professionalism lapses.

Methods

Setting

BWM, a 793-bed tertiary care facility, serves as a major teaching hospital of Harvard Medical School. The physician and scientist faculty is composed of 2,738 individuals (1,630 [60%] men and 1,108 [40%] women), who represent 13 major specialty departments. The number of faculty at each rank includes instructor, 1,434 (52%); assistant professor, 638 (23%); associate professor, 395 (14%); and professor, 271 (10%).

Establishing the Center for Professionalism and Peer Support

In 2008 we established the CPPS to strengthen and support a culture of trust explicitly predicated on mutual respect for individuals, teams, the institution, and patients and their families. The mission of the CPPS is to encourage a culture that values and promotes mutual respect, trust, and teamwork. To achieve this, we established several key programs, including the professionalism initiative, a disclosure and apology process, peer support, and defendant support programs (Figure 1, above). We chose to define professionalism as any intent, action, or words that foster trustworthy relationships. Inui has stated:

...“the present intensity of our discourse about professionalism in medicine represents both a flight from commercialism, on the one hand, and a corresponding need to reaffirm our deeper values and reclaim our authenticity as trusted healers, on the other.”

Trust embraces such concepts as integrity, transparency, and self-awareness, which require an understanding of our own motivations. Over time, trusting relationships throughout an institutional community encourage and provide support, particularly during difficult times. According to Drucker, “Organizations are no longer built on force but on trust. . . . Taking responsibility for relationships is therefore an absolute necessity.”

Trust is the unifying concept—trust among health care team members, as well as between us and our patients and society. Conversely, unprofessional behaviors are those that diminish or destroy relational trust. For example, a conflict of interest may violate the trust between the clinician and society; disrespectful behavior breaches the trust between the clinician and the patient; and disruptive behavior erodes the trust between the clinician and other health care providers.

The CPPS initiated its professionalism educational efforts and handling concerns process with a focus on physicians and scientists. This choice partially reflected the roles of individuals for whom complaints had been received historically, as well as an understanding of the hierarchical patterns of culture and behavior inherent in the practice of medicine. Many leadership organizations, including the American Board of Internal Medicine, the American College of Surgeons, the Accreditation Council for Graduate Medical Education Outcome Project, and The Joint Commission, have documented comprehensive definitions of professionalism that include stated expectations of physician behavior. That said, everyone in the institution is expected to be accountable for their behavior. Issues deeply embedded into the medical culture (for

* Leadership (LD) Standard LD.03.01.01. Leaders create and maintain a culture of safety and quality throughout the hospital. Element of Performance (EP) 4: Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety. EP 5: Leaders create and implement a process for managing behaviors that undermine a culture of safety.
example, a hierarchical, highly competitive, sometimes punitive environment) can undermine the sense of trust and as a consequence, professionalism. Lesser et al. observed, “professional behaviors are profoundly influenced by the organizational and environmental context of contemporary medical practice.”

To support a culture of professionalism at an institutional level, organizations must address unprofessional behavior in a substantive and direct way. In 2008 The Joint Commission suggested that health care organizations “develop and implement policies and procedures/processes” that address ‘zero tolerance’ for intimidating and/or disruptive behaviors,” which include “overt actions such as verbal outbursts and physical threats,” as well as more subtle behavior such as intimidation, “reluctance or refusal to answer questions” or answer pages/calls, “condescending language or voice intonation,” and “impatience with questions.”

**Critical Dimensions in Developing and Implementing an Effective Professionalism Program**

In our experience, several dimensions are critical in developing and implementing an effective professionalism program: leadership support, establishing behavioral expectations and assessments, emphasizing communication engagement and skills training, and creating a process for assessing and responding to concerns.

**Leadership Support and the Code of Conduct.** In 2003, following a number of employment lawsuits, BWH leadership recognized that health care institutions, including ours, lacked widespread understanding of employment law and the principles of appropriate workplace behavior. In 2006 we partnered with an employment law educational company to develop a series of professionally acted videotaped vignettes and a workbook, which formed the basis of a required educational program for all physicians.

During the following several years, various challenges and opportunities emerged, prompting us to begin the development of a broader initiative. We realized that true cultural transformation requires a partnership between institutional champions and like-minded teammates who are able to deliver and reinforce the message that these initiatives are key to our fundamental mission. Such initiatives also can and should be created with enough consistency and intentionality that their outcomes can be measured and their effects sustained.

The founding director of the CPPS [J.S.] is a surgeon who has worked in that capacity at BWH since 1986. As the Associate Director of Graduate Medical Education for Partners Healthcare, which includes BWH, Massachusetts General Hospital, and affiliates, she had been involved in some of the nascent programs regarding professionalism and peer support that were initiated by Anthony Whitemore, MD, the then BWH chief medical officer (CMO). She proposed creating a center to further the development and leadership of the disparate initiatives to focus the cultural change mission and to strengthen each program. Gary Gotlieb, MD, who was then president of BWH, fully supported the creation of the CPPS. In 2008 the CPPS director was given responsibility for creating institutional change through access to key people and support for programmatic development.

We solicited the ideas of thought leaders within the institution from various departments, committees, and resources. We made the physicians and scientists aware of the CPPS by publicizing our mission, logo, and contact information, and indicating that our physical location in the hospital was staffed daily during regular business hours. Recognition and acceptance of our professionalism initiative was driven by the development of (1) an educational program to clarify expectations and teach skills in professional behavior and interpersonal communication, and (2) a process for reporting, assessing, and remediating individuals with unprofessional behavior.

Under the authority of the CMO to whom she reports, the director is supported as a 0.7 full-time equivalent. The center has a manager who assists in the development and evaluation of programs, as well as an administrative assistant to assist with scheduling meetings and programs. In 2011 an additional clinician [L.C.T.] with clinical research experience and leadership was appointed as associate director as the scope and number of evaluations and programs increased.

We developed an institutional Code of Conduct (Appendix 1, available in online article), which provided an opportunity for us to restate our commitment to one another and to our patients, in a multidisciplinary, inclusive, and iterative process. In addition, we formed a trusted group of advisors that meets regularly. Each time we gather, this Professionalism Leadership Group, composed of physicians, nursing administrators, and other leaders, discusses CPPS updates and issues and then reflects on our work, using the principles developed by Palmer in his work regarding courage and renewal.

**Educational Programs.** To support the identification, prevention, and management of unprofessional behavior, we recognized that policies and codes of conduct alone do not change behavior. The experience of the CPPS director and other BWH thought leaders, as well as the extensive organizational leadership literature, reinforced our belief that the elements needed
to promote professionalism among individuals and teams include conflict and stress management, communication and teamwork, an awareness of systems resources, and the presence of a supportive community. To facilitate such awareness and skills, we collaborated again with the employment law educational company to revise our training materials on the basis of feedback from earlier sessions. These materials are used in a 1.5-hour, interactive educational session for which attendance by every physician (from trainee to senior physician) and scientist is required to maintain institutional credentials. Although we recognized that professionalism concerns were not limited to physicians and scientists, we focused our initial training on those groups, while maintaining a collaborative relationship with the institution’s leadership, including nursing, administration, and human resources. An average of two sessions per month are scheduled at various times to accommodate different work schedules. The content of the sessions fulfills the following functions:

- Emphasizes the hospital’s commitment to a safe and respectful working environment
- Includes discussions on harassment, bullying, and responses to work-hour requirements
- Provides an exploratory and learning opportunity for clinicians to communicate with colleagues regarding individual and organizational challenges to professional behavior
- On the basis of a frame-based approach derived from our work with the Center for Medical Simulation, provides specific strategies for managing conflict and giving feedback to colleagues who have behaved unprofessionally
- Details the institution’s program for addressing concerns

Because the participants represent a diversity of specialties and experiences, the open discussions provide an opportunity to share a variety of perspectives that frequently illuminate the range of unprofessional behaviors and the responsibility of colleagues and bystanders to speak up.

In addition to these professionalism training sessions, we lead a series of voluntary, interactive workshops to enhance skills in communicating and giving feedback.

Creating a Process for Managing Professionalism Concerns. The process for assessing and responding to concerns includes (1) intake of professionalism concerns, (2) an assessment process, and (3) remediation and monitoring.

1. Intake of Professionalism Concerns. In developing a system for reporting, evaluating, and responding to professionalism lapses, we created a process that is confidential, centralized, clear, and respectful. Protecting the confidentiality of the reporting individual is imperative, particularly for those individuals considered vulnerable to retaliation. The individual cited as being unprofessional—the focus person (FP)—must also be treated respectfully. Our centralized system, in contrast to a disseminated model within specialty departments, has several advantages in that it allows for a more consistent response, eliminates favoritism and a sense of futility, facilitates the aggregation of data so that patterns become evident, and enhances our ability to recognize and intervene when microcosms of unprofessional behavior are team based.

Reports of interprofessional behavior problems are brought to the attention of the director or associate director by affected individuals, as well as by concerned leaders. Our mandatory professionalism education program is one way in which we raise awareness of our availability as a resource for handling professionalism concerns.

For this article, we analyzed all concerns reported to the CPPS from January 1, 2010, through June 30, 2013. We responded to all reports, with the nature of the response dependent on variables such as the severity and frequency of the behaviors. Decisions about the severity of the behavior were made on the basis of the perspective of the person reporting the behavior, as well as multisource interviews with others who may have experienced or witnessed the behaviors. We developed a system for categorizing the types of reported behaviors of the physicians/scientists (Table 1, page 172). The categories were developed as an iterative process by the CPPS director and associate director.

The cases involved individuals from different departments (Table 2, page 172), including many individuals who served in senior leadership roles within their laboratory, division, or department. A few cases involved a limited interpersonal conflict between two individuals or elements not directly relevant to our code of conduct (for example, technical competence or knowledge base issues).

The CPPS is not a disciplinary body and thus does not funnel behavior complaints into the ongoing professional practice evaluation (OPPE) process. We encourage division chiefs to do so, as many have already done.

Although we primarily focus on interprofessional behavior concerns, we are also attuned to clinician-patient professionalism issues. Concerns involving patient complaints are filtered to us through two routes. The CPPS director sits on the Medical Staff Credentialing Committee, where patient complaint data from our electronic database are routinely reviewed. If a physician has generated repeated patient complaints, the center’s director facilitates a feedback intervention and monitors subsequent patient complaints. In addition, the CPPS meets regular-
ly with the BWH Department of Patient and Family Relations to review all patient complaints from the database and identify patterns that require intervention.

2. Assessment Process. In designing the assessment process, we felt that an algorithm would be constraining and could be perceived as unfair if we deviated from it in any way. It is important to have a process that is consistent but also flexible enough to deal with the nuances of each case.

The assessment process must discreetly determine the validity of the reported professionalism lapses and any potentially exacerbating issues. The first step involves an in-depth conversation with the person voicing the concern (the reporter). If the concern is not egregious or is an isolated incident and the FP has not had any other issues, we usually coach the reporter on how to give the FP direct feedback regarding the incident. If the person does not feel “safe” in giving direct feedback, we involve a more senior colleague to facilitate. If the behavior is severe, its severity is unclear, or its validity is in question, the director or associate director performs multisource interviews. Some cases, such as those regarding harassment or discrimination, may require an investigation by Human Resources. If, after the assessment or investigation, the concerns are found to be either repetitive or egregious, the director or associate director discusses the findings with a physician of meaningful authority in the FP's professional life (for example, division chief, department chair, or CMO). We develop a plan and then, in a feedback intervention, present anonymous findings to the FP in the presence of his or her supervisory physician—and explicitly define expectations for corrected behavior, outline a monitoring process, and state the consequences of not adhering to the professional behavioral expectations (Table 3, page 173). Occasionally, an outside evaluation or treatment is required. In rare cases, and pertinent to the nature of the complaint, immediate suspension may be necessary during the investigation.

Feedback given to the FP regarding his or her perceived behavior should protect the person(s) who reported or corroborated the concerns. During the feedback intervention, we explicitly state the institution’s unwillingness to tolerate any form of retaliation. Feedback conversations in the presence of the FP’s department chair, division chief, or supervising physician emphasize the importance of the intervention and add local oversight and encouragement.

3. Remediation and Monitoring. Resources for supporting behavior change include professional behavioral coaching, conflict resolution programs, and mental health support for emotional stressors if such stressors are raised by the FP as a concern. At this stage, use of these resources is usually encouraged but not mandated. The intent is to help the FP alter the exhibited behavior rather than to attempt to diagnose the behavior. Although physicians almost reflexively try to explain unprofessional behavior as a consequence of mental or physical illness, that is not our role in these situations. Ultimately, it is the FP’s choice whether to change the behavior. He or she is more likely to do so if this choice is internally motivated. As part of the feedback intervention, hearing the FP’s explanation for the be-

<table>
<thead>
<tr>
<th>Complaint Category</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demeaning</td>
<td>55 (27)</td>
</tr>
<tr>
<td>Angry</td>
<td>51 (25)</td>
</tr>
<tr>
<td>Uncollelgial</td>
<td>16 (8)</td>
</tr>
<tr>
<td>Patient communication</td>
<td>16 (8)</td>
</tr>
<tr>
<td>Shirking responsibilities</td>
<td>11 (5)</td>
</tr>
<tr>
<td>Hypercritical</td>
<td>8 (4)</td>
</tr>
<tr>
<td>Clinical competence</td>
<td>8 (4)</td>
</tr>
<tr>
<td>Misconduct</td>
<td>7 (3)</td>
</tr>
<tr>
<td>Sexual innuendo</td>
<td>6 (3)</td>
</tr>
<tr>
<td>Other (for example, sexual harassment, substance abuse, boundary issues, leadership competence)</td>
<td>23 (11)</td>
</tr>
</tbody>
</table>

Table 1. Primary Reported Professionalism Lapses by Physicians/Scientists, January 1, 2010–June 30, 2013 (N = 201)

<table>
<thead>
<tr>
<th>Department</th>
<th>Total</th>
<th>Percentage of Total Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>51</td>
<td>24.4</td>
</tr>
<tr>
<td>Medicine</td>
<td>51</td>
<td>24.4</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>31</td>
<td>14.8</td>
</tr>
<tr>
<td>Radiology</td>
<td>11</td>
<td>5.3</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>10</td>
<td>4.8</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>9</td>
<td>4.3</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>6</td>
<td>2.9</td>
</tr>
<tr>
<td>Newborn Medicine</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>5</td>
<td>2.4</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>Neurology</td>
<td>3</td>
<td>1.4</td>
</tr>
<tr>
<td>Dermatology</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Pathology</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Other (for example, dental, ophthalmology, nuclear medicine, rehabilitation medicine, departments from affiliated institutions)</td>
<td>16</td>
<td>7.7</td>
</tr>
</tbody>
</table>

Table 2. Department Affiliation of the Reported Individual or Team, January 1, 2010–June 30, 2013 (N = 209)*

*Reports concerned 201 physicians/scientists and 8 health care teams. OB/GYN, obstetrics/gynecology.
behavior can be helpful in identifying overlap between the team's needs and the FP's goals. For example, if the discussion reveals that the FP (Dr. Jones) raises his voice and criticizes his team because he is trying to advocate for his patients, the feedback provider can honor that intent and point out that such behavior actually represents a risk to his patients. We recognize that unprofessional behaviors may be a habitual response to stressful or conflicted situations, or related to age, culture or ethnicity, gender, upbringing, or perceptions regarding organizational systems failures or hierarchy. We repeatedly highlight that what is important is not the intent but rather the impact of one's behavior.

After a period of time (typically, three to six months), another series of more limited (in number and duration) interviews are performed to determine if progress in the FP's behavior has been made; additional meetings and consequences may result from these interviews. If the behavior has improved, the FP is given positive feedback. If there is insufficient improvement, there are a series of escalating consequences, modeled after the accountability pyramid described by Hickson and colleagues.

Assessments and consequences are meticulously documented. Several other leaders are often involved, including the CMO and the Office of General Counsel. Depending on the circumstances, on some occasions we refer for an occupational health or neurocognitive evaluation. Issues of misconduct or substance abuse may trigger other pathways, such as disciplinary action (in accordance with the hospital bylaws), a required evaluation by Physician Health Services, or reporting to the Board of Registration in Medicine. We also formed a Professionalism Advisory Committee to provide regular case review.

Results

**PARTICIPANT EVALUATION OF PROFESSIONALISM TRAINING SESSIONS**

At the conclusion of the mandatory professionalism training sessions, participants are asked to complete an evaluation indicating their professional role (for example, training level) and provide an assessment (for example, 1 = "strongly agree"; 5 = "strongly disagree") of three elements: (1) whether the objectives of the session were met (for example, accepting their responsibility in supporting the institution's professionalism culture), (2) whether the session improved their understanding of professionalism, and (3) whether the session enhanced their professional practice. In addition, participants are asked to provide written comments on the most important "take-away" lessons, the strengths of the session, and improvements that could be made to the training sessions.

The first training sessions were held in 2005, and since then thousands of physicians, scientists, nurse practitioners, and physician assistants have been trained. A total of 1,287 physicians and scientists completed the session from October 10, 2010, through December 31, 2012. We instituted a session evaluation in 2011, and 529 individuals completed the evaluation form; although precise response rates are not available, the estimated rate was more than 90%. The sessions were highly favorably rated, with mean scores of 1.5, 1.7, and 1.8 for objectives being achieved, awareness being increased, and their sense that the session will enhance their professional practice, respectively. In 2012, 757 individuals completed the evaluation form, which indicated mean scores of 1.6, 1.7, and 1.8 for the same outcomes. The most common written comments indicated an

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**Table 3. Center for Professionalism and Peer Support Process for Handling Repetitive or Egregious Lapses**

<table>
<thead>
<tr>
<th>Steps</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1: Receive Report of Concerning Behavior</td>
<td>Conduct confidential conversation with reporter regarding focus person (FP) to determine next steps. For example, if the concern is deemed an isolated incident, the FP has not had any other issues, and the reporter feels safe to do so, we provide coaching for the person bringing forward concerns on how to give the FP direct feedback regarding the incident. If the concerns are more complex, we proceed to Step 2.</td>
</tr>
<tr>
<td>Step 2: Assessing Concerns</td>
<td>To validate the concerns and assess their frequency and severity, multisource interviews are conducted to provide comprehensive insight into and corroboration of alleged behavior.</td>
</tr>
<tr>
<td>Step 3: Feedback Intervention</td>
<td>Share findings of investigation with department chair, division chief, or supervising physician initially without FP, then again with FP. A summary of specific behaviors, resources for facilitating behavioral changes, and warnings regarding retaliation is detailed. Follow-up processes are put into place.</td>
</tr>
<tr>
<td>Step 4: Intervention to address subsequent lapses</td>
<td>The institutional administration is involved, with legal counsel present and a plan of action developed. Selected institutional administrators meet with FP to detail expected behavioral changes and consequences, including termination.</td>
</tr>
<tr>
<td>Step 5: Communication with those reporting complaints</td>
<td>Communication with reporter to detail that an intervention has occurred, with encouragement for reporting of unchanged behavior or any form of retaliation; respect for the privacy of the FP is maintained.</td>
</tr>
</tbody>
</table>

acceptance of a personal role in ensuring a culture of professionalism and appreciation that a functional system exists to manage unprofessional behaviors.

**Reported Concerns Regarding Professional Behavior**

The number of reports has steadily increased each year, with 45, 51, and 71 submitted in 2010, 2011, and 2012, respectively. From January 1, 2010, through June 30, 2013, the CPPS received reports of 201 physicians/scientists and 8 health care teams about whom concerns were raised (for a total of 209 reports). There was excellent interrater agreement (90.3%) between the two raters for 41 randomly selected scenarios (Cohen’s kappa = 0.88; standard error, 0.07; p < .0001).

A number of different interventions were used (Figure 2, right), depending on multiple factors such as the type, severity, and frequency of the behaviors. The most common intervention was a feedback conversation with the FP and his or her supervisory physician, usually facilitated by the CPPS director or associate director. Some FPs underwent behavioral coaching.

Career outcomes for the FPs are shown in Figure 3 (right). A minority of cases required demotion from positions of authority or having the individual leave the institution.

To assess behavioral outcomes (Figure 4, page 175), the director and associate director reviewed each case and obtained as much follow-up information from various sources, including those who brought the concerns forward, other health care team members, and supervisory physicians, as possible. We recognize that such information is highly subjective but believe that it is nonetheless worthwhile. This process revealed substantive changes in the behavior of multiple individuals.

Many cases were resolved by the feedback intervention, as individuals became aware of how other people perceived them and as they took active steps to mitigate some of the external stressors. Some FPs, although initially angered or confused at being identified as unprofessional, were subsequently appreciative of our process for enabling them to find their “former,” more professional, selves.

**Discussion**

Our intention in creating the CPPS was, above all, to create a more supportive professional community, one in which we can, as Walsh stated, “begin to define and experience leadership as a collective project that derives its power and authority from a cooperative attachment to mutually defined commitments and values.”

Our findings indicate that mandatory education sessions on professional development are successful in engaging physicians and scientists in discussing and participating in an enhanced professionalism culture, and that our processes for responding to professionalism concerns have been able to address, and most often alter, repetitive unprofessional behavior in a substantive and beneficial manner.

The recognition that professionalism plays a significant role in workplace satisfaction and patient safety and malpractice risk...
has been highlighted by several investigators. The Sentinel Event Alert from The Joint Commission, the policy (H-225.956) on “Behaviors That Undermine Safety” from the American Medical Association, the “Code of Professional Conduct” from the American College of Surgeons’ Task Force on Professionalism, and a similar code from the American Board of Internal Medicine, all recognize the necessity of responses to unprofessional behavior within health care institutions. The universal applicability of these documents to the practice and science of medicine indicates that all institutions, regardless of size, academic orientation, or geographical placement, must take steps to enhance the culture of professionalism.

We agree with other leaders in the field that any professionalism initiative cannot succeed without the commitment of both the leadership and engaged champions for this process. In our case, the hospital leadership supported the development of a robust, systematic, and multifactorial process to begin addressing this foundational issue.

We developed an institutional definition of professionalism and an associated code of conduct. Our definition of professionalism as that which supports trustworthy relationships became a focal point toward which a common purpose, language, ethos, and code of conduct could develop. To create awareness of our code of conduct and our expectations for professionalism, we developed an interactive educational program. Many institutions have incorporated similar programs, with content frequently derived from professional subspecialty societies, and have demonstrated subsequent improvement in professionalism awareness among participants. Kumar et al., using the American College of Surgeon’s case-based multimedia materials, improved the ability of residents to define and recognize components of professionalism and discuss unprofessional behavior. Hultman et al., who created a 6-week, 12-hour course within an academic plastic surgery practice, demonstrated a significant increase in professionalism knowledge and a decrease in sentinel events related to professionalism.

The video vignettes that we use in our mandatory professionalism training sessions facilitate a mixture of didactic and interactive education, which fosters greater learning and concept retention than either method alone. Moreover, the vignettes enable learners to observe and practice responses to specific behaviors and attitudes—and thereby adopt the new skills. McLaren, Lord, and Murray indicated that the use of vignettes, movie clips, or reflective writings in education programs focused on correcting unprofessional behavior make concepts more relatable and engender greater self-reflection and awareness.

The CPPS’s initiation of its work with physicians and scientists partially reflected the roles of individuals for whom complaints had been received historically, as well as an understanding of the hierarchical patterns of culture and behavior inherent in the practice of medicine. Ultimately, however, professionalism is a shared responsibility among all individuals within a health care institution, and multidisciplinary team training is an important component. We did expand our required professionalism training to all nurse practitioners and physician assistants. Although we believe that most other clinical, educational, and research personnel would benefit from the interactive professionalism training sessions, those sessions are particularly resource intensive. We have therefore chosen to focus our other multidisciplinary approaches on specific groups that have asked for interventions to improve teamwork communication. In recent years, we have begun drawing on the work of Gittell, et al. on relational coordination to assess and guide team-based interventions.

By introducing our professionalism initiative at the orientation seminar for all new interns, residents, fellows, staff physicians, and scientists, we establish the expectations and boundaries for acceptable behavior, as well as the importance of holding one another accountable for our behavior. Particularly for new health care practitioners and scientists, our program sets expectations and highlights our commitment to professional behavior early in their career development, which may be critical to the formation of lifelong habits and professional identity. The need for early exposure to professionalism expectations is increasingly salient, given the greater mobility and globalization of our trainee population, for whom cultures, practices, and behaviors can vary considerably.

Despite a growing number of programs demonstrating notable and salutary improvements in professionalism aware-
ness, Papadakis et al. observed that we “generally do not have the knowledge, skills, and methodologies to address unprofessional behavior when we encounter it.”24 (p. 1095) We believe that approaching those persons with professionalism lapses in a compassionate manner with the intent of supporting their intrinsic motivation to remediate their behaviors is most likely to lead to sustained behavioral change. That said, the expectations and consequences of not behaving professionally need to be clear. Indeed, we strongly believe that educational programs must be coupled with a robust program for reporting, assessing, and managing individuals exhibiting unprofessional behaviors. A central tenet of any process is that it be consistently applied throughout the institution, with no protected individuals, teams, or divisions. Our most senior institutional leadership, including the president and CMO, have stood by the commitment to hold everyone to a high professional standard. This means that we are each held accountable for our behaviors; if, after feedback and reiterating expectations, as well as providing remediation resources, the unprofessional behavior is either repetitive or egregious, there need to be consequences for the individual such as removal from teaching roles, demotion from leadership positions, or termination.

We face the challenge of how to better measure the success of the CPPS initiative. Have we indeed positively affected the culture in our institution? And if so, what is the respective contribution of each of the CPSS programs to such a culture change? Other institutions have used validated scales of measurement to assess the impact of professionalism programs on provider behavior and the overall work environment. For example, DuPree et al.8 used the US Agency for Healthcare Research and Quality Hospital Survey on Patient Safety Culture43 and the Institute for Safe Medication Practices Survey on Workplace Intimidation44 to measure the impact of their multidisciplinary program on a labor and delivery suite at Mount Sinai Hospital (New York City). In addition, we need to improve our follow-up of FPs’ behavior so that we can better assess the outcomes of our interventions.

According to the Hickson et al. accountability pyramid, a greater number of individuals exhibit a single incident of unprofessional behavior that is observed as an anomaly and responsive to an informal intervention; fewer individuals show an apparent or persistent pattern of unprofessional behavior, which is followed up with an “awareness” or “authority” intervention; and even fewer demonstrate no behavior change, which results in disciplinary action.29 In contrast, most of our reported concerns have involved patterns of recurrent unprofessional behavior rather than single anomalous incidents. Our program is also unique in its focus on interprofessional behavior, as well as clinician-patient professionalism.

We view the increasing number of individuals being reported to the CPPS with each subsequent year as a reflection of trust in our center and its processes. DuPree et al.6 also reported a steady increase in the number of reports (during a six-year period). We have noticed a trend toward earlier reporting of unprofessional behaviors—when the behaviors are less severe and have been manifest for less time. This trend decreases the need for multisource interviews and enables us to do more coaching of peers to provide difficult feedback regarding interprofessional lapses. In addition, we are increasingly finding lesser severity of unprofessional behavior among team members, even if patterns of communicating and relating among various groups within the team are sometimes less than ideal.39

Conclusions
Initiating and sustaining changes in professional relationships requires a significant and sustained commitment to cultural change. We have made substantial progress in professionalism with the creation of our Center for Professionalism and Peer Support, which includes a code of conduct; mandatory educational programs; and a robust reporting, assessment, and management process for handling concerns regarding professionalism lapses. Future work is needed to more carefully categorize different types of unprofessional behavior, track the most appropriate and effective behavior modification strategies, and identify methods for conflict resolution, team training, and relational coordination between different types of providers.1

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Appendix 1. Code of Conduct

Code of Professional Conduct Policy
Brigham and Women’s Hospital
Brigham and Women’s Physicians Organization

Brigham and Women's Hospital and the Brigham and Women's Physicians Organization are committed to providing the highest quality health care to patients and their families, to expanding the boundaries of medicine through research, and to educating the next generation of health care professionals. We are also committed to ensuring an ideal work environment for all employees, medical staff and trainees whereby our core values of excellence, compassion, respect, and diversity are embraced by all. We believe in and uphold the principles of a fair and just culture and communicate these beliefs and values throughout the institution.

We expect our employees, medical staff and trainees to:

• Adhere to hospital policies and procedures.
• Maintain a professional demeanor at all times and treat each person with courtesy, decency, and respect. Use words and actions that are thoughtful, constructive, tolerant, and compassionate.
• Be collegial team members and recognize and support each member's value in our interactions with them.
• Be accountable for our behavior and avoid retaliation against those who report concerns.
• Never engage in or tolerate inappropriate, disruptive, or abusive behavior.
• Never work while impaired by any substance or condition that compromises ability to function safely and competently.
• Listen and respond to patients, patients' families, and community members.
• Respect and value diversity.
• Respect our patients' confidentiality and privacy.
• Maintain the highest ethical standards and address conflicts of interest honestly and directly.
• Be honest and forthright in representing information and ensure accurate attribution for all work.
• Report near misses and errors and disclose and apologize to patients in order to improve patient care.
• Make wise use of the hospital's human, financial, and environmental resources.
• Support quality, safety, and efficiency initiatives in order to enhance patient care.
• Attempt to resolve differences in a spirit of cooperation and to create solutions that benefit all parties.