



The RCCI Newsletter

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Relationship-Centered Care Initiative

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3D Meets RCCI

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When you think about the RCCI and its goal of improving the informal curriculum of medical education, your mind probably doesn't leap immediately to budgeting and the allocation of discretionary funds within the medical school.

The way financial decisions are made, however, has a profound effect on the organizational culture, particularly with regard to attitudes about authority and the use of power. In the past year, IUSM has started to implement a new approach for allocating funds to its departments called Data Driven Decision-making (or "3D").

The roll-out of this new method creates an opportunity for a landmark change in management culture – a shift from control-oriented to relationship-centered administrative processes throughout the school.

To understand just how significant a change this is, we must first examine the typical budget negotiation process in a medical school.

Typically department chairs negotiate one-on-one with the dean to gain as large a share of discretionary funds as possible (e.g. funds from tuition, unrestricted gifts and general appropriations; most of a school's revenues such as grants, contracts, and program-specific governmental appropriations are earmarked for specific purposes and are not subject to the dean's or anyone else's discretionary use). The chairs don't know how much discretionary money is available or how much money other departments get.

This system of "secret deals" creates an information imbalance that has traditionally been the source of the dean's power, but it also backfires. Chairs commonly assume that all the other departments are getting more favorable treatment, so the only rational thing for them to do is to constantly maximize their demands for funds in the hope that they'll get some fraction of what they request. The dean gets no help from them in balancing and prioritizing their requests.

Two other limitations of the traditional allocation proc-

ess are the heavy constraint of historical precedent (it is hard to alter previous departmental allocations, even when they've been negotiated by different people and under very different circumstances) and the establishment of departmental needs by the dynamics of personal power and persuasion rather than by an integrated school-wide mission and data on each department's actual contributions. Other than crude measures of research and clinical revenues and volume of teaching, such data do not exist).

That's exactly where 3D comes in. It involves the collection of much more information about the clinical, teaching, research and administrative activities of individual faculty members, and tracks of quality measures, as well. Composite pictures of each department's contribution to the school's mission and strategy can then be created and funds can be allocated accordingly.

There are two potential limitations to the 3D approach. First, the data can never be perfect. There will always be controversy about the fairness, validity and pri-



We are a group of individuals who are fostering relationship-centered organizational change at IUSM by embodying that change ourselves.



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Professional Conduct: the value of a simple apology



During a vertical mentoring meeting, a student shared an experience he had had on his surgery rotation concerning what it means to conduct oneself professionally.

The student observed a surgery resident who was to have begun a surgical procedure and have the patient ready for the attending to take over when he arrived. When the attending didn't arrive at the agreed upon time, the resident told those assembled that he would wait since he had never done this procedure before and "didn't feel right" about starting it without supervision. This caused great discomfort among those in the room (and some discussion), but the resident held firm.

When the attending arrived, he publicly "bawled out" the resident for the better part of a half hour. After the attending calmed down and reflected for a bit he said in front of everyone in the room that he was wrong to have bawled the resident out. He told him that what he had done was exactly what he should have done, and apologized for making a scene and being late. He even admitted that his strong reactions were due to his own discomfort and embarrassment at coming in late.

The student then reported that everyone involved had agreed that the attending's admission of responsibility was a model of "conducting oneself professionally." It left a permanent and positive impression on the student, and doubtless it did with the others who had witnessed it as well.

Dr. Keith Lillemoe, Chair of the Surgery Department, gives the following commentary about the above critical incident.

The events described in the incident report unfortunately happen far too commonly on the surgical service and most frequently in the operating room.

Factors contributing to this include: stress associated with the life and death nature of some surgeries; the surgeon, feeling he or she is the captain of the ship, has the need to command absolute authority; or the technical and cognitive complexity of the environment where so many little things can go wrong and add stress to the situation.

Unfortunately many surgeons acquire or learn bad behavior by having seen such actions practiced by their teachers and generations of surgeons before them.. Regardless of the factors, a lot went wrong in the case described above, but the outcome ended up right.

Further analysis of the event may lead to a better understanding of the circumstances involved. First and most importantly, a surgical resident, regardless of his or her level of experience, is still a trainee. Certainly, there are aspects of an operation that a resident can proceed with safely and confidently. However, at no time should a resident be asked to proceed without supervision in a setting in which he or she feels uncomfortable. The decision of the resident in this case, to not bow down to pressure to start the case, was clearly the correct one.

The initial response of the surgeon was predictable. Being late to the operating room would obviously create a domino effect for the rest of his day, a stressful situation for anyone. His only salvation, in his own mind, was to hope that the resident had made appropriate progress to help him "catch up." When he discovered that this was not accomplished, his frustration led to a public display of displeasure directed

toward the resident. Having been there myself on a number of occasions, I am sure that the attending realized within minutes that the resident had done the right thing and that it was HIS reaction that was inappropriate.

But rather than try to save face and continue to show his ultimate "command" of the situation, he made the effort to publicly apologize so that everyone in the room recognized that it was his error and that the resident had made the right decision. The senior surgeon had "repaired" the situation by affirming the resident's actions.

Whether directed toward a resident, scrub or circulating nurse, anesthesia team, or anyone else who happens to create displeasure for the surgeon in the operating room, initial responses to unmet expectations can often be harsh.

It is important for the surgeon to remember that everyone is trying to do the best possible job. Even if he or she feels displeased and a strong response is justified at the time, the day may still be salvaged with a brief apology and a thank you to everyone involved at the conclusion of the case.

Recognizing and acknowledging difficult interpersonal dynamics can go a long way to soothing any hard feelings. This incident shows that we surgeons are learning to better deal with frustrating situations. It is my hope that my surgical colleagues will continue to maintain this progress.



Recognizing and acknowledging difficult interpersonal dynamics can go a long way to soothing any hard feelings



"No problem can be solved from the same level of consciousness that created it."

—Albert Einstein

Up-Coming Events

Discovery Team Meetings:

Held in the Lilly Library, Room 301, and available by videoconference.

April 28th 10:30-12:30

May 24th 10:00-12:00

Anyone interested in learning about the RCCI is encouraged to attend all or part of a meeting. NEW MEMBERS ARE ALWAYS WELCOME!

Alumni Weekend: Appreciative interviewing with students and alumni, May 13, 12-1:30 pm

OPEN FORUM (Town meeting) for the IUSM Community: May 24, 4:00-5:30, Research 4 Bldg

AAPP National Faculty Development Course, “Professionalism as a Relationship Issue”: June 5-9, Med Science Bldg. For info, see www.physicianpatient.org.

“Exploring Relationship in Health or Health of Relationships” Conference, July 21-24, University Place, International Association for Relationship Research. Email privconf@iupui.edu.

3D Meets RCCI, Cont.

oritization of performance measures. Second, if the dean uses all this additional data to make unilateral budget decisions, the information imbalance is enormously intensified and so are perceptions of unfairness. A “Big Brother” mentality – a demoralizing feeling of being depersonalized and controlled – can take root. So enhanced performance data is not by itself an adequate solution to the problems of traditional revenue allocation. A different kind of budget conversation is also required. And that is where Relationship-Centered Care comes in.

RCC is based on *partnership* – information sharing, exploring each other’s perspectives and collaborative decision-making. The 3D process has fully embraced the principles of RCC in its implementation to date. There has been broad participation in the development of performance measures, reducing (although never fully eliminating) disagreements about validity.

More importantly, Craig Brater has shared with the members of the 3D Committees, including most of the chairs, a complete analysis of where all the funds in the medical school come from and where they go. Included in this analysis

are past allocations to each department and what changes in funding are anticipated for the future. This is possibly the first time anywhere that such data has ever been shared so widely.

The process eliminates the problematic imbalance of information and enables the chairs to join the dean in being responsible for the whole rather than just for their parts. This information-sharing also makes the chairs accountable to each other as well. If one department is getting an inappropriate deal—whether good or bad—it will be evident to everyone, and there will be significant peer pressure to correct it.

3D is still new and largely untested. The distribution of actual departmental performance data and the first round of data-driven fund allocations are milestones still to be accomplished. But for the individuals who have been directly involved in the new collaborative methods, trust has already started to grow.

Moreover, the chairs now have the opportunity to bring this new relationship-centered process of information sharing, dialogue and collaborative decision-making to the performance reviews and financial negotiations that take place within their departments.

Examining the interface between 3D and the RCCI makes it clear that it is the

quality of conversation and shared decision-making that will determine whether 3D is perceived as a tool for top-down control or a rich source of data to support responsible participation in collaborative decision-making. With deans, chairs, division directors and faculty all participating in collaborative budget negotiations, the contribution to a Relationship-Centered culture at IUSM will be profound indeed.

Commentary by Craig Brater, Dean

To me, 3D represents an opportunity for a number of things that I believe are important to our collectively achieving the success that we desire.

I believe being a top School requires that we have a culture that does the following:

Allows us to reward and celebrate the accomplishments of individual faculty members no matter where in the school they are based;

Allows Departments, Center and all administrative units to mutually depend upon one another by

o Expecting and enacting transparency

o Helping solve one another’s challenges

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The Relationship-Centered Care Initiative at IUSM was created in January 2003 by a grant from the Fetzer Institute. Our goal is to study how the dimensions of relationship-centered care—interactions between physicians and patients, physicians and the community and physicians and other caregivers—can be incorporated in the IUSM curriculum and learning environment to improve the way future physicians practice medicine.

We invite your active involvement in helping IUSM lead the way in transforming the culture of medical centers through successful integration of relationship-centered practices.

Ten thousand candles can be lighted from a single flame and the life of that candle will not be shortened, but lengthened.

Dean Brater on Data Driven Decision-Making

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If we do these things, we will amplify the innate skills and talents of our faculty. We will make the School the kind of place that we truly care about, because each of us individually truly believes that we are part of a greater whole.

We will know that our legacy is not only having made contributions as an individual but that each of us was and is part of something bigger, something that is an example of what our profession should be.

We will not only be positive role models as individuals but we will be an institutional role model. Why should we settle for anything less ?

That to me is what 3D is all about.

The challenge that we face with 3D is that to many the process feels intrusive, and it is new to our culture. One reflex is to dismiss a process like 3D on the grounds of academic freedom.

But I suggest that one cannot sus-

tain academic freedom unless we attain the culture described above and that 3D is a mechanism for preserving all that we hold most dear.

If we are not mindful, 3D can indeed be done in a fashion that is intrusive; that is what I think is so important about the relationship-centered care program that we are simultaneously pursuing. 3D without RCC can become a divisive, big brother imposition.

If we do 3D in a relationship-centered way, it becomes a way to break down barriers and to be more open and honest with one another. I hope that we all agree that we'll have a better ethos and culture if we can get away from a system where everyone thinks that everyone else has a better "deal" and that all their energies must be directed toward the next "deal."

By being open and willing to reveal our needs and challenges to others, we can create a sense of oneness across the whole school wherein there is true joint problem-solving and priority-setting.

A relationship-centered 3D process can position us for a better future by creating a team-oriented culture where we all work together towards common goals and then celebrate each others successes.

I believe that the character and quality of our faculty are such that we can do this better than anyone else and in doing so create the foundation that will be integral to our future success.

Help Out at the Next Open Forum

The next RCCI Open Forum is scheduled for May 24th, from 4:00-5:30pm. Open Forums inform the IUSM community about RCCI and solicit input for future direction. Please contact Dave Mossbarger if you are interested in helping with this event.